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The "Quality Movement" that originated in industrial production and has since influenced the professions prescribes standardized work, root cause analysis of errors, peer review, and performance measurement. While these reforms have transformed medicine and some other professions, their influence has lagged in the legal profession. This Essay reviews the limited progress of the reforms in law and assesses the cultural, institutional, and doctrinal obstacles they face.

INTRODUCTION

The quality movement that transformed manufacturing in the mid-twentieth century is having a profound influence on the professions these days. The quest for "total quality" or "continuous improvement" is visibly reshaping basic norms and practices in engineering, social work, education, and medicine.[1]

Law, however, has been substantially bypassed in this trend. The *market* for legal services and the *economic* organization of law firms are vastly different from what they were a few decades ago. But the

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1. I use the term quality movement to embrace a convergent set of reforms that include "lean production" manufacturing and "evidence-based" social service practice. *E.g.*, JAMES P. WOMACK & DANIEL T. JONES, LEAN THINKING (1996); Bruce A. Thyer, *What Is Evidence-Based Practice?*, *in* FOUNDATIONS OF EVIDENCE-BASED SOCIAL WORK PRACTICE 35 (Albert R. Roberts & Kenneth R. Yeager eds., 2006).

production process is much less changed. It tends to lack key features prescribed by the quality movement. The rhetoric associated with the quality movement is increasingly familiar to lawyers, and there have been some notable reform initiatives. However, reforms seem to be more limited or more superficial in law than in other professions.

The issues raised by the quality movement are fundamental. Most obviously, they concern the cost and efficacy of service to clients. They also reach questions of the profession's gatekeeper or compliance roles. As Donald Langevoort has explained, much corporate noncompliance arises less from calculated deviance than from cognitive and emotional disabilities.[2] The quality movement suggests that the strength of these disabilities is not invariant but depends in part on organizational context, and the practices it recommends are designed to mitigate them.

In addition, the quality movement raises important issues about pride and satisfaction in work. As economic pressures increase, law practice is becoming more stressful and more regimented. Lawyers may feel that their autonomy and opportunities for creativity are shrinking. The quality movement has an important but ambiguous relation to these concerns. The practical reforms associated with the movement tend to routinize practice and intensify monitoring of it. In this sense, the movement might seem a threat to personal satisfaction in work, and certainly, many quality movement initiatives seem crassly materialistic and oppressively bureaucratic.[3] But others are more ambitious. In this more ambitious perspective, while the reforms limit *individual* autonomy, they enlist lawyers in a *collective* project of self-assessment and institutional improvement that might prove personally satisfying. In attempting to make work more transparent and adaptable, the reforms have the potential for making it more reflective and thus in a sense, more professional, than the informal and slow-to-change structures they would replace.

In Part I, I introduce the quality movement and discuss some indications that problems of the sort that it has responded to in other areas are present in the legal profession. Part II describes the four main practical prescriptions of the movement—standardized work, root cause analysis of errors, peer review, and performance measurement. I suggest that, while these practices have made some headway in the

2. *E.g.*, Donald C. Langevoort, *Getting (Too) Comfortable: In-House Lawyers, Enterprise Risk and the Financial Crisis*, 2012 WIS. L. REV. xxx.

3. *See* Anthony V. Alfieri, *The Fall of Legal Ethics and the Rise of Risk Management*, 94 GEO. L.J. 1909 (2006) (arguing that some of the practices associated with the quality movement are in tension with professional ideals).

profession, all are less prominent than they are elsewhere, and two of them—root cause analysis and peer review—are barely visible.

Part III briefly considers some of the obstacles to a more thorough embrace of quality reforms in law. These obstacles are cultural, institutional, and doctrinal. By and large, they seem the product of a conception of law practice that is out of date, and not just because of economic change. The traditional doctrines of professionalism have assumed that lawyering tends to be both individual and ineffable. The paradigmatic lawyer was the sole practitioner. His work was considered impractical to observe, and except in egregious cases, to evaluate. Thus, both law firms and regulators focused their efforts to insure quality on entry decisions—hiring for the firms and licensing for the regulators—rather than on direct and ongoing regulation of quality. The premises of this approach are no longer true. Lawyers increasingly practice in large organizations, and both within and across organizations, in teams. There are norms and tools for the assessment of practice that are far richer than lawyers have traditionally used. Organizational clients have professional assistance that enables sophisticated observation and assessment of their lawyers. The quality movement seems potentially a useful response to these developments.

