Chapter 34
Pinto Fires and Personal Ethics: A Script Analysis of Missed Opportunities

Dennis A. Gioia

In the summer of 1972 I made one of those important transitions in life, the significance of which becomes obvious only in retrospect. I left academe with a BS in Engineering Science and an MBA to enter the world of big business. I joined Ford Motor Company at World Headquarters in Dearborn Michigan, fulfilling a long-standing dream to work in the heart of the auto industry. I felt confident that I was in the right place at the right time to make a difference. My initial job title was "Problem Analyst" – a catchall label that superficially described what I would be thinking about and doing in the coming years. On some deeper level, however, the title paradoxically came to connote the many critical things that I would *not* be thinking about and acting upon.

By that summer of 1972 I was very full of myself. I had met my life's goals to that point with some notable success. I had virtually everything I wanted, including a strongly-held value system that had led me to question many of the perspectives and practices I observed in the world around me. Not the least of these was a profound distaste for the Vietnam war, a distaste that had found me participating in various demonstrations against its conduct and speaking as a part of a collective voice on the moral and ethical failure of a democratic government that would attempt to justify it. I also found myself in MBA classes railing against the conduct of businesses of the era, whose actions struck me as ranging from inconsiderate to indifferent to simply unethical. To me the typical stance of business seemed to be one of disdain for, rather than responsibility toward, the society of which they were prominent members. I wanted something to change. Accordingly, I cultivated my social awareness; I held my principles high; I espoused my intention to help a troubled world; and I wore my hair long. By any measure I was a prototypical "Child of the 1960s."

D.A. Gioia (✉)
Department of Management and Organization, Smeal College of Business Administration, Pennsylvania State University, University Park, PA 16802, USA
e-mail: dag4@psu.edu

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Therefore, it struck quite a few of my friends in the MBA program as rather strange that I was in the program at all ("If you are so disappointed in business, why study business?"). Subsequently, they were practically dumbstruck when I accepted the job offer from Ford, apparently one of the great purveyors of the very actions I reviled. I countered that it was an ideal strategy, arguing that I would have a greater chance of influencing social change in business if I worked behind the scenes on the inside, rather than as a strident voice on the outside. It was clear to me that somebody needed to prod these staid companies into socially responsible action. I certainly aimed to do my part. Besides, I liked car.

Into the Fray: Setting the Personal Stage

Predictably enough, I found myself on the fast track at Ford, participating in a "tournament" type of socialization (Van Maanen 1978), engaged in a competition for recognition with other MBA's who had recently joined the company. And I quickly became caught up in the game. The company itself was dynamic; the environment of business, especially the auto industry, was intriguing; the job was challenging and the pay was great. The psychic rewards of working and succeeding in a major corporation proved unexpectedly seductive. I really became involved in the job.

Market forces (international competition) and government regulation (vehicle safety and emissions) were affecting the auto industry in disruptive ways that only later would be common to the wider business and social arena. They also produced an industry and a company that felt buffeted, beleaguered, and threatened by the changes. The threats were mostly external, of course, and led to a strong feeling of we-vs-them, where we (Ford members) needed to defend ourselves against them (all the outside parties and voices demanding that we change our ways). Even at this time, an intriguing question for me was whether I was a "we" or a "them." It was becoming apparent to me that my perspective was changing. I had long since cut my hair.

By the summer of 1973 I was pitched into the thick of the battle. I became Ford's Field Recall Coordinator – not a position that was particularly high in the hierarchy, but one that wielded influence for beyond its level. I was in charge of the operational coordination of all of the recall campaigns currently underway and also in charge of tracking incoming information to identify developing problems. Therefore, I was in a position to make initial recommendations about possible future recalls. The most critical type of recalls were labeled "safety campaigns" – those that dealt with the possibility of customer injury or death. These ranged from straight-forward occurrences such as brake failure and wheels falling off vehicles, to more exotic and faintly humorous failure modes such as detaching axles that announced their presence by spinning forward and slamming into the startled driver's door and speed control units that locked on, and refused to disengage, as the car accelerated wildly while the spooked driver futilely tried to shut it off. Safety recall campaigns, however, also encompassed the more sobering possibility of on-board gasoline fires and explosions....

