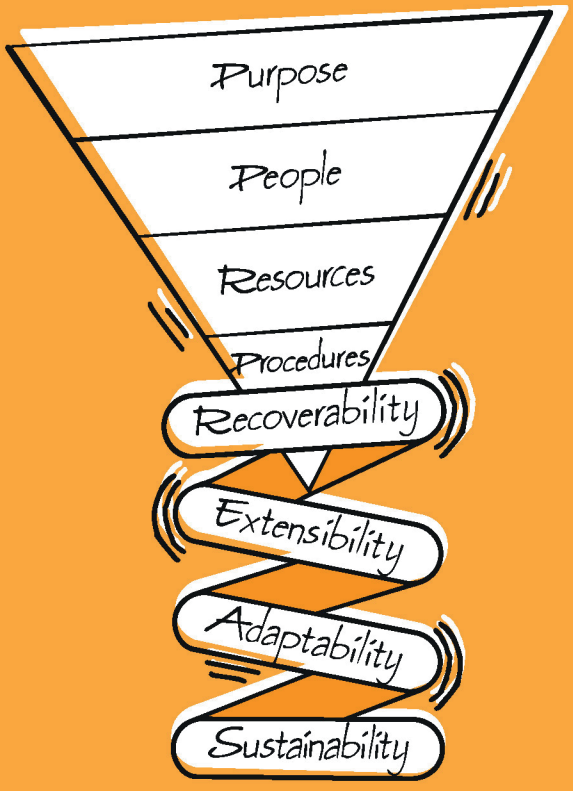
embrace uncertainty

121 Suggestions for More Organisational Resilience



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Foreword

By Carsten Busch

When I started working in safety — in the early 1990s — 'resilience' was a word reserved for other domains. Physicists, athletes, and car mechanics sometimes talked about it. You wouldn't, however, find it in the textbooks of the Higher Safety Studies programme I attended. Back then, 'risk' had just entered the field of occupational health and safety through tools like the Risk Inventory & Evaluation (RI&E).

Another concept that emerged around that time was the hierarchy of controls anchored in the law. Elimination at the source was considered the highest form of prevention. Over the years, especially in my recent roles within the police force, I realised that while prevention is desirable, it is not always feasible or practical. Some things simply cannot be prevented — a police officer, for instance, will always have to anticipate a degree of violence. Prevention also requires knowledge we don't always have. We can't foresee everything, making prevention difficult. Lastly, there are things we choose not to prevent because doing so would be too costly or would hinder other goals.

If we can't or don't want to prevent everything, we must look for other measures that limit the consequences. Think of your car's crumple zone, seat belts and airbags. We must also learn to deal with hazards, and in particular, with the variability that comes with a complex world. That's where resilience comes in. Through resilience, we adapt our behaviour, detect signals from our environment, and respond appropriately. When something unexpected happens, resilience helps us adjust so that things still go well.

Resilience is important, but it also has several pitfalls that I'd like to address here, drawing on my previous work. It may seem odd to find cautionary notes in a book on resilience, but think of them as a leaflet you read before use. These challenges stem in part from the popularity of the term. Buzzwords quickly

lose value when they appear to mean everything and nothing. Think of 'safety culture,' which often becomes a hollow phrase or a term used by managers and consultants merely to impress.

It is a misconception that resilience is inherently a good trait. Many negative phenomena—like diseases, terrorism, racism, and crime—are highly resilient. Another problem is what I call 'hearing the bell but not knowing where the clapper is.' Some people think resilience is just another word for safety or a synonym for risk management, and that traditional risk approaches are no longer necessary. Resilience is also not the same as improvisation. Improvisation can be a form of resilience, but resilience always requires some preparation. How do you know whether the improvisation was successful? Workarounds that help in the short term may have negative long-term effects. Too much apparent resilience can also turn into recklessness. Nothing is infinitely stretchable. At some point, limits must be drawn, yet assessing resilience is difficult. Often, we only know after the fact whether we were resilient enough.

Perhaps the greatest pitfall is the illusion that if something ends well, we were resilient. Things often go well despite what we do, not because of it. Sometimes there's spontaneous resilience, in spite of the system. Think of the boy who put his finger in the dike. The presence of resilience through individual initiative can also mask weaknesses in a system. A system may appear stronger than it is because people make sure things that don't really work go unnoticed. Often, the effort of individuals hides the true weaknesses of a system, and when that effort falters, things tend to go wrong.