I. THE TURN TO QUALITY

A milestone in the emergence of the quality movement in the professions was the 1991 Harvard study of hospital medical errors. Re-examining randomly selected cases from New York hospitals, the researchers found serious errors in nearly four percent.[4] Later research produced even more striking findings. "Studies have found that at least 30 percent of patients with stroke receive incomplete or inappropriate care from their doctors, as do 45 percent of patients with asthma and 60 percent of patients with pneumonia."[5]

Taking a cue from the manufacturing sector, the quality reformers in medicine argue that such studies indicate the need for organizational reform. "New laboratory science is not the key to saving lives," Atul Gawande writes.[6] "The infant science of improving performance—of

4. Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients—Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 370-71 (1991).

5. ATUL GAWANDE, THE CHECKLIST MANIFESTO: HOW TO GET THINGS RIGHT 10 (2009).

6. ATUL GAWANDE, BETTER: A SURGEON'S NOTES ON PERFORMANCE 242 (2007).

implementing our existing know-how—is."[7] The fundamental principle of this infant science is what the Japanese automakers call *kaizen*—continuous self-assessment and self-correction. So far, its key organizational features seem to be standardized work, root cause analysis, peer review, and performance measurement.

It is not possible to do a Harvard-type study of randomly selected cases for lawyering errors. Yet, there is no reason to believe that, if such a study could be done, the results would be any less disturbing than those of the medical studies. Both our general knowledge of organizational behavior and the occasional glimpses of the inner workings of law practice we get when things go visibly wrong suggest that errors occur routinely.

A spectacular example is the indictment and conviction of Arthur Andersen on obstruction-of-justice charges arising from the destruction of Enron-related documents in 2001. (The conviction was later reversed on procedural grounds after the firm had ceased operating.) One of the bases of the charges was a two-sentence e-mail from an in-house Andersen lawyer in Chicago, sent shortly after Enron's accounting manipulations became public and the SEC began investigating. The e-mail suggested that the head of the Houston office "consider reminding" the Enron team of the firm's document retention policy and enclosed the policy's URL reference.[8]

Prosecutors alleged that the lawyer intended to encourage mass shredding of Enron documents, which in fact occurred. The lawyer asserted in her defense that she was only urging her colleagues to be "compliant" with the policy.[9] Regardless of which interpretation is accepted, the story suggests significant deficiencies in the provision of legal advice to Andersen, and not just in the conduct of this one lawyer. Even if we credit the lawyer's testimony about her motives, sending a citation to a written policy without explanation is hardly an effective way to advise a client in a high-stakes sensitive situation. However, the quality movement warns that we should look beyond individual mistakes in situations like this. In disasters of all kinds—from airplane crashes to financial mismanagement—"human error" usually turns out to be the consequence of defective organizational structures and practices.

At Andersen, the task of advising on a difficult question with momentous stakes was left, whether by design or inadvertence, to a

7. *Id.* at 242-43.

8. *Destruction of Enron-Related Documents by Andersen Personnel: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 107th Cong. 45 (2002).

9. *Id.* at 137-38.

single lawyer to perform on her own. Apparently, Andersen and its lawyers had no written protocol for dealing with document issues when it learned that an investigation or proceeding had been initiated. The general policy document transmitted with the e-mail, far from offering specific advice tailored to the situation, was a mass of ambiguities and contradictions. (A third interpretation of the lawyer's motivations—in addition to the prosecutor's claim she was urging destruction and her own claim that she was urging compliance—is that she didn't know what the right advice to give was because the written policy was incomprehensible.) This was not a situation that was hard to anticipate. Enron followed a series of high-profile financial disclosure scandals, including those arising from Waste Management and Sunbeam, that had entangled Andersen in many costly proceedings. Yet, Andersen's lawyers failed to prepare it to respond effectively.

A more extensive body of data implying lawyer error has emerged in connection with the investigations into the backdating of stock option grants at public companies. The SEC has investigated more than a hundred companies, and more than eighty have restated earnings in connection with backdating concerns. Using statistical modeling correlating stock prices with grant dates, economists Randall Heron and Erik Lie estimated that options were backdated or comparably manipulated at 29.2% of the 7,774 firms in their database between 1996 and 2005.[10]

Although we don't know much about particular circumstances, there are no plausible explanations of this phenomenon that do not involve widespread failures of lawyer judgment. In a large fraction of cases, the executives who signed off on the grants did not benefit directly, and many, including Apple's Steve Jobs, have said that they didn't know that the backdating was illegal. In virtually all cases, lawyers could have stopped the practice by admonishing the executives, or if necessary, the board. No doubt the most common excuse is that the lawyers were unaware of the practice, but it seems likely that, for each of these firms, there was *some* lawyer (whether inside or outside) who *should* have known what was happening in this critical compliance area.