The Pinto Case: Setting the Corporate Stage

In 1970 Ford introduced the Pinto, a small car that was intended to compete with the then current challenge from European cars and the ominous presence on the horizon of Japanese manufacturers. The Pinto was brought from inception to production in the record time of approximately 25 months (compared to the industry average of 43 months), a time frame that suggested the necessity for doing things expediently. In addition to the time pressure, the engineering and development teams were required to adhere to the production "limits of 2,000" for the diminutive car: it was not to exceed either $2,000 in cost or 2,000 lb in weight. Any decisions that threatened these targets or the timing of the car's introduction were discouraged. Under normal conditions design, styling, product planning, engineering, etc., were completed prior to production tooling. Because of the foreshortened time frame, however, some of these usually sequential processes were executed in parallel.

As a consequence, tooling was already well under way (thus "freezing" the basic design) when routine crash testing revealed that the Pinto's fuel tank often ruptured when struck from the rear at a relatively low speed (31 mph in crash tests). Reports (revealed much later) showed that the fuel tank failures were the result of some rather marginal design features. The tank was positioned between the rear bumper and the rear axle (a standard industry practice for the time). During impact, however, several studs protruding from the rear of the axle housing would puncture holes in the tank; the fuel filler neck also was likely to rip away. Spilled gasoline then could be ignited by sparks. Ford had in fact crash-tested 11 vehicles; 8 of these cars suffered potentially catastrophic gas tank ruptures. The only three cars that survived intact had each been modified in some way to protect the tank.

These crash tests, however, were conducted under the guidelines of Federal Motor Vehicle Safety Standard 301 which had been proposed in 1968 and strenuously opposed by the auto industry. FMVSS 301 was not actually adopted until 1976; thus, at the time of the tests, Ford was not in violation of the law. There were several possibilities for fixing the problem, including the option of redesigning the tank and its location, which would have produced tank integrity in a high-speed crash. That solution, however, was not only time consuming and expensive, but also usurped trunk space, which was seen as a critical competitive sales factor. One of the production modifications to the tank, however, would have cost only $11 to install, but given the tight margins and restrictions of the "limits of 2,000," there was reluctance to make even this relatively minor change. There were other reasons for not approving the change, as well, including a widespread industry belief that all small cars were inherently unsafe solely because of their size and weight. Another more prominent reason was a corporate belief that "safety doesn't sell." This observation was attributed to Lee Iacocca and stemmed from Ford's earlier attempt to make safety a sales theme, an attempt that failed rather dismally in the marketplace.

Perhaps the most controversial reason for rejecting the production change to the gas tank, however, was Ford's use of cost-benefit analysis to justify the decision. The National Highway Traffic Safety Association (NHTSA, a federal agency) had

approved the use of cost-benefit analysis as an appropriate means for establishing automotive safety design standards. The controversial aspect in making such calculations was that they required the assignment of some specific value for a human life. In 1970, that value was deemed to be approximately $200,000 as a "cost to society" for each fatality. Ford used NHTSA's figures in estimating the costs and benefits of altering the tank production design. An internal memo, later revealed in court, indicates the following tabulations concerning potential fires (Dowie 1977):

Costs: $137,000,000
(Estimated as the costs of a production fix to all similarly designed cars and trucks with the gas tank aft of the axle (12,500,000 vehicles × $11/vehicle))

Benefits: $49,530,000
(Estimated as the savings from preventing (180 projected deaths × $200,000/death) + (180 projected burn injuries × $67,000/injury) + (2,100 burned cars × $700/car))

The cost-benefit decision was then construed as straightforward: No production fix would be undertaken. The philosophical and ethical implications of assigning a financial value for human life or disfigurement do not seem to have been a major consideration in reaching this decision.

Pintos and Personal Experience

When I took over the Recall Coordinator's job in 1973 I inherited the oversight of about 100 active recall campaigns, more than half of which were safety-related. These ranged from minimal in size (replacing front wheels that were likely to break on 12 heavy trucks) to maximal (repairing the power steering pump on millions of cars). In addition, there were quite a number of safety problems that were under consideration as candidates for addition to the recall list. (Actually, "problem" was a word whose public use was forbidden by the legal office at the time, even in service bulletins, because it suggested corporate admission of culpability. "Condition" was the sanctioned catchword.) In addition to these potential recall candidates, there were many files containing field reports of alleged component failure (another forbidden word) that had led to accidents and, in some cases, passenger injury. Beyond these existing files, I began to construct my own files of incoming safety problems.