Another trap is the normative use of resilience—for example, incorporating it into regulations or standards. This often leads to behavioural approaches – where individual behaviour is targeted without providing resources – to a blame culture – in hindsight, you can always say someone should have been more resilient – and to a shifting of responsibility to the weaker parties. We see this particularly when resilience is used in governance by so-called 'retreating governments'.

Despite these limitations, challenges and pitfalls, resilience remains a valuable addition to other approaches to risk management. This book offers excellent tools in that regard. Let's get started!

Carsten Busch is a Safety Mythologist, known as *The Indiana Jones of Safety*. He is an expert in safety, risk and human factors. He has a critical and innovative perspective on safety and quality management. As an author and speaker, he challenges professionals to look at safety and quality differently, using sharp insights and a provocative style.

Carsten lives and works in Norway and is affiliated with Lund University. He has written several books, including *Safety Myths 1-2-3* (2016), *If You Can't Measure It... Maybe You Shouldn't* (2019), *The First Rule of Safety Culture: A Counter-C-Word Manifesto* (2021), and *Risicoflectie* (2023). He also owns mindtherisk.com and is active in various professional forums, including Arbo-online and the Dutch Society for Safety Science (NVVK). He is currently working on doctoral research on the adoption of safety concepts.

People are less foolish than we sometimes think.

Most people do not want to make mistakes, and most do not expect to when they do.

Mistakes arise when ordinary people respond in ordinary ways to the circumstances they face.

People act from a drive to succeed, but with limited time, knowledge, resources, and information. And without knowing in advance whether things will go well.

Humans have resilience and adaptive capacity by nature. They make things work, even when systems do not, despite our attempts to force them into rigid rules and procedures.

Relying on people not to make mistakes is naive. If we do not wish to be surprised, we must change how we deal with people and with mistakes.

We cannot change the human condition, but we can change the conditions under which people work.

Gerben Bekooy

Preface

Wrestling with Safety Work

Wrestling with **safety work**

Why do we do what we do in the name of safety?

Why do people not always follow the rules? Why do we immediately look for someone to blame when something goes wrong? If someone ignores a rule, does that make them a bad person? And if good people also bend the rules, what does that say about the rules themselves? Why do things almost always go right, even when not every rule is followed?

Why do we keep churning out new rules, laws, procedures and standards that hardly anyone actually knows? Why do we keep doing risk analyses without asking what they really add? Why do we turn everything into a KPI? Why can hardly anyone explain what 'culture' actually is, yet we are eager to measure it? Why do we copy and paste old project plans, tidy up the day before an audit and tick off checklists, while we so rarely check whether any of this is actually effective? And how do these activities, this *safety work*, really contribute to better results, to the actual *safety of work*[1], and to our ability to deal with an uncertain and rapidly changing world?

These questions follow me through organisations in my role as a *corporate jester*[2]. The gap between what is written on paper and what happens on the shop floor is growing. Many people recognise this. But do we talk about it enough? And, more importantly, are we willing to act on it?

Kayfabe – Pretending it is real and not talking about it

We all know wrestling icons like Hulk Hogan or John Cena. We also know the fights are staged. WWE even changed its name from World Wrestling Federation to World Wrestling Entertainment. Yet we still watch.

Former wrestler Nick Rogers put it well: "We'll present you something clearly fake under the insistence that it's real, and you will experience genuine emotion.

Neither party acknowledges the bargain, or else the magic is ruined." This shared illusion, where everyone silently agrees to act as if something fake is real, is called *kayfabe*[3].

> Kayfabe is the tacit agreement between professional wrestlers and their fans to act as if openly staged wrestling events, stories, and characters are real.
>
> Merriam-Webster Dictionary

How long have we known that we are watching a scripted show?

Not long after professional wrestling began, the media already suspected it was scripted (Griffin, 1937). Winners and storylines were predetermined. Wrestlers were paid to play their roles and even continued them outside the ring, amplifying disputes in public. Newspapers eventually stopped reporting wrestling results, yet WWE grew into a billion-dollar industry.