II. QUALITY REFORMS AND LAW PRACTICE

Recognizing that error occurs routinely even among highly qualified and respected practitioners led to quality movements in

10. Randall A. Heron & Erik Lie, *What Fraction of Stock Option Grants to Top Executives Have Been Backdated or Manipulated?*, 55 MGMT. SCI. 513, 514 (2009).

medicine and other professions. Yet, there is no movement with that name in law. True, there are some trends in law firm management that resonate with quality movement reforms. There is a stronger emphasis on group practice and collaborative judgment than in the past. Law firms usually have ethics committees and opinion committees, and these committees seem to have increasingly more authority. In-house training programs are better configured to address issues that arise in practice. A range of services rate law firms on the basis of client satisfaction reports. Yet, such developments have been more modest than in other professions.

The basic types of reform the quality movement prescribes are standardized work, systematic error detection, peer review, and performance measurement. In the legal profession, quality rhetoric is usually associated with standardization and performance measurement, though the need and potential is at least as great for error detection and peer review.

A. Standardized Work

Quality reforms require the codification of work practices in detailed protocols or checklists. It is useful to distinguish two types of norms found in such codifications.

Some norms routinize practice either by dictating specific conduct, such as the angle that a nurse should hold a syringe in making an injection, or directing that the actor check that certain indicators are within an appropriate range, such as the instrument checks pilots do when preparing for take-off. Other norms regulate the process of making decisions that may themselves be non-routine. When engineers develop new software products, they use a standardized development process, even as they produce non-standard products. The surgery checklist that Gawande developed with the World Health Organization has both types of norms. For example, a routinizing norm directs that a nurse do and report a sponge and instrument count. A decision process norm prescribes, "Anesthesia team reviews [with surgery and nursing teams whether there] . . . are any patient-specific concerns."[11]

Formal experiment showed that the checklist improved practice, even though it was addressed to one of the most sophisticated contexts of professional endeavor.[12] Protocols help, not only by

11. WORLD ALLIANCE FOR PATIENT SAFETY, SURGERY SAFETY CHECKLIST, (2008), *available at* http://www.who.int/patientsafety/safesurgery/ss_checklist/en/; *see* GAWANDE, *supra* note 5, at 136-41.

12. *See* GAWANDE, *supra* note 5, at 142-57.

reminding practitioners of things they are prone to forget, but by inducing reflectiveness, communication, and transparency. The function of rules in the new quality movement is different from their function in traditional bureaucracy. Their primary goal is not to minimize discretion. Indeed, often, the rules are not supposed to be followed if there's a good reason to do otherwise (though the deviation and the reason for it must typically be documented). Their key function is to facilitate change by making practice more self-conscious and transparent. Formulating the rules requires that people reflect on what they do. Following the rules allows them to compare their experiences. "Only when you have standardization can you systematically improve your operations," a manufacturing text advises.[13] The process of measuring the relative efficacy of different practices requires that we be able to specify the practices that produced the outcomes.

In law, checklists and other forms of standardization have long been associated with some tasks, such as "due diligence" in securities offerings, and more recently, venture capital financings. Some lawyers have reported more ambitious efforts. The reports occasionally embrace the rhetoric and practices associated with the industrial quality movement. The Association of Corporate Counsel has been a leader with its Value Challenge, which encourages and facilitates information about quality-oriented collaboration between in-house lawyers and outside counsel.[14] A few law firms, including Seyfarth Shaw, and in-house legal staffs, including Dupont's, have adopted the quality management methodology known as Six Sigma. Some have even gone so far as to have themselves certified by one of the various organizations that train and assess Six Sigma skills. [15]

Although the accounts of these efforts are often vague, all of them seem to involve an effort to standardize work to facilitate continuous re-assessment and improvement. Typically, the initiative begins by defining a set of client goals and then mapping and analyzing the associated legal services in an effort to trim waste and improve coordination.

13. PRODUCTIVITY PRESS DEV. TEAM, STANDARD WORK FOR THE SHOPFLOOR 10 (2002).

14. *ACC Value Challenge*, ASS'N CORP. COUNS., http://www.acc.com/valuechallenge/index.cfm (last visited Mar. 8, 2012).

15. Thomas L. Sager & Scott L. Winkelman, *Six Sigma: Positioning for Competitive Advantage*, 19 ACCA DOCKET 18 (2001) (in-house lawyer and outside counsel describing adoption of Six Sigma at Dupont); Elaine Schmidt, *Law and Order: 64-Year-Old Firm Adapts Six Sigma to the Delivery and Billing of Legal Services*, iSIX SIGMA MAGAZINE, Nov.-Dec. 2009, at 26.