One of these new files concerned reports of Pintos "lighting up" (in the words of a field representative) in rear-end accidents. There were actually very few reports, perhaps because component failure was not initially assumed. These cars simply were consumed by fire after apparently very low speed accidents. Was there a problem? Not as far as I was concerned. My cue for labeling a case as a problem either required high frequencies of occurrence or directly-traceable causes. I had little time for speculative contemplation on potential problems that did not fit a pattern that suggested known courses of action leading to possible recall. I do, however, remember

being disquieted by a field report accompanied by graphic, detailed photos of the remains of a burned-out Pinto in which several people had died. Although that report became part of my file, I did not flag it as any special case.

It is difficult to convey the overwhelming complexity and pace of the job of keeping track of so many active or potential recall campaigns. It remains the busiest, most information-filled job I have ever held or would want to hold. Each case required a myriad of information-gathering and execution stages. I distinctly remember that the information-processing demands led me to confuse the facts of one problem case with another on several occasions because the tell-tale signs of recall candidate cases were so similar. I thought of myself as a fireman – a fireman who perfectly fit the description by one of my colleagues: "In this office everything is a crisis. You only have time to put out the big fires and spit on the little ones." By those standards the Pinto problem was distinctly a little one.

It is also important to convey the muting of emotion involved in the Recall Coordinator's job. I remember contemplating the fact that my job literally involved life-and-death matters. I was sometimes responsible for finding and fixing cars NOW, because somebody's life might depend on it. I took it *very* seriously. Early in the job, I sometimes woke up at night wondering whether I had covered all the bases. Had I left some unknown person at risk because I had not thought of something? That soon faded, however, and of necessity the consideration of people's lives became a fairly removed, dispassionate process. To do the job "well" there was little room for emotion. Allowing it to surface was potentially paralyzing and prevented rational decisions about which cases to recommend for recall. On moral grounds I knew I could recommend most of the vehicles on my safety tracking list for recall (and risk earning the label of a "bleeding heart"). On practical grounds, I recognized that people implicitly accept risks in cars. We could not recall all cars with *potential* problems and stay in business. I learned to be responsive to those cases that suggested an imminent, dangerous problem.

I should also note, that the country was in the midst of its first, and worst, oil crisis at this time. The effects of the crisis had cast a pall over Ford and the rest of the automobile industry. Ford's product line, with the perhaps notable exception of the Pinto and Maverick small cars, was not well-suited to dealing with the crisis. Layoffs were imminent for many people. Recalling the Pinto in this context would have damaged one of the few trump cards the company had (although, quite frankly, I do not remember being overtly influenced by that issue).

Pinto reports continued to trickle in, but at such a slow rate that they really did not capture particular attention relative to other, more pressing safety problems. However, I later saw a crumpled, burned car at a Ford depot where alleged problem components and vehicles were delivered for inspection and analysis (a place known as the "Chamber of Horrors" by some of the people who worked there). The revulsion on seeing this incinerated hulk was immediate and profound. Soon afterwards, and despite the fact that the file was very sparse, I recommended the Pinto case for preliminary department-level review concerning possible recall. After the usual round of discussion about criteria and justification for recall, everyone voted against recommending recall – including me. It did not fit the pattern of recallable

standards; the evidence was not overwhelming that the car was defective in some way, so the case was actually fairly straightforward. It was a good business decision, even if people might be dying. (We did not then know about the pre-production crash test data that suggested a high rate of tank failures in "normal" accidents (cf., Perrow 1984) or an abnormal failure mode.)

Later, the existence of the crash test data did become known within Ford, which suggested that the Pinto might actually have a recallable problem. This information led to a reconsideration of the case within our office. The data, however, prompted a comparison of the Pinto's survivability in a rear end accident with that of other competitors' small cars. These comparisons revealed that although many cars in this subcompact class suffered appalling deformation in relatively low speed collisions, the Pinto was merely the worst of a bad lot. Furthermore, the gap between the Pinto and the competition was not dramatic in terms of the speed at which fuel tank rupture was likely to occur. On that basis it would be difficult to justify the recall of cars that were comparable with others on the market. In the face of even more compelling evidence that people were probably going to die in this car, I again included myself in a group of decision makers who voted not to recommend recall to the higher levels of the organization.