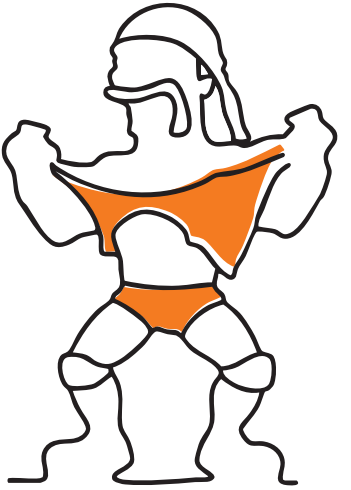
With the rise of the internet and social media, it became obvious that wrestlers were different people in real life, that injuries were often staged and that supposed enemies were friends. Still, interest did not decline.

Why? Because kayfabe is a *form of respect*. Wrestlers know that fans pay for the illusion, so they protect it. Kayfabe became the way to protect the business model. We love the illusion. Former wrestler Al Snow calls kayfabe "never stop selling the gimmick". If we keep selling the gimmick, we keep doing what we always did. Kayfabe protects the status quo, even when everyone knows it is not real.

Kayfabe is silence

Today the term stands for keeping reality hidden. It is the polished Instagram holiday, politicians with 'no active memory', conveniently leaked budget plans, the omertá in professional cycling about doping. We know we are fooling one another, and we stay silent.

Kayfabe safety



The parallel with many safety practices is striking. We also *perform* safety. We complete procedures, reports and checklists not because they always work, but because they give the illusion of control. Like wrestlers, we rarely speak about what we know to be fake.

Much of what this book describes, such as certification rituals, risk matrices and paper systems, can be understood as safety kayfabe. We create the illusion and we do not talk about it.

Impression management

Erving Goffman (1956, 2022) showed that people play roles everywhere. We adapt our behaviour to shape how others see us. He calls the polished side we show to others the front region. Behind it lies the back region, where we can be more honest, make mistakes and be ourselves.

Teams collectively maintain this performance. They hide errors or backstage realities to preserve harmony, avoid blame and manage expectations. The same dynamic shapes safety management. Tools and surveys that claim to 'measure safety culture' or compliance are strongly influenced by *impression management*. People give the answers they think are wanted, often out of fear of negative consequences. The data then reflects appearances, not reality.

Suppressing uncertainty and anxiety

In his keynote *False Assurance* at the EHS Congress 2024, Drew Rae argued that the primary goal of much safety work is not safe work, but the *reduction of tension* and worry about unsafety. Safety work becomes a way to suppress the uncomfortable feeling of uncertainty.

We design activities to show that everything is under control: risk registers,

bowties, audits, dashboards. They create demonstrated safety, the appearance of safety, but not necessarily safer work. Once you see this, it is difficult to unsee.

Willful blindness

Margaret Heffernan (2011) calls this willful blindness, or *conscious avoidance*: turning a blind eye to what we suspect, in order to feel safe, avoid conflict, reduce anxiety or protect status. It feels good in the short term, while longer-term consequences remain unseen. Heffernan argues that the biggest threats we face are not those that are invisible, but those we refuse to see. *We are willfully blind to uncertainty*.

Who is fooling whom?

In wrestling they say that with kayfabe you sell the result. The result we sell each other in organisations is the *illusion* that we are safe and resilient. Kayfabe maintains a pseudo-reality. Everyone pretends that safety work is real, effective and rational, and we do not talk about the gaps. But why keep this up? Kayfabe does not make us safer, more resilient or more successful.

More troubling is what sociologist Riesman (2024) calls *neo-kayfabe*: the spreading confusion between truth and illusion in modern society. With AI, deepfakes, social and geopolitical unrest and misinformation, it is increasingly hard to see what is real. Inside organisations the same confusion arises. We see through the illusion yet say nothing. It becomes less clear when we are being fooled and when we are seeing reality.

> Demonstrated safety and kayfabe reduce worries about unsafety and suppress the feeling of uncertainty. We sell the illusion that we are safe. We must stop that.