Nevertheless, insofar as one can estimate from available information, current standardization efforts appear limited in some respects. First, they seem to be disproportionately focused on relatively simple and repetitive tasks that can be governed by routinizing norms and less attentive to relatively complex and differentiated tasks that call for decision process norms. There is particular enthusiasm for standardization of tasks that can either be given to on-site paraprofessional staff or outsourced. E-discovery has been subject to especially sophisticated standardization efforts.[16] Reformers also report efforts to standardize more complex but repetitive tasks such as employment litigation, intellectual property licensing, and environmental compliance. They generally do not describe such efforts specifically enough to give a sense of what they involve.

We hear little in these discussions about the standardization of the kind of decisions involved in the Andersen meltdown and the backdating scandals. These are high-stakes decisions that cannot be routinized but that could benefit from protocols standardizing consultation, deliberation, and documentation. I mentioned that the fateful in-house decision that led to the shredding of Enron documents was left to a single junior lawyer to make on her own with virtually no written guidance. Backdating had many variations, including some involving deliberate wrongdoing. But as Victor Fleischer has suggested, many seem to have involved inadequate administrative structures that left matters to ungoverned low-visibility decisions by solitary actors.[17] Many managers claimed that their actions were approved by the auditors, although in most such instances it appears that the alleged approvals took the form of ambiguous oral statements rather than clear written ones. Protocols of the sort that Gawande developed that combine routinizing and decision process norms would likely have helped avoid some of the failures that resulted.

A second possible limitation suggested by some reports is that there is much more concern with cost-cutting than with quality improvement or practice innovation. The reports frequently boast of dramatic and specific cost savings. They rarely describe striking innovations. It is possible that this imbalance reflects concerns that disclosure of practice innovations will lead to a loss of competitive advantage, but I doubt it. Competitors share a good deal of technical information in most industries. Lawyers do not seem to be an

16. KPMG, SIX SIGMA IN THE LEGAL DEPARTMENT: OBTAINING MEASURABLE QUALITY IMPROVEMENTS IN DISCOVERY MANAGEMENT (2006).

17. Victor Fleischer, *Options Backdating, Tax Shelters, and Corporate Culture*, 26 VA. TAX REV. 1031, 1045-52 (2007).

exception. At bar association and continuing legal education sessions, lawyers are constantly telling their peers how they accomplish their successes. They may do this in the hope that others will reciprocate to their benefit. Or they may do this because it is the only credible way to demonstrate their superior expertise and thus obtain the prestige and referrals that it attracts.[18] Thus, it seems revealing that, so far, the quality literature has more to say about cost than about quality.

Third, the reports are ambiguous about the effect of quality undertakings on hierarchy. Standardization can be a way of enlisting all workers in re-assessment and innovation, or it can be a way of imposing hierarchical judgments on lower-status workers.[19] Some of the legal reports have a technocratic flavor that suggests the latter. Of course, hierarchy may be the most efficient way to organize some kinds of work. But to the extent that we are interested in the potential of the quality movement to vindicate the aspirations of traditional professionalism for meaningful work, the more bureaucratic forms of standardization have a cost.

B. Root Cause Analysis

A key premise of the quality movement is that mistakes are learning opportunities. Since mistakes are usually consequences of structures and processes, analyzing mistakes diagnostically can reveal potential institutional improvements.

Japanese auto manufacturing prescribes that mistakes be addressed in terms of the "5 Whys." For example, the immediate problem is that a machine is malfunctioning, but when we trace back the root cause, we find that the malfunction occurred because the worker failed to maintain it properly, that he failed to maintain it properly because he was pre-occupied with another machine that kept jamming, and that the second machine jammed because of a design defect in the part that it stamped. The most useful intervention is to re-design the part, but we never learn that if we stop at the "human error" of the maintenance worker.

18. ERIC VON HIPPEL, DEMOCRATIZING INNOVATION 77-91 (2005) (explaining why innovators often freely reveal their innovations).

19. For an example of the egalitarian version, see MICHEL GREIF, THE VISUAL FACTORY: BUILDING PARTICIPATION THROUGH SHARED INFORMATION 213 (1989) ("By decentralizing and providing management tools at the production location [i.e., practice standards and performance indicators], management has in effect expanded the number of managers.").