Coda to the Corporate Case

Subsequent to my departure from Ford in 1975, reports of Pinto fires escalated, attracting increasing media attention, almost all of it critical of Ford. Anderson and Whitten (1976) revealed the internal memos concerning the gas tank problem and questioned how the few dollars saved per car could be justified when human lives were at stake. Shortly thereafter, a scathing article by Dowie (1977) attacked not only the Pinto's design, but also accused Ford of gross negligence, stonewalling, and unethical corporate conduct by alleging that Ford knowingly sold "firetraps" after willfully calculating the cost of lives against profits (see also Gatewood and Carroll 1981). Dowie's provocative quote speculating on "how long the Ford Motor Company would continue to market lethal cars were Henry Ford II and Lee Iacocca serving 20 year terms in Leavenworth for consumer homicide" (1977, p. 32) was particularly effective in focusing attention on the case. Public sentiment edged toward labeling Ford as socially deviant because management was seen as knowing that the car was defective, choosing profit over lives, resisting demands to fix the car, and apparently showing no public remorse (Swigert and Farrell 1980–1981).

Shortly after Dowie's (1977) expose, NHTSA initiated its own investigation. Then, early in 1978 a jury awarded a Pinto burn victim $125 million in punitive damages (later reduced to $6.6 million, a judgment upheld on an appeal that prompted the judge to assert that "Ford's institutional mentality was shown to be one of callous indifference to public safety" (quoted in Cullen et al. 1987, p. 164)). A siege atmosphere emerged at Ford. Insiders characterized the mounting media campaign as "hysterical" and "a crusade against us" (personal communications).

The crisis deepened. In the summer of 1978 NHTSA issued a formal determination that the Pinto was defective. Ford then launched a reluctant recall of all 1971–1976 cars (those built for the 1977 model year were equipped with a production fix prompted by the adoption of the FMVSS 301 gas tank standard). Ford hoped that the issue would then recede, but worse was yet to come.

The culmination of the case and the demise of the Pinto itself began in Indiana on August 10, 1978, when three teenage girls died in a fire triggered after their 1973 Pinto was hit from behind by a van. A grand jury took the unheard of step of indicting Ford on charges of reckless homicide (Cullen et al. 1987). Because of the precedent-setting possibilities for all manufacturing industries, Ford assembled a formidable legal team headed by Watergate prosecutor James Neal to defend itself at the trial. The trial was a media event; it was the first time that a corporation was tried for alleged *criminal* behavior. After a protracted, acrimonious courtroom battle that included vivid clashes among the opposing attorneys, surprise witnesses, etc., the jury ultimately found in favor of Ford. Ford had dodged a bullet in the form of a consequential legal precedent, but because of the negative publicity of the case and the charges of corporate crime and ethical deviance, the conduct of manufacturing businesses was altered, probably forever. As a relatively minor footnote to the case, Ford ceased production of the Pinto.

Coda to the Personal Case

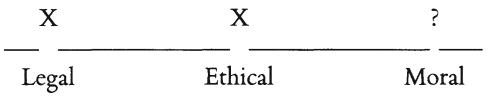
In the intervening years since my early involvement with the Pinto fire case, I have given repeated consideration to my role in it. Although most of the ethically questionable actions that have been cited in the press are associated with Ford's intentional stonewalling after it was clear that the Pinto was defective (see Cullen et al. 1987; Dowie 1977; Gatewood and Carroll 1981) – and thus postdate my involvement with the case and the company – I still nonetheless wonder about my own culpability. Why didn't I see the gravity of the problem and its ethical overtones? What happened to the value system I carried with me into Ford? Should I have acted differently, given what I knew then? The experience with myself has sometimes not been pleasant. Somehow, it seems I should have done *something* different that might have made a difference.