Moral friction

Maintaining kayfabe creates moral friction. More people see that the facade is fragile and that they are part of maintaining it. The more we talk about this, the more it feels as if we contribute to deception, pseudo-certainty and

a culture of silence, and thus to less success, less quality and less safety. How long do we want to keep fooling each other?

The power of the less powerful begins with honesty

Kayfabe only breaks the moment we admit that the scripted story is not the real story. In his now famous lecture at the World Economic Forum 2026 in Davos[4], Canadian Prime Minister Mark Carney urged us to let go of our "hope that compliance will buy safety" and to tap into our *"capacity to stop pretending"*. He called on countries to "take the sign out of the window", referencing Václav Havel's essay *The Power of the Powerless* (1978[5]), and to "stop invoking the rules-based international order as though it still functions as advertised."

In our organisations, we face the same choice: either we keep performing re-assuring rituals, or we use that capacity to stop pretending and invest our scarce time and attention in the messy, practical work that actually builds resilience.

Honesty, candour and trust

What we need, as people and as organisations, is honesty, candour and trust. Unexpected events happen every day; the world is not simple.

Outside the organisation we face wars, inflation, shortages, climate and energy crises, migration and political indecision. Inside we face burnout, staff turnover, broken promises, missed targets, disengaged teams, demanding clients, failing suppliers and boards pushing hard for results.

To stay relevant and healthy we must stay alert and *keep adapting*. Many organisations already show an impressive ability to cope with these pressures. Let us not pretend everything is bad: most of us genuinely deserve a compliment for how we have made things work in recent years. Resilience is already there; the challenge is to keep it alive in a world of growing uncertainty – and that starts with the courage to stop pretending.

Embracing uncertainty

Uncertainty is the central character in this book. Geo-economic confrontations and trade wars, shifting military power balances, a relentless technological

race and a constant stream of mis- and disinformation mean that the future can no longer be predicted from the past. For organisations this uncertainty is not a temporary disturbance but the normal operating condition. The question is no longer how to eliminate it, but how to recognise it early and remain effective when it hits. This book argues that *embracing uncertainty*, seeing it clearly, talking about it honestly and designing resilience into our systems and relationships has become a core leadership task.

Organisational resilience

What exactly is *organisational resilience*? Where does it come from? How can we strengthen it? What role does our safety work play? Do we really know what makes our organisations resilient, and what undermines that resilience? The better we understand this, the more consciously we can build resilience. The question is whether we are resilient enough for future adversity, or whether kayfabe quietly erodes it.

As turbulence and complexity increase, themes such as psychological, social and emotional safety, integrity and inclusion become more important. They are closely linked to the central topics in this book: people, the position of rules, controls and systems, and the suggestions for approaching them differently, so that we achieve more resilience, safety and success.

> Paraphrasing Havel: "The power of the powerless in organisations lies in their willingness to stop playing along with the lie and to live the truth in their daily work."

The purpose of this book

This book is a call to action: let us build more resilient organisations. By re-examining how we manage safety and quality, and by putting scientific research next to everyday practice, we can design better systems. This is not about chasing trends, but about regaining curiosity. Asking better questions. Approaching work with humility, curiosity and appreciation.

Most suggestions in this book are based on research and on the principles of *Human and Organisational Performance* (HOP), *Resilience Engineering* and the various *New View Safety* movements.

Criticism of 'New View Safety'

'New View Safety' also receives criticism, for example from Cooper (2022), Le Coze (2022) and Karanikas and Zerguine (2024). They note that it is logically attractive but often abstract, that learning from everyday work can clash with regulations, that evidence is still limited, that measurement is difficult and that practical guidance is sometimes vague. In short, it is not always clear what to actually do.

These criticisms are not unfair. There are many frameworks, models, theories and standards. Whether they help depends on context and on trust. George Box famously said that all models are wrong and some are useful.

With that in mind, this book aims to make organisational resilience more practical and usable. If what we do is not working well enough, we must be willing to adapt. Many so-called new insights are not new at all. The real risk is old wine in new bottles. What matters is the Purpose behind our methods and the mindset with which we apply them. This book does not replace traditional risk management, but reframes it to better support organizational resilience.

> New View insights should provide more certainty that traditional safety management practices work.