Mention of error detection and root cause analysis is rare in the legal literature on quality management. An interesting exception in a discussion by KPMG of how Six Sigma might be applied to e-discovery gives an example of the 5 Whys applied to errors in decisions as to whether material is privileged:

> ***Why #1:*** *Why are there too many defects related to privilege calls and redactions?*
> Answer: The review team may not have case specifics.
> ***Why #2:*** *Why doesn't the review team have the case-specific information necessary to make accurate privilege calls and redactions?*
> Answer: The review team does not have a list of all custodian and counsel names to track attorney-client communication that could potentially be privileged or require redaction.
> ***Why #3:*** *What custodian names and counsel names pertain to this matter?*
> Answer: A list of 20 custodian and 5 counsel names was provided to the review team.
> ***Why #4:*** *It the list accurate? What about the surrounding privilege and confidential issues related to Joe Smith and Kelli Jones?*
> Answer: We don't see Joe Smith or Kelli Jones on this list of custodian or counsel names. This could be a root cause![20]

Most of the legal quality literature is silent on error detection and correction. This is particularly surprising with respect to Six Sigma partisans, since the term Six Sigma refers to a mathematical ratio (three per million) proposed in the industrial engineering literature to designate an acceptable error rate.[21] This particular standard is arbitrary even in the manufacturing context, and there is no reason to think that it has any application to law practice. Yet, the legal literature does not discuss how errors are addressed or what are acceptable tolerances.

While KPMG's effort to apply Six Sigma to law practice is thus innovative, the example quoted above is inept in a symptomatic way. The analysis treats as four separate stages what is really a single cause—the review team lacks a complete counsel/custodian list. More importantly, it appears to stop prematurely. There is no canonical way to define what constitutes a single "Why", and "5" is an illustrative number, rather than a requirement. The basic goal is to trace back

20. KPMG, *supra* note 16, at 16-17.

21. Sager & Winkelman, *supra* note 15, at 18.

the problem as far as is likely to be productive. Yet, in KPMG's example, it seems likely that it would be worthwhile to go another step or two. Why doesn't the review team have a complete list? Is it because the list was compiled or taken from some separate source that has inaccuracies? (If so, the remedy should extend to that source.) Is it because the team does not include people who have access or the ability to interpret essential information. (If so, the team or its lines of communication should be re-configured.)

One could imagine that KPMG's truncated analysis might lead to the conclusion that whoever failed to give the team a complete list should be blamed and disciplined. Such a conclusion would be contrary to the spirit of root cause analysis, which is intended to counter the tendency among both regulators and companies to individualize responsibility. The danger of this tendency is that it may discourage the systemic perspective. The SEC has disciplined a few lawyers, including Apple's General Counsel, in connection with backdating, but, understandably, it has prioritized cases of intentional wrongdoing, especially for direct personal gain, and has thus focused on individual motivation, rather than defective structures and processes. Law firms appear spontaneously inclined to take the individual perspective. When they are caught in a scandal, they often look for individual wrongdoers and respond by disciplining or firing them.[22] A consultant for liability insurers tells me that, when he visits a firm where serious professional failure has occurred, the most common response he hears is, "We had a problem, but we got rid of him."

Firms understandably seek to minimize publicity around scandals; so we have limited information of how they respond to the discovery of high-stakes errors. But as far as we know, they tend not to respond with structural re-assessment and reform. There is no indication that any of the firms or in-house staffs implicated in the backdating cases responded with anything resembling root cause analysis.

C. Peer Review

Gawande and others have pointed to the Mayo Clinic and Western Medical Associates in Grand Junction, Colorado, as a kind of healthcare "gold standard" that combines effective treatment with low costs. One of the key distinguishing features of these organizations is

22. An example is Milbank Tweed's response to the perjury prosecution of one of its bankruptcy partners. MILTON C. REGAN, EAT WHAT YOU KILL: THE FALL OF A WALL STREET LAWYER 229-31 (2006).

strong peer review.[23] Peer review enlists social pressures of shame and honor in favor of good performance, and it facilitates sharing of information. It also encourages the professionals being reviewed to be more reflective and articulate about their practice.

Peer review takes many forms, but in medicine, the most demanding and rewarding form is the case analysis in which the treatment of a particular patient or group of patients is critically appraised by a group of colleagues. This is the type of review that most directly and richly engages professional skills. Legislatures, licensing authorities, hospital accreditation bodies, and third-party payers require a range of case-focused peer review processes. For example, hospital "mortality reviews" assess the treatment of patients who die in the hospital. The focus is on errors or sub-optimal care. The treating doctors explain what they did and receive critical feedback from peers. Hospitals are supposed to engage in routine peer review of staff and attending physicians. The review includes scrutiny of a sample of the physician's cases. And third-party payers routinely undertake "utilization reviews" that assess the medical necessity of the treatment provided.[24]

As the quality movement has advanced in education and social work, such review has become more common in those fields. Kathleen Noonan, Charles Sabel, and I recently described an impressive peer review process performed in the child protective service agencies of several states. The process involved an audit of selected cases by teams consisting of supervisors and social workers from other states' systems.[25] Not all peer review processes have powerful effects; some are empty formalities or occasions for casual socializing. I would put the peer review process I know best—the one associated with law school accreditation—somewhere between the poles of high efficacy and triviality. In my experience, the schools occasionally get valuable ideas from the peer critics, but not often. However, the process of self-assessment that occurs in preparation for the peer sessions is usually valuable.

