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Introduction

When I began this essay, a television in the background was continually broadcasting a request for doctors and nurses to report to hospitals in the San Fernando Valley section of Los Angeles. Another earthquake had occurred, and local radio and television stations discontinued normal programming to report the disaster. Helicopters gave us aerial pictures of collapsed freeways and burning homes, field reporters interviewed victims waiting stoically for treatment in the parking lot of a damaged hospital, and in-studio anchors summarized the tally of deaths and damage. This stream of pictures and words was interrupted not by the usual commercials but by briefings from earth scientists, telephone conversations with spokespersons for a variety of public agencies and pledges of government assistance from politicians. The risk of earthquakes, normally part of the stereotype of a future "Big One," was on display at every integer of the TV remote control.

In the aftermath of that catastrophe, a story line appeared that also usually follows accidents and disasters associated with technological hazards. Reporters once again discovered that safety — the inverse of risk — is administered by formal organizations. Actions and inactions, decisions and non-decisions were examined much in the manner of the play-calling of football coaches by Monday morning quarterbacks. In the aftermath of catastrophe, some of those actions and decisions took on meanings they would not have had otherwise. Several writers have commented on this process, which I will call "coupling" to emphasize its logical structure.

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Selectivity in Coupling Organizational "Causes" with Catastrophic "Effects"

Two examples of coupling appeared in the local news here in January 1994. One involved the December 15, 1993 crash of a corporate jet in which the five people on board were killed. The pilot lost control while following a Boeing 757 on final approach to the runway; the crash was attributed to turbulence created by the jetliner. Subsequent reporting by the Los Angeles Times disclosed that the federal agency which regulates the airline industry, the Federal Aviation Administration (FAA), had known about the turbulence problem associated with Boeing 757's for more than two years but had taken no action. One week after the December 15 crash, the FAA issued a directive to all domestic air traffic controllers that they give wake turbulence warnings to pilots landing behind 757's. The Times quoted several experts and officials on the FAA's "dilemma" in assuring the safety of commercial air travel on the one hand while promoting the economic well-being of the airline industry on the other.

The second example of coupling comes from one of the many stories arising from the January 17, 1994, Northridge, California earthquake. The Los Angeles Times on January 27 (at A1 and A24) reported that less that 10% of $376 million dollars generated by an increase in property taxes in 1990 specifically designated for seismic safety improvements had been spent at the time of the earthquake. Similarly, only $53 million of $229 million raised for earthquake retrofitting projects by two earlier voter-approved bond measures had been spent. Reporters described the money as "languishing" in the city treasury. Officials quoted in the article offered differing reasons for the ratio of spent to unspent funds. City department heads pointed to a lack of sufficient staff to draw up plans, write bid specifications and monitor contracts at a more rapid pace. They also noted the many checks-and-balances built into the process of contracting publicly-funded projects. City council members in contrast complained about a lack of leadership at the departmental level and asserted that their

refusal to authorize the hiring of additional staff reflected their intent to hold down the size of city government as well as to ensure that money raised for seismic projects was preserved for direct costs. The article was interspersed with examples of earthquake damage suffered by the types of publicly-owned structures that were targeted for seismic updating under these programs.

Both of these examples identify an aspect common to reporting about risks that have suddenly been realized in the form of accidents and catastrophes. In hindsight, the catastrophe or some aspect of it is depicted as having been caused by some characteristic of a formal organization. The link between organizational "cause" and catastrophic "effect" becomes a "working hypothesis" that shapes news coverage of the event. Working hypotheses provide a framework explaining to journalists and their audiences alike why things happened, serving as definitions of the situation or quasi-theories. The causal chain formed by coupling disaster with some prior organizational trait also influences the assignment of blame and political responsibility.

Working hypotheses connecting organizational characteristics and disastrous outcomes differ from formal research hypotheses. No empirical evidence is ever presented with which they might be tested. Their plausibility and the stature of news sources who endorse them seem to be the principal forms of "confirmation." Indeed, in most cases it is hard to think of any way to apply standard research methods to evaluate them empirically. In the FAA illustration, for example, wake turbulence testing has been done on the Boeing 757, and other crashes attributed to 757 turbulence have been documented. However, these data suggest only that the physical effects of one type of aircraft can be a risk to lighter and smaller airplanes following in its wake. The two working hypotheses linking *organizational* phenomena and accidents remain untested. One hypothesis is that the failure of the FAA to issue a wake-turbulence warning caused the accident. The other is that the goal structure of the FAA causes aircraft accidents. The coupling of refusal to act on available information and aircraft crash seems like a plausible hypothesis. However, there must be thousands of other

instances in which the same organization chose not to issue a safety advisory that have not — or have not yet — been linked by reporters to a tragic event. And the hypothesis coupling the agency's goals with accidents ignores the fact that the interests of groups concerned with safety and those of profit-making organizations like the airlines will conflict regardless of how the agency is configured.