Moral justness

Dutch poet Lieke Marsman (2025) observed that we often confuse acting within bureaucratic, rule-based systems with acting in a morally and rationally just way. That confusion contributes to today's tense and ethically flawed world.

Hannah Arendt made a related point. Much harm does not stem from malicious intent, but from the absence of critical thinking. For more resilience we need

moral justness. We need to 'get back to *the Purpose*'.

> Do not fight what you don't want. Fight for what you do want.

Not every suggestion in this book will be equally useful for everyone. My message is: choose what fits and make it your own. If this book sparks discussion about the sense and nonsense of how we manage organisations, and if it serves as a stepping stone toward better practices and more resilience, then it has done its job.

I hope the suggestions help to make safety work, which sometimes feels like a chore, more useful and effective, and more focused on the safety of the work itself. We need more attention for feeling safe and being safe, and for being better prepared for the unexpected. That is resilience.

Structure of this book

The book consists of three parts.

- Part 1, chapters 1 to 6, explains what organisational resilience is and why organisations are not always resilient.
- Parts 2 and 3 offer 121 suggestions for increasing resilience through practices and building blocks in operations and management systems.
- Part 2 focuses on reducing compliance and control activities that may undermine resilience.
- Part 3 focuses on activities that build trust and craftsmanship, and thereby resilience.

Each chapter in parts 2 and 3 can be read independently. This is not a story you must follow in sequence. The 121 suggestions are numbered consecutively across Parts 2 and 3 so you can refer to them easily.

For whom?

This book is for anyone who wants to build more organisational resilience. It is meant for members of management and leadership teams, for those responsible for the quality or safety of work, for operational managers and supervisors, and for anyone who is curious about how work is organised and how its governance can improve.

The book aims to shift the focus from doing safety work to achieving the safety of work and to update our understanding of what makes organisations resilient. It is written for everyone, from the boardroom to the shop floor and everywhere in between, who feels the need to take the red pill and break the pattern.

Reading guide and definitions

Health, risk and safety

In this book, safety is what we do to protect people's health and well-being. *Health* means the physical, mental and emotional well-being and capacity of people. *Risk* is the potential for harm to that health in the way we design and organise work and in the conditions in which work takes place. *Safety* is the deliberate set of actions and controls that remove or reduce those risks and that strengthen the conditions in which people can do their work well. Health is influenced by risks and moderated by safety. This definition is based on Karanikas and Zerguine (2025).

Safety is therefore multidisciplinary. It is about far more than operational rules and measures. It includes the safe design of products, processes and workplaces, collaboration, freedom, trust and how we deal with uncertainty. It is about reliability, integrity and belonging, about being physically safe and feeling safe, including psychological, social and emotional safety.

Safety is not a fixed state but an ongoing dialogue and alignment between everyone involved. It spans technical, social, psychological and biological dimensions and contributes to job satisfaction, work quality, health and sustainable results. In this way, it supports organisational continuity and is a core element of resilience. As Flinterman (2025) notes, safety is a living process: a constant negotiation between freedom and duty, rules and adaptation, perception and judgement.

Ultimately, safety is a practical consensus among stakeholders. What is seen as safe in one context may be regarded as unsafe in another.

The Purpose

The Purpose is what the organisation stands for. It is our ambition and what

we want or need to achieve. Others might call this *the Why* or *Commander's Intent*. In this book, I consistently use the term Purpose.

Management

Management refers to anyone in a steering role who is responsible and accountable for operations and who has significant influence, authority and a duty to realise the Purpose. That duty is not only legal, above all it is moral.

Employees

Employees are all people who work in or for the organisation: permanent staff, temporary workers, subcontractors, freelancers and volunteers.

Safety manager

The term safety manager is used broadly. It includes roles in safety, health, quality, information security and environmental management, often combined under labels such as QHSE. Safety managers are typically responsible for implementing and maintaining management systems, for compliance and certification and for keeping those systems alive and kicking.

It is not an easy role. In many organisations these functions sit at the edge of core operations and must fight for support, decisions and resources. Safety managers often have limited authority. They do not lead teams, do not purchase equipment and do not select contractors, yet they are held responsible for employee safety. Legally they are responsible for their advice, not for execution, but in practice, they are often treated as if they own the outcome.