Peer review is strikingly underdeveloped in law. In law schools, legal scholarship is notoriously divorced from practice, and clinical

23. Atul Gawande, *The Cost Conundrum*, NEW YORKER, June 1, 2009, *available at* http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande.

24. ROBERT J. MARDER ET AL., EFFECTIVE PEER REVIEW (2d ed. 2007); PRATHIBHA VARKEY, MEDICAL QUALITY MANAGEMENT (2d ed. 2009).

25. Kathleen Noonan, Charles Sabel & William H. Simon, *Legal Accountability in the Service-Based Welfare State: Lessons from Child Welfare Reform*, 34 LAW & SOC. INQUIRY 523 (2009).

teachers have never developed the art of the case presentation. The most common type of peer exchange among practitioners is "continuing legal education," which even at its best, tends to take the form of general lectures and discussions only occasionally and vaguely focused on lawyering. CLE lecturers have an unfortunate tendency to model their pedagogy on that of the law schools. They are thus much more likely to talk about recent appellate decisions than about how they organize their practices or how they respond to recurring practical issues where statutes and cases provide little guidance.

Within firms, ongoing practice takes place increasingly in groups or teams that involve peer exchange over current decisions. But as I noted in connection with root cause analysis, there does not appear to be any developed practice even within firms of critical retrospective assessment of past decisions.

Outside counsel rating systems aggregate impressionistic judgments by clients about their lawyers, sometimes in a very sophisticated way. The resulting rankings can be informative, but they do not involve the kind of focused deliberative exchange of the more developed peer review systems. The client judgments that are aggregated are not made in a structured group process, and they are not focused on specific cases and practices. Thus, they do not produce the diagnostic learning that peer review aims at.

However, there appear to be some more ambitious exceptions. For example, FMC Technologies engages in "After Action Reviews" of completed matters. The review involves intense discussion of the question, "How could the matter have been handled better (procedurally)?" The process focuses on "continuous improvement as opposed to dwelling on the past."[26]

Recent regulatory reform in New South Wales, Australia, carries the peer review idea much farther than American requirements. Firms who adopt the Incorporated Legal Practice (ILP) form must have "appropriate management systems."[27] The Office of the Legal Services Commissioner audits periodically (and with greater frequency for firms considered high-risk) to assess compliance, and it provides technical assistance to regulated firms. The assistance takes the form, not just of general lectures, but advice tailored to the circumstances of

26. *Value Practice: Focus on After Action Review as a Way of Adding Value*, ASS'N CORP. COUNS., http://www.acc.com/advocacy/valuechallenge/toolkit/loader.cfm?csModule=security/getfile&pageid=40522 (last visited Mar. 8, 2012).

27. Christine Parker et al., *Regulating Law Firm Ethics Management: An Empirical Assessment of an Innovation in Regulation of the Legal Profession in New South Wale*s, 37 J.L. SOC'Y 466, 471 (2010).

particular firms.[28] This type of oversight and advice is sometimes provided to American firms from liability insurers, but many U.S. lawyers, probably including most of those who need it most, do not receive it.

Such practices are potentially valuable, but from the perspective of the quality movement, they suffer from an important limitation: They are confined to matters of "structure and process" and do not scrutinize judgments in specific cases.

D. Performance Measurement

Of the four categories of quality-related endeavor, performance measurement is the most familiar and developed in law offices. Firms use business metrics, such as hours billed in relation to hours worked, revenues in relation to billings (realization rates), and profits. They aggregate supervisor, peer, and client judgments of the quality of work and of results. Such judgments may be made for individual lawyers, practice groups, or the firm as a whole. Firms use such judgments for promotion, compensation, and training decisions. Business clients use them to decide how to allocate their work.

While such metrics and judgments are necessary for efficient personnel and procurement decisions, they do not necessarily address quality in the strong sense that the quality movement prescribes. An ambitious quality effort strives, not just to reward quality, but to improve it. For that purpose, we need metrics that have diagnostic value. Declining profits or client retention may tell the firm that it is doing something wrong, but such metrics do not give it any indication what that something is. More specific metrics may be more helpful, but of course, specific metrics can be ambiguous or misleading. In a hospital, a high mortality rate for cardiac surgery might indicate a quality problem with the surgical team, but it might also indicate that the hospital has frailer patients. When regulators forced hospitals to publish raw mortality data, some surgeons reportedly responded by trying to avoid vulnerable patients. The regulators' response was to adjust the data with an algorithm designed to account for the relative vulnerability of patients. But such complex metrics are costly to develop and apply, and some kinds of professional practice are not measurable in this way.[29]

28. *Id.* at 471–74.