As a consequence of this line of thinking and feeling, some years ago I decided to construct a "living case" out of my experience with the Pinto fire problem for use in my MBA classes. The written case description contains many of the facts detailed above; the analytical task of the class is to ask appropriate questions of me as a figure in the case to reveal the central issues involved. It is somewhat of a trying experience to get through these classes. After getting to know me for most of the semester, and then finding out that I did *not* vote to recommend recall, students are often incredulous, even angry at me for apparently not having lived what I have been teaching. To be fair and even-handed here, many students understand my actions in the context of the times and the attitudes prevalent then. Others, however, are very disappointed that I appear to have failed during my time of trial. Consequently,

I am accused of being a charlatan and otherwise vilified by those who maintain that ethical and moral principles should have prevailed in this case no matter what the mitigating circumstances. Those are the ones that hurt.

Those are also the ones, however, that keep the case and its lessons alive in my mind and cause me to have an on-going dialogue with myself about it. It is fascinating to me that for several years after I first conducted the living case with myself as the focus, I remained convinced that I had made the "right" decision in not recommending recall of the cars. In light of the times and the evidence available, I thought I had pursued a reasonable course of action. More recently, however, I have come to think that I really should have done everything I could to get those cars off the road.

In retrospect I know that in the context of the times my actions were *legal* (they were all well within the framework of the law); they probably also were *ethical* according to most prevailing definitions (they were in accord with accepted professional standards and codes of conduct); the major concern for me is whether they were *moral* (in the sense of adhering to some higher standards of inner conscience and conviction about the "right" actions to take). This simple typology implies that I had passed at least two hurdles on a personal continuum that ranged from more rigorous, but arguably less significant criteria, to less rigorous, but more personally, organizationally, and perhaps societally significant standards:



It is that last criterion that remains troublesome.

Perhaps these reflections are all just personal revisionist history. After all, I am still stuck in my cognitive structures, as everyone is. I do not think these concerns are all retrospective reconstruction, however. Another telling piece of information is this: The entire time I was dealing with the Pinto fire problem, I owned a Pinto (!). I even sold it to my sister. What does that say?

What Happened Here?

I, of course, have some thoughts about my experience with this damningly visible case. At the risk of breaking some of the accepted rules of scholarly analysis, rather than engaging in the usual comprehensive, dense, arms-length critique, I would instead like to offer a rather selective and subjective focus on certain characteristics of human information processing relevant to this kind of situation, of which I was my own unwitting victim. I make no claim that my analysis necessarily "explains more variance" than other possible explanations. I do think that this selective view is enlightening in that it offers an alternative explanation for some ethically questionable actions in business.

The subjective stance adopted in the analysis is intentional also. This case obviously stems from a series of personal experiences, accounts, and introspections. The analytical style is intended to be consistent with the self-based case example; therefore, it appears to be less "formal" than the typical objectivist mode of explanation.

I suspect that my chosen focus will be fairly non-obvious to the reader familiar with the ethical literature (as it typically is to the ethical actor). Although this analysis might be judged as somewhat self-serving, I nonetheless believe that it provides an informative explanation for some of the ethical foibles we see enacted around us.

To me, there are two major issues to address. First, how could my value system apparently have flip-flopped in the relatively short space of 1–2 years? Secondly, how could I have failed to take action on a retrospectively obvious safety problem when I was in the perfect position to do so? To begin, I would like to consider several possible explanations for my thoughts and actions (or lack thereof) during the early stages of the Pinto fire case.

One explanation is that I was simply revealed as a phony when the chips were down; that my previous values were not strongly inculcated; that I was all bluster, not particularly ethical, and as a result acted expediently when confronted with a reality test of those values. In other words, I turned traitor to my own expressed values. Another explanation is that I was simply intimidated; in the face of strong pressure to heel to company preferences, I folded – put ethical concerns aside, or at least traded them for a monumental guilt trip and did what anybody would do to keep a good job. A third explanation is that I was following a strictly utilitarian set of decision criteria (Velasquez et al. 1983) and, predictably enough, opted for a personal form of Ford's own cost-benefit analysis, with similar disappointing results. Another explanation might suggest that the interaction of my stage of moral development (Kohlberg 1969) and the culture and decision environment at Ford led me to think about and act upon an ethical dilemma in a fashion that reflected a lower level of actual moral development than I espoused for myself (Trevino 1986, 1992). Yet another explanation is that I was co-opted; rather than working from the inside to change a lumbering system as I had intended, the tables were turned and the system beat me at my own game. More charitably, perhaps, it is possible that I simply was a good person making bad ethical choices because of the corporate milieu (Gellerman 1986).

