Book Review


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In 1981, Binghampton, New York was the site of a particularly modern high-tech tragedy, the results of which are still apparent today: hundreds of victims were exposed to deadly toxic chemicals, numerous local business closings, reams of contaminated State and County files, unclear dangers to present and future generations of Binghamtonians, and one inhabitable toxic tower, to mention a few. After a switch gear failed in the basement of the Binghampton State Office Building, the intense heat from a resultant electrical arc caused a ceramic bushing on a PCB-loaded transformer to give way, spilling 180 gallons of highly toxic coolant on the floor. The heat converted the coolant to vapor, which, together with the soot, was subsequently dispersed throughout the building and released into the atmosphere. Faced with a myriad of technical, administrative and public health questions, a number of organizations on the county, state, and national levels were thrust into the unenviable position of dealing with a highly ambiguous situation: an unmatched, ill-defined problem without organizational structures in place to manage it. First, the contamination of a single office building with large amounts of PCBs, dioxins, furans, among others was unprecedented. Second, although New York State holds the dubious distinction of being reasonably experienced in the field of toxic decontamination by way of their other toxic encounters, most notably at Love Canal, there is hardly a consensus among experts as to what constitutes ‘acceptable’ intake levels of these contaminants, if amounts can be accurately measured at all. Third, no single organization was intrinsically responsible for the building and its employees, as the structure is the centrepiece of an office complex housing both Broome County and New York State employees comprising a number of agencies.

Setting the tone for how the relevant organizations would define acceptable risk, the New York State Office of General Services, responsible for the general maintenance of the facility, sent in a group of untrained janitors to clean up the building, all the while asserting that the decontamination could be cleared within one month. At the same time, the Broome County Department of Health commenced medical surveillance of the firefighters called in to blanket the blaze, as blood samples were hastily taken and physical examinations performed. Unfortunately, the extent of the firefighters and janitors’ contamination could not be gleaned from the test results for two reasons: blood samples were not taken according to sound medical protocol, and state-of-the-art detection technologies were not employed. While the New York State Department of Health was downplaying the building's risk to public health, the Broome County Department of Public Health pressed on with the concerted, if inappropriate, medical surveillance. However, because the department...
was in desperate need of State assistance, the organizational clash hampered the exchange of vital resources. It was only after one year and after the director of the Broome County Health Department had been ousted that the State assumed ownership of the State Office Building’s risks and undertook a formal risk assessment. Public health had been relegated to a secondary issue, while the organizations disputed the proper response to the toxic outbreak.

Clarke takes up the main ambiguities of the situation — the unclear nature of the problem and the lack of a mandate for a proper organizational response — to shed light on how interrelated organizations act in unclear situations and how political as well as structural factors influence the behaviour of organizations and their definition of acceptable risk. He departs from two conventional theories of organizational behaviour to explain the bungled handling of the incident, as the ‘callous bureaucracy’ theory and ‘rational choice’ theory. With regard to the first, he argues that public officials were indeed concerned with public health and did not undertake a pernicious cover-up or a deliberate relativization of the danger involved. In the case of the second theory, he contends that the organizations did not behave according to organization-specific duties and abilities. Instead, the author redefines and, in part, strengthens Marsh and Olsen’s ‘garbage can’ theory of intra-organizational behaviour by applying it to its more suitable context: inter-organizational relations. As the Garbage Can Theory holds that the loose couplings of organizational components cause decisions to be made and problems to be solved in an almost random fashion, decision-making among inter-related organizations magnifies this when viewed in a similar context. As Clarke argues, albeit with only two very general representations, members of a single organization are indeed ordered according to a division of labour and a distribution of responsibilities. The randomness of inter-organizational decision-making is not as stark as the ‘garbage-can’ theory maintains, because lower-level members do not exert as much influence over decisions in even the most loosely delineated organizations, such as universities. It is groups of organizations devoid of a centralized office and an unmistakable governing body, that deserve attention in the study of decision-making and the ‘garbage-can’ models to explain it.

The strength of Clarke’s book lies in the pain-staking analysis of how, in this case, organizational interests superseded public health in the definition of acceptable risk. For Clarke, ‘organizations, [and not the public], are the crucial risk assessors in modern society’. Besides being a well-written and informative narrative, the work utilizes the existing work on organizational theory to provide new directions. In the study of the management of toxic environment, it should be placed alongside other primary sources of organizational dynamics of modern technological nightmares, such as Lavine’s book on Love Canal.