The most troubling aspect of this process of coupling in news work is its selectivity. Working hypotheses are nearly always monocausal; the events they endeavor to explain seem more complex. An alternative view of cause and effect would assume that everything people do on behalf of the organizations responsible for administering safety is part of a continuous and complex causal sequence winding through and beyond any catastrophe. In this view, singling out one or two antecedents as causes is a social (some might say political) rather than "scientific" process. It raises several important questions about how working hypotheses develop in news coverage of technological hazards and disasters, most importantly: What kinds of actions are selected for coupling with a catastrophe?

The more proximate the act, the more likely it is to be coupled with some catastrophic outcome. Proximate acts have two characteristics. They are proximate in the sense of being located in time closer to the outcome that they are alleged to have caused. Less proximate acts are those that took place farther back in time. However, this temporal dimension masks a more important aspect of proximity. Proximate acts are those carried out at the "lowest rung on the ladder." Proximate acts are the things that operators and inspectors do, for example. It is this aspect of proximity that is reflected in empirical data showing operator error to be the most frequent officially-selected cause of many types of technological accidents.

When the same hypothesis is stated in reverse, the selectivity of coupling becomes more evident. That is, the less proximate the act, the easier it is for those associated with it to resist being coupled with a disastrous outcome. In the (greatly simplified) hierarchy enveloping

public organizations, operators and inspectors take orders from supervisors who in turn are managed by department heads whose bosses are the elected officials who "work" for the voters. The ability to deflect causal responsibility for harm roughly parallels this hierarchical arrangement. In the FAA example, voters' desires for "doing something about the economy," travelers' preferences for convenient departure times and inexpensive air fares, international events involving U.S. diplomatic and military intervention as well as wake turbulence data on Boeing 757's could all have been coupled with the crash in California, but only the last emerged in the working hypothesis in stories about it.

Two intervening variables further elaborate the hypothesis of proximity and causal coupling. One is the collection of "heroes, villains and fools" available in the cultural repertoire at a given time. Public organizations (bureaucracies) and the people who work in them (bureaucrats) currently have an especially negative reputation. Politicians who otherwise might have their own image problems have little difficulty casting themselves in the role of heroes vis-a-vis "the bureaucracy" in interviews with reporters. For example, it is much easier for us — and for journalists — to envision ineptitude, incompetence, or even corruption in what building inspectors do during a typical work day, for example, than to see their frequent arguments with homeowners, contractors and developers as "heroic struggles" to increase seismic safety. Similarly, it is easier to see those who recommend against taking immediate action concerning 757 wake turbulence as "captives" of the aviation and airline industries than as professionals who have doubts about the quality of existing data, the adequacy of previous tests, or whatever. In contrast, "heroes" are more likely to avoid becoming causally linked to catastrophic outcomes in the news. In the Northridge earthquake, some collapsed freeways had been assigned low priority in a seismic strengthening program based upon recommendations by earth scientists (about the only cultural heroes in this area). Yet, the decision by government officials to prioritize rather than the recommendations of scientists was coupled with collapsed freeway bridges in news reports.

A second intervening variable further elaborates the hypothesis relating proximity and coupling. The longer a story containing a working hypothesis runs in the news, the more likely that less proximate organizational acts will be coupled with the outcome. Even a proximate act such as the decision to postpone seismic upgrading can itself over time be coupled with a less proximate act such as voter preferences for reducing the size and cost of government. Long-running stories almost by definition mean that reporters have come up with a new "angle" or "slant." The passage of time allows reporters to explore how a sequence of events led to the act (e.g., the decision to postpone) that in hindsight had tragic consequences. The passage of time also allows news consumers to understand how more remote acts tie in with the act that has been singled out.

An Alternative View: Risk and Safety as Organizational Variables

In the public sector, risk is distributed across and through the organizations (public, for-profit and non-profit) that carry out public policy. (Markets distribute risk in much the same way in the private sector.) Safety is rationed within an interorganizational network as public attention and political priorities shift from one type of risk to another, as events make cooperation among organizations and public support for their efforts more or less likely, and as organizational resources are increased or withdrawn. Whatever level of safety public policy is able to achieve, it is accomplished in the everyday work routines of organizations.

Even though safety is not simply a function of resources, the allocation of resources is symbolic of the seriousness with which various risks are taken. Budget allocations described in dollar amounts provide an understandable metric of commitment even though the level of risk reduction they purchase is unknown. For example, increasing the budget for the building department by 10% when the budgets for other departments of local government are being reduced may show a commitment to deal with the threat of earthquakes even though no

measurable amount of increased seismic safety can be specified precisely. Likewise, performing three tests on wake turbulence rather than two seems like greater commitment to aviation safety, four tests rather than three even more so, etc. At some point, however, someone in an organization must decide when enough money has been spent on wake-turbulence testing. Someone has to balance the seriousness of wake turbulence against other risks such as the age of airframes, the combustibility of fabrics and other materials used within the cabin, and procedures for deicing aircraft during winter storms. These decisions and the controversies that erupt over them are about acceptable costs, not acceptable risks. Risk is determined to a very real yet unknown extent when decisions about costs are made.