I doubt that this list is exhaustive. I am quite sure that cynics could match my own MBA students' labels, which in the worst case include phrases like "moral failure" and "doubly reprehensible because you were in a position to make a difference." I believe, however, on the basis of a number of years of work on social cognition in organizations that a viable explanation is one that is not quite so melodramatic. It is an explanation that rests on a recognition that even the best-intentioned organization members organize information into cognitive structures or schemas that serve as (fallible) mental templates for handling incoming information and as guides for acting upon it. Of the many schemas that have been hypothesized to exist, the one that is most relevant to my experience at Ford is the notion of a script (Abelson 1976, 1981).

My central thesis is this: *My own schematized (scripted) knowledge influenced me to perceive recall issues in terms of the prevailing decision environment and to unconsciously overlook key features of the Pinto case, mainly because they did not fit an existing script. Although the outcomes of the case carry retrospectively obvious ethical overtones, the schemas driving my perceptions and actions precluded consideration of the issues in ethical terms because the scripts did not include ethical dimensions.*

Script Schemas

A *schema* is a cognitive framework that people use to impose structure upon information, situations, and expectations to facilitate understanding (Gioia and Poole 1984; Taylor and Crocker 1981). Schemas derive from consideration of prior experience or vicarious learning that results in the formation of "organized" knowledge – knowledge that, once formed, precludes the necessity for further active cognition. As a consequence, such structured knowledge allows virtually effortless interpretation of information and events (cf., Canter and Mischel 1979). A *script* is a specialized type of schema that retains knowledge of actions appropriate for specific situations and contexts (Abelson 1976, 1981). One of the most important characteristics of scripts is that they simultaneously provide a cognitive framework for *understanding* information and events as well as a guide to appropriate *behavior* to deal with the situation faced. They thus serve as linkages between cognition and action (Gioia and Manz 1985).

The structuring of knowledge in scripted form is a fundamental human information processing tendency that in many ways results in a relatively closed cognitive system that influences both perception and action. Scripts, like all schemas, operate on the basis of prototypes, which are abstract representations that contain the main features or characteristics of a given knowledge category (e.g., "safety problems"). Protoscripts (Gioia and Poole 1984) serve as templates against which incoming information can be assessed. A pattern in current information that generally matches the template associated with a given script signals that active thought and analysis is not required. Under these conditions the entire existing script can be called forth and enacted automatically and unconsciously, usually without adjustment for subtle differences in information patterns that might be important.

Given the complexity of the organizational world, it is obvious that the schematizing or scripting of knowledge implies a great information processing advantage – a decision maker need not actively think about each new presentation of information, situations, or problems; the mode of handling such problems has already been worked out in advance and remanded to a working stock of knowledge held in individual (or organizational) memory. Scripted knowledge saves a significant amount of mental work, a savings that in fact prevents the cognitive paralysis that would inevitably come from trying to treat each specific instance of a class of problems as a unique case that requires contemplation. Scripted decision making is thus efficient decision making but not necessarily good decision making (Gioia and Poole 1984).

Of course, every advantage comes with its own set of built-in disadvantages. There is a price to pay for scripted knowledge. On the one hand, existing scripts lead people to selectively perceive information that is consistent with a script and thus to ignore anomalous information. Conversely, if there is missing information, the gaps in knowledge are filled with expected features supplied by the script (Bower et al. 1979; Graesser et al. 1980). In some cases, a pattern that matches an existing script, except for some key differences, can be "tagged" as a distinctive case (Graesser et al. 1979) and thus be made more memorable. In the worst case scenario, however, a situation that does not fit the characteristics of the scripted perspective for handling problem

cases often is simply not noticed. Scripts thus offer a viable explanation for why experienced decision makers (perhaps *especially* experienced decision makers) tend to overlook what others would construe as obvious factors in making a decision.