29. David Weil et al., *The Effectiveness of Regulatory Disclosure Policies*, 25 J. POL'Y ANALYSIS & MGMT. 155, 173–74 (2006).

In the legal profession, government lawyers appear to have done the most sophisticated thinking so far on diagnostic measures.[30] Many prosecutors' offices have focused on conviction rates (including pleas). But a single-minded focus on this metric can encourage over-charging (so as to generate pressure to plead to a lesser offense), not to mention unethically aggressive behavior. The newer techniques take account of whether convictions were to the offenses charged or to lesser offenses, and treat high fractions of pleas to lesser charges as signals of possible over-charging. They also score measures of timeliness, consistency of charging decisions, and reported victim and witness satisfaction with their treatment. Some measures are related to particular local strategies. An office adopting a "broken windows" policing strategy might measure convictions for specified "quality of life" offenses. Another experimenting with a drug treatment diversion program might measure the fraction of certain categories of cases diverted. Metrics may include estimates of occurrence of specified crimes in the relevant community.

From a diagnostic point of view, it is useful to distinguish practice or process metrics from outcome metrics. The practice metrics measure the extent to which the lawyers are complying with their standardized work norms. The fraction of cases meeting the relevant criteria that are diverted to a treatment program would be an example. Outcome measures report on the extent to which goals are being achieved. Recidivism rates among arrestees in the diversion categories would be an example. The practice metrics indicate the extent to which the program is being implemented. The outcome metrics give some indication of the extent to which it is accomplishing its goals.[31]

Of course, the interpretation of such measurements is complex and speculative. The causal relation between practice (diversion) and outcome (recidivism) will usually be speculative. A low outcome score could indicate that the practice was misconceived, but it could also mean that the outcome measure is inadequate. Note, however, that for diagnostic purposes, progress does not necessarily require statistical rigor. Analysis can detect remediable errors and produce learning even if it does not produce uncontroversial generalizations of the sort that would support sanctions and rewards. Moreover, even

30. *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-04-422, U.S. ATTORNEYS: PERFORMANCE-BASED INITIATIVES ARE EVOLVING (2004); *see also* M. ELAINE NUGENT-BOROKOVE ET AL., NAT'L DIST. ATTORNEYS ASS'N & AM. PROSECUTORS RESEARCH INST., EXPLORING THE FEASIBILITY AND EFFICACY OF PERFORMANCE MEASURES IN PROSECUTION AND THEIR APPLICATION TO COMMUNITY PROSECUTION (2009).

31. *See* ROBERT S. KAPLAN & DAVID P. NORTON, THE BALANCED SCORECARD: TRANSLATING STRATEGY INTO ACTION 147-55 (1996).

speculative data can usefully direct attention fruitfully and structure discussion. It would usually not be fair to blame or sanction prosecutors for increasing crime rates, given the many factors beyond their control that affect crime. But it is still useful for the prosecutors to examine crime rate data and consider what it might suggest about the efficacy of their practices.

Some performance measures, such as conviction rates, are based on readily available numbers. Others, however, require complex judgment. The performance assessment instrument for social workers that colleagues and I studied included scores for qualitative assessments of such matters as the adequacy of planning and services for the child in a given case. Experience showed that, as long as examiners discussed their views with each other when they were unsure, judgments tended to be consistent. Social scientists have techniques for establishing "inter-rater reliability" for qualitative judgments. The techniques are often costly and time-consuming, but consistency is not necessarily precluded by the qualitative nature of the relevant judgments.

To judge by public discussions, the quality efforts in private firms have not begun to exploit the diagnostic and learning potential of performance measurement to the extent that lawyers in the public sphere and practitioners in other fields have done.

III. OBSTACLES TO QUALITY EFFORTS IN LAW PRACTICE

Several distinctive conditions may explain the relatively slow progress of quality initiatives in the legal profession. None seem insuperable, but some may require institutional reforms before significant progress can be made.

A. Professional Culture

A few years ago the director of a legal services program explained to me the process by which the program evaluated its lawyers. For each lawyer, evaluators interviewed peer and staff colleagues on their views of the lawyer's strengths and weaknesses and contacted a sample of the lawyer's clients to get their views of the quality of the representation they received. When I asked whether the evaluation involved a peer review of a sample of the lawyer's cases, the director said no and expressed surprise. "These people are professionals," he said. "They don't expect others to be second-guessing their judgments."

The notion of professionalism implicit in the director's response is long-standing. In this view, lawyers practice on their own. They are

not subject to close supervision. Their judgments tend to be tacit and ineffable. Their decisions cannot be assessed by lay people, and even among peers, distinctions between good and bad practice can only be made in extreme situations.