System

In this book, a system is a collection of interconnected components or parts that work together to deliver a joint performance. In other words, a group of elements or functions that operate as a whole to fulfil a specific Purpose or objective. That is how Deming (1994) defined it.

> The more important question is not what a system is, but what a system does.

Note 1: Local applicability

For every statement in this book, it is understood that it may not apply everywhere and always, but that it is common or frequent. The wording reflects this. The aim is not to attack or insult employees or organisations. Fortunately, there are many organisations where things are done consciously, consistently, effectively and resiliently.

Note 2: The use of AI as IA

This book was originally written and published in Dutch in 2023. It was tempting to use AI tools for the translation, and I tried. The translations were technically strong, but they lacked my voice and emotion. They did not evoke the response I intended.

Using artificial intelligence too much can be like asking the chef to cook for you, serve the food and then eat it on your behalf. You receive none of the nutrients yourself. The struggle of rewriting and translating this book has made me a better version of myself. That process, however, is invaluable.

I now use AI as IA, as my Intelligent Assistant. It supports my thinking and writing, but it does not replace them. Understanding cannot be outsourced. Nor can being human.

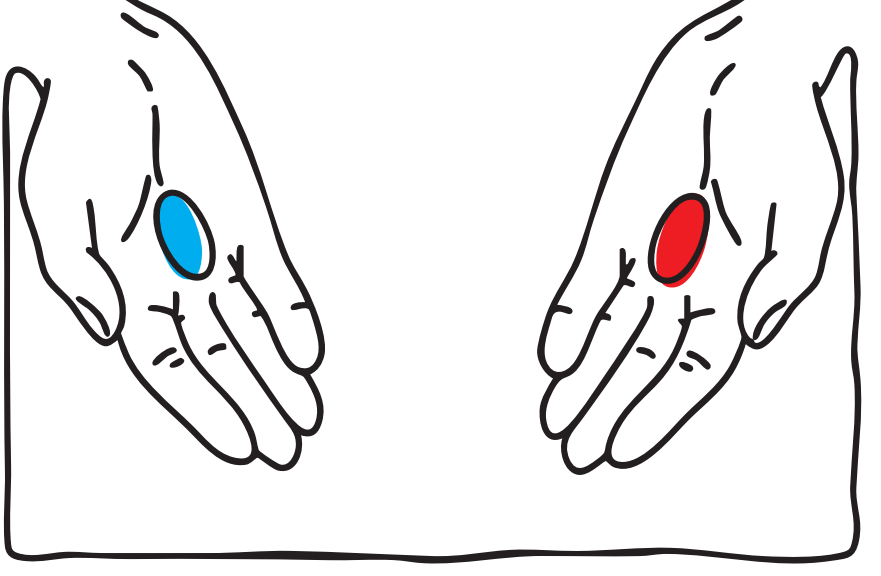
AI does not take responsibility. What is true for me is true for organisations: AI transitions rarely fail because of technology, but because of leadership – unclear boundaries, postponed responsibility and silence where dissent is needed.

> Understanding cannot be outsourced. Being human cannot be outsourced. The struggle of the process, though, is invaluable!

That, in the end, is what this book is about: being human and treating each other as human beings. I hope you will read it in that spirit and forgive me where my English is not perfect.

PROLOGUE

Juan, if we had not had you



"Juan, if we had **not** had you"

I recently met the technical service team of a factory. At the heart of their operations is a blast furnace with a large tank of thousands of litres of oil underneath. The process is driven by several failure-prone pumps that must keep running. If one fails, it has to be repaired or replaced within hours. Otherwise, the pump can overheat, the oil can ignite and the whole hall can burn down. That has happened before.

Everyone knows that these pumps are the most critical part of their work. Technicians receive extra training, procedures are strict and checks are carried out several times a day. On paper it looks solid. Yet in our conversation I mainly heard fear. Their nightmare is being alone on a night shift when a pump fails and feeling that the whole factory sits on their shoulders.

In the Spanish branch you will find Juan, 62, who has been with the company for forty years. He has no formal degree, but immense experience and tacit knowledge. He is a maintenance technician, just like the others, but he knows the pumps in a way the manuals never will. When he walks into the hall, he can hear how they are doing. Certain sounds, rattles and vibrations tell him when a pump is drifting toward failure. He fixes problems before they appear.