Given the relatively rare occurrence of truly novel information, the nature of script processing implies that it is a default mode of organizational cognition. That is, instead of spending the predominance of their mental energy thinking in some active fashion, decision makers might better be characterized as typically *not* thinking, i.e., dealing with information in a mode that is akin to "cruising on automatic pilot" (cf., Gioia 1986). The scripted view casts decision makers as needing some sort of prod in the form of novel or unexpected information to kick them into a thinking mode – a prod that often does not come because of the wealth of similar data that they must process. Therefore, instead of focusing what people pay attention to, it might be more enlightening to focus on what they do *not* pay attention to.

Pinto Problem Perception and Scripts

It is illustrative to consider my situation in handling the early stages of the Pinto fires case in light of script theory. When I was dealing with the first trickling-in of field reports that might have suggested a significant problem with the Pinto, the reports were essentially similar to many others that I was dealing with (and dismissing) all the time. The sort of information they contained, which did not convey enough prototypical features to capture my attention, never got past my screening script. I had seen this type of information pattern before (hundreds of times!); I was making this kind of decision automatically every day. I had trained myself to respond to prototypical cues, and these didn't fit the relevant prototype for crisis cases. (Yes, the Pinto reports fit a prototype – but it was a prototype for "normal accidents" that did not deviate significantly from expected problems). The frequency of the reports relative to other, more serious problems (i.e., those that displayed more characteristic features of safety problems) also did not pass my scripted criteria for singling out the Pinto case. Consequently, I looked right past them.

Overlooking uncharacteristic cues also was exacerbated by the nature of the job. The overwhelming information overload that characterized the role as well as its hectic pace actually forced a greater reliance on scripted responses. It was impossible to handle the job requirements *without* relying on some sort of automatic way of assessing whether a case deserved active attention. There was so much to do and so much information to attend to that the only way to deal with it was by means of schematic processing. In fact, the one anomaly in the case that might have cued me to gravity of the problem (the field report accompanied by graphic photographs) still did not distinguish the problem as one that was distinctive enough to snap me out of my standard response mode and tag it as a failure that deserved closer monitoring.

Even the presence of an emotional component that might have short-circuited standard script processing instead became part of the script itself. Months of squelching the disturbing emotions associated with serious safety problems soon made muffled

emotions a standard (and not very salient) component of the script for handling *any* safety problem. This observation, that emotion was muted by experience, and therefore de-emphasized in the script, differs from Fiske's (1982) widely accepted position that emotion is tied to the top of a schema (i.e., is the most salient and initially-tapped aspect of schematic processing). On the basis of my experience, I would argue that for organization members trained to control emotions to perform the job role (cf., Pitre 1990), emotion is either not a part of the internalized script, or at best becomes a difficult-to-access part of any script for job performance.

The one instance of emotion penetrating the operating script was the revulsion that swept over me at the sight of the burned vehicle at the return depot. That event was so strong that it prompted me to put the case up for preliminary consideration (in theoretical terms, it prompted me cognitively to "tag" the Pinto case as a potentially distinctive one). I soon "came to my senses," however, when rational consideration of the problem characteristics suggested that they did not meet the scripted criteria that were consensually shared among members of the Field Recall Office. At the preliminary review other members of the decision team, enacting their own scripts in the absence of my emotional experience, wondered why I had even brought the case up. To me this meeting demonstrated that even when controlled analytic information processing occurred, it was nonetheless based on prior schematization of information. In other words, even when information processing was not automatically executed, it still depended upon schemas (cf., Gioia 1986). As a result of the social construction of the situation, I ended up agreeing with my colleagues and voting not to recall.

The remaining major issue to be dealt with, of course, concerns the apparent shift in my values. In a period of less than 2 years I appeared to change my stripes and adopt the cultural values of the organization. How did that apparent shift occur? Again, scripts are relevant. I would argue that my pre-Ford values for changing corporate America were bona fide. I had internalized values for doing what was right as I then understood "rightness" in grand terms. They key is, however, that I had not internalized a *script* for enacting those values in any specific context outside my limited experience. The insider's view at Ford, of course, provided me with a specific and immediate context for developing such a script. Scripts are formed from salient experience and there was no more salient experience in my relatively young life than joining a major corporation and moving quickly into a position of clear and present responsibility. The strongest possible parameters for script formation were all there, not only because of the job role specifications, but also from the corporate culture. Organizational culture, in one very powerful sense, amounts to a collection of scripts writ large. Did I sell out? No. Were my cognitive structures altered by salient experience? Without question. Scripts for understanding and action were formed and reformed in a relatively short time in a way that not only altered perceptions of issues but also the likely actions associated with those altered perceptions.