Going one step further, organizations also deal with issues of "overhead." They may have little control over some components of overhead such as the costs of group health insurance and of hiring procedures that conform with affirmative-action laws. They do decide (within limits) how organizational resources are allocated. No organization commits all of its "troops" to the "frontlines." Not every member of the building department is an inspector or a blueprint checker, for example. Building departments also assign people to answer the telephones and take messages, supervise other employees, represent the department in budget meetings and engage in a variety of activities that support seismic safety but do not directly involve plan checking or field inspection. Whether resources consumed by managerial and support functions are "essential" or "excessive" can look different in hindsight than they would otherwise.

Consider the annual salary paid to a department head; it may look essential if the city is to attract a person well qualified for the job, but it may look excessive in the aftermath of catastrophe if that person's performance becomes coupled with negative aspects of the outcome. (The opposite is also possible; a salary that once seemed excessive can look like "money well spent" if coupled with positive aspects of some disastrous outcome.) Regardless, the qualifications of the building

department head are in some way connected to the level of seismic safety in a city, and the salary of the department head is in some way connected to those qualifications, hence to safety as well. The same is true for building inspectors and plan checkers. Is not the same true of support personnel; of the quality and quantity of vehicles the department is able to purchase; even the quality and quantity of telephones, pagers and fax machines that it is able to afford?

In short, risk is embedded in organizations in these and all the other characteristics of organizations as organizations. I therefore propose an alternative hypothesis: the characteristics of organizations as organizations determine levels of risk to which the public is exposed to a greater extent than does any single act or decision. Yet it is the single act that looks so decisive in hindsight. What are the consequences of treating risk in monocausal fashion, as occurs in the coupling process, rather than treating it as a variable property of organizations?

Blame Versus Policy Choices

First, the coupling that occurs in news coverage of technological accidents and natural disasters alike overestimates the certainty of our knowledge about risk. In hindsight, we know that following too close to a 757 on approach can cause accidents. We know that some structures which had undergone seismic retrofitting stood while others which had not collapsed. Focusing on what organizations did not do — failing to issue a directive, falling behind a previously-established time-table for bidding and awarding contracts — ignores the question of whether those actions would have prevented *that* crash or the collapse of *that* particular structure. More accurately, it implicitly answers the question in the affirmative.

Second, because the hindsight involved in coupling makes it appear that organizations had certain knowledge of what the consequences of their actions would be, the failure to utilize such knowledge needs to be explained. Not surprisingly, given the cultural context, journalists overwhelmingly seek out individuals to blame. Individual incompetence, ignorance, lack of sensitivity, or malfeasance become

explanations for risk. Sometimes news reports do portray individuals as being caught up in organizational structures. However, the negative images of organizations predominate: For example, organizations stifle individual responsibility and discretion; organizations foster a lack of concern for the public among employees; and interorganizational turf wars prevent the sharing of relevant information.

Third, because coupling steers blame toward some actors and away from others, it presents news audiences with a selective and partial description of causal responsibility. It fixes blame at the same time that it obscures accountability. Identifying those who are to blame is a consequence of coupling that we all applaud in cases where illegal acts have taken place (e.g., bribing building inspectors, deliberately disregarding federal regulations). However, fixing responsibility by coupling only one or two aspects of an organization with a catastrophic outcome makes it more difficult to envision a variety of policy options that might change organizations responsible for administering safety.

This is the vantage point provided by viewing risk and safety as organizational phenomena. It sees day-to-day compromises and trade-offs not as sinister but as inevitable features of work organizations. It sees risk in multivariate fashion as a function of everything that impinges upon organizational performance. Most importantly, it sees organizations as the mechanisms for managing whatever level of safety a society achieves. Rather than blaming "the usual suspects," an organizational view expands the list of those accountable, widening the range of policy options.

Is it naive to expect journalists to construct news reports about technological hazards and natural disasters that reflect an organizational view of risk? Time constraints and a preference for the visual aspects of events make hard news coverage in television news an unlikely arena for such a perspective. However, the print media, particularly investigative reporters (especially those in the prestige press), can craft stories that go beyond the "sound bites" of politicians attempting to deflect criticism and administrators defending their agencies. By choosing whom to

interview and what questions to ask, journalists can place stories about risk in a context in which decisions affecting organizations. No matter how remote they may seem at first, these are also decisions affecting safety.