When management realised how valuable Juan's nose for trouble was, his job changed. He began visiting other sites as a technical adviser, sharing what he had learned. In the last years of his career, Juan moved from being an invisible 'unskilled' worker to a respected mentor, coach and friend of the whole company. Juan the craftsman. Juan who creates trust.

Juan is (not) The One

There are thousands of Juans. Almost every organisation has one, often more. Juan is the person everyone calls when there is a problem. Juan solves it. The fact

that he does not always follow the rules does not bother us. He has earned a lot of goodwill. He gets us out of trouble. He gives people comfort. Around him, others thrive. "Juan, if we had not had you." Juan gives the organisation resilience.

The choice we face

Roughly speaking, we have two ways to run our organisation. We can embrace Juan's craftsmanship and give him trust and freedom to do his work as he thinks best. Or we can insist that he must follow the rules like everyone else.

If we choose the first path, we fear losing control. What if Juan makes a wrong call? What if he cuts a corner once too often? So, we tighten the rules, add checks and keep him under closer supervision.

But when we manage our Juans this way, we frustrate them. They are not children and they do not need policing. They need good tools, information, time and trust. Tight monitoring does not motivate them to work better. Often it does the opposite.

This tension between centralised control and craftsmanship has been around for a long time. In the first view we assume that success follows if people stick to plans and procedures. In the second view we accept that unexpected events are normal and that people must adapt plans, shortcuts and methods to make things work.

The more we rely on plans and procedures alone, the less able we are to adapt to surprises. In an increasingly complex, dynamic world it becomes impossible to keep everything planned, controlled and measurable. The trap is this: the more we push for control, the more we default to rules, the more often we are surprised and lose control. Our system becomes brittle.

Guided Adaptability

Hollnagel and Woods (2005) describe the paradox sharply. People are both good at causing errors and good at preventing and recovering from them. We are *saints and sinners* at the same time. Research and practice show that the two views can be bridged (Woods, 2023). That bridge is guided adaptability, a central

theme in this book and explained in more detail in chapter 6.

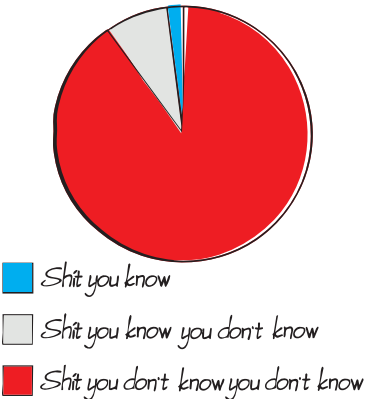
Guided adaptability means building people's ability to sense change and risk and then supporting them in decision-making. It is about helping employees deal well with uncertainty, variation and unexpected situations. We give trust and recognise craftsmanship, while still offering direction and boundaries. It is not 'letting go'. *Guidance is the key word*.

Guided adaptability requires a different mindset. It asks leaders to *embrace uncertainty* instead of fighting it with ever more rules. Done well, it makes organisations more resilient.

Do we choose the blue pill or the red pill?

This dilemma between rules and trust reminds me of *The Matrix*. Neo is offered a choice. Morpheus tells him: "You take the blue pill, the story ends. You wake up in your bed and believe whatever you want to believe. You take the red pill, you stay in Wonderland, and I show you how deep the rabbit hole goes. All I am offering is the truth."

The blue pill means staying with what we have always done. Command and control. The comfort of checklists, dashboards and procedures. The five percent 'shit you know'. The red pill means opening up to the 95 percent 'shit you do not know you do not know': *unknown unknowns*. It means being willing to see how things really work and what else could be possible. Do we cling to the apparent certainty of the blue pill, or do we embrace uncertainty and choose the red pill?



Embrace the Red, Question the Green

This book is an invitation to choose the red pill. The red pill stands for the journey toward more resilience and guided adaptability. The blue pill stands for *centralised control*, box-ticking and green dashboards that hide red realities.

Choosing the red pill means breaking kayfabe: stopping the collective pretence that our safety work and paperwork automatically make the work itself safe. It means re-examining how we deal with risk, compliance, KPIs, inspections, audits and people like Juan. It means putting Purpose, learning from everyday work, candour and craftsmanship at the centre. Less compliance and control, more trust and guided adaptability.