I might characterize the differing cognitive structures as "outsider" versus "insider" scripts. I view them also as "idealist" versus "realist" scripts. I might further note that the outsider/idealist script was one that was more individually-based than the insider/realist script, which was more collective and subject to the influence of

the corporate milieu and culture. Personal identity as captured in the revised script became much more corporate than individual. Given that scripts are socially constructed and reconstructed cognitive structures, it is understandable that their content and process would be much more responsive to the corporate culture, because of its saliency and immediacy.

The recall coordinator's job was serious business. The scripts associated with it influenced me much more than I influenced it. Before I went to Ford I would have argued strongly that Ford had an ethical obligation to recall. After I left Ford I now argue and teach that Ford had an ethical obligation to recall. But, *while I was there*, I perceived no strong obligation to recall and I remember no strong *ethical* overtones to the case whatsoever. It was a very straightforward decision, driven by dominant scripts for the time, place, and context.

Whither Ethics and Scripts?

Most models of ethical decision making in organizations implicitly assume that people recognize and think about a moral or ethical dilemma when they are confronted with one (cf., Kohlberg 1969; Trevino 1992). I call this seemingly fundamental assumption into question. The unexplored ethical issue for me is the arguably prevalent case where organizational representatives are not aware that they are dealing with a problem that might have ethical overtones. If the case involves a familiar class of problems or issues, it is likely to be handled via existing cognitive structures or scripts – *scripts that typically include no ethical component in their cognitive content.*

Although we might hope that people in charge of important decisions like vehicle safety recalls might engage in active, logical analysis and consider the subtleties in the many different situations they face, the context of the decisions and their necessary reliance on schematic processing tends to preclude such consideration (cf., Gioia 1989). Accounting for the subtleties of ethical consideration in work situations that are typically handled by schema-based processing is very difficult indeed. Scripts are built out of situations that are normal, not those that are abnormal, ill-structured, or unusual (which often can characterize ethical domains). The ambiguities associated with most ethical dilemmas imply that such situations demand a "custom" decision, which means that the inclusion of an ethical dimension as a component of an evolving script is not easy to accomplish.

How might ethical considerations be internalized as part of the script for understanding and action? It is easier to say what will *not* be likely to work than what will. Clearly, mere mention of ethics in policy or training manuals will not do the job. Even exhortations to be concerned with ethics in decision making are seldom likely to migrate into the script. Just as clearly, codes of ethics typically will not work. They are too often cast at a level of generality that can not be associated with any specific script. Furthermore, for all practical purposes, codes of ethics often are stated in a way that makes them "context-free," which makes them virtually impossible to associate with active scripts, which always are context-bound.

Tactics for script *development* that have more potential involve learning or training that concentrates on exposure to information or models that explicitly display a focus on ethical considerations. This implies that ethics be included in job descriptions, management development training, mentoring, etc. Tactics for script *revision* involve learning or training that concentrate on "script-breaking" examples. Organization members must be exposed either to vicarious or personal experiences that interrupt tacit knowledge of "appropriate" action so that script revision can be initiated. Training scenarios, and especially role playing, that portray expected sequences that are then interrupted to call explicit attention to ethical issues can be tagged by the perceiver as requiring attention. This tactic amounts to installing a decision node in the revised scripts that tells the actor "Now think" (Abelson 1981). Only by means of similar script-breaking strategies can existing cognitive structures be modified to accommodate the necessary cycles of automatic and controlled processing (cf., Louis and Sutton 1991).

The upshot of the scripted view of organizational understanding and behavior is both an encouragement and an indictment of people facing situations laced with ethical overtones. It is encouraging because it suggests that organizational decision makers are not necessarily lacking in ethical standards; they are simply fallible information processors who fail to notice the ethical implications of a usual way of handling issues. It is an indictment because ethical dimensions are not usually a central feature of the cognitive structures that drive decision making. Obviously, they should be, but it will take substantial concentration on the ethical dimension of the corporate culture, as well as overt attempts to emphasize ethics in education, training, and decision making before typical organizational scripts are likely to be modified to include the crucial ethical component.

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