Choosing the red pill is necessary, but not easy. It is not a project with an end date; it is a journey. Many of us earn our living maintaining the current way of working, just like wrestlers who keep selling the gimmick. The question is: how long do we want to keep pretending?

> "It is difficult to get a man to understand something when his salary depends upon his not understanding it."
>
> Upton Sinclair

Suggestion 1: *Choose the red pill, make kayfabe visible, and work to eliminate it*

Break the silence. Look honestly at where kayfabe and demonstrated safety appear in your organisation. Where do you act as if everything is under control while you know the system is fragile? Make that gap tangible with examples:

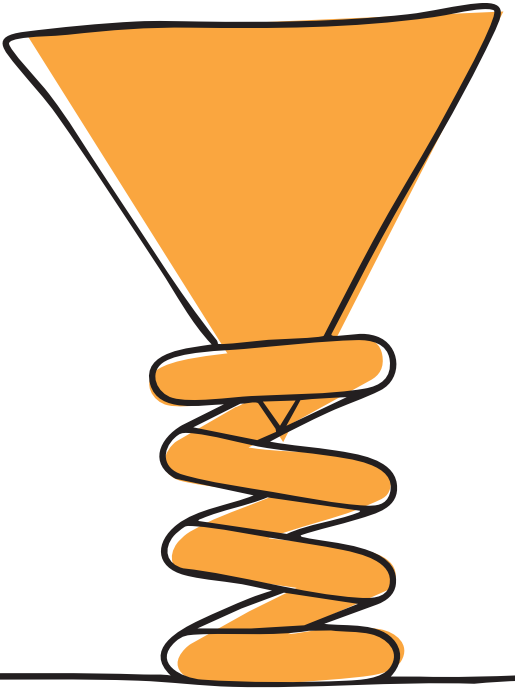
- Where does safety work (forms, procedures, audits) diverge from the safety of work in practice?
- Where do you manage to impress auditors and clients while employees still rely on last-minute heroics?

Name these patterns. Show them. Use them to explain what really creates resilience and what it requires. Then choose a few suggestions from this book that fit your context and define a route for your journey.

Choosing the red pill means committing to build more resilience in your organisation, step by step, with Juan and his colleagues in the lead. It also means accepting uncertainty as the normal operating condition and using our Purpose as the compass for how we respond.

Chapter 1

What is organisational resilience?



1 What is **organisational resilience?**

What is organisational resilience?

Resilience is an *organisational capability*. It consists of positive, proactive activities aimed at being ready for situations you cannot truly prepare for. Resilience is the embedding of necessary adaptations to absorb unexpected, often complex future events. Resilience is not something an organisation has; it is something it does. In that sense, resilience is a verb, something we continually work at.

Following Woods (2015), organisational resilience shows up in *four cumulative abilities*. Each subsequent ability only works if the previous ones function well.

The four abilities that demonstrate resilience are:

- Recoverability – the ability to observe adversity and adjust or bounce back before things go wrong.
- Extensibility – the ability to absorb unplanned events and continue or extend operations while things go wrong.
- Adaptability – the ability to continuously adjust to the situation to achieve intended results.
- Sustainability – the ability to continuously learn from adversity and improve operations.

Recoverability – the ability to observe adversity and bounce back

Recoverability is the ability to notice that something is going wrong and to intervene before it escalates. It depends on taking *weak signals* and *early warnings* seriously and acting on them proactively.

embrace uncertainty

Things will go wrong. The real question is how well we can still protect our people and their work when they do. In an age of uncertainty with geopolitical shocks, technological disruption and information chaos, more rules and KPIs no longer keep us safe. Much safety work now suppresses uncertainty instead of facing it: box-ticking and paperwork that create an illusion of control while weakening real protection.

Embrace Uncertainty offers a different path. Drawing on research and real cases, it clarifies organisational resilience and gives 121 practical suggestions to design systems that bend without breaking and to shift from doing safety work to achieving the safety of work.

For leaders, safety and quality professionals, and anyone ready to trade compliance theatre for real resilience.

gerbenbekooy

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