In this view, the solitary and ineffable nature of professional work was portrayed as a necessity, but it also came to be seen as a prerogative. The profession attracted people who liked to work on their own and disliked supervision. Part of the prestige and dignity of the professions was tied to these conditions. Thus, it is not surprising to find professionals resisting the pressures for standardized work or performance measurement of the sort promoted by the quality movement.

Professional ideology tends to view the lawyers "independence" (or isolation) as a safeguard of the client's interests, and to see almost any efforts at organizational accountability as presenting threats to client interests. After abandoning its more categorical opposition, the bar continues to mount ambiguous resistance to efforts by insurance companies and legal aid programs to exert organizational control over the lawyers they compensate on behalf of third-party clients. They often oppose supervision as inconsistent with the lawyer's duty to reject "interference with the lawyer's independence of professional judgment."[32]

To an important extent, such views seem anachronistic. Lawyers, like most professionals, now practice for the most part in large organizations. They tend to do their work in groups. These groups are often interdisciplinary. In addition to inducing reflection, standardization facilitates communication across disciplines.

The legal aid director with whom I discussed staff evaluation assumed that the major satisfactions of professional work were connected to freedom from supervision. It's true that supervision can be oppressive. However, the newer style of professional work is more collaborative than the traditional one, and many people will find this collaborative dimension more satisfying. Moreover, the newer style potentially increases the experience of self-conscious learning and innovation.

Organizational control can threaten client interests, but a key lesson of the quality movement is that it is also potentially a safeguard of them. Error studies show that solitary ineffable professional

32. MODEL RULES OF PROF'L CONDUCT R. 1.8(f)(2) (2011); *see, e.g.*, ABA Comm. on Ethics & Prof'l Responsibility, *Lawyers Participation in For-Profit Prepaid Legal Service Plan*, Formal Op. 87-355 (1987) (suggesting that almost any supervision by provider of prepaid legal insurance of lawyers' activities has "a potential for improper control" under this rule).

judgment often produces errors that can be avoided by institutional controls. Although we don't have comparable studies for lawyers, there is no reason to think that lawyers are immune from the cognitive limitations that quality reforms are designed to correct. The bar's preoccupation with independence needs to be tempered with a recognition that too much independence is at least as dangerous as too little.[33]

B. Economic Context

The quality movement came to medicine only after third-party payment became the dominant manner of compensation for medical services. It came at the insistence of the third-party payors—the insurers and the government. In law, we also see insurers and the government as salient movers behind quality initiatives, but in contrast to medicine, third party payors account for a small fraction of the market. Most legal bills are paid by clients.

We might expect clients to push quality reforms, and as I've noted, we do to some extent. Client efforts vary, however, depending on whether they are government actors, businesses, or individuals.

We've seen that, among clients, government agencies have undertaken the most sophisticated efforts to reform the practices of the lawyers who work for them. Businesses with large legal bills have also been active, but their efforts appear not to have been as energetic or creative as those of public-sector actors. A possible distinction has to do with the relative duration and breadth of the lawyer-client relations. Government agencies and their lawyers have a long-term and encompassing relation. Business lawyers and their clients sometimes have such relations but more often do not. The deeper and longer the relation, the more it makes sense to make the kinds of relational investments required for quality processes. The most

33. A major step in this direction is Model Rule 5.1, which mandates that law firm partners make efforts to ensure that "the firm has in effect [reasonable] measures" to ensure compliance with their ethical obligations. MODEL RULES OF PROF'L CONDUCT R. 5.1(a) (2011). Prior to that rule, professional responsibility doctrine treated lawyers as solitary individuals concerned only with their own conduct. *See* Ted Schneyer, *Professional Discipline for Law Firms*, 77 CORNELL L. REV. 1, 4-6 (1991); *see also* Parker et al., *supra* note 27, at 493, 499 (reporting that client complaints appear to have declined in Australian firms subject to rules mandating organizational controls, relative to firms not subject to the rules).

ambitious quality initiatives in the private sector seem associated with relational contracting.[34]

If government clients seem to be taking care of their interests in quality and business clients at least have the capacity to do so, that leaves individual clients, particularly one-shot unsophisticated clients, uncovered. The malpractice action is designed to protect them, but it is a crude and expensive method of quality control. The medical error studies indicate that only a small fraction of even serious errors eventuate in tort claims.[35] Preventive regulation seems desirable. As long as the organized profession exercises predominant control over the regulatory process, prevention-oriented reform will be difficult, but the Australian example shows that significant progress is possible in some circumstances.

Another pertinent economic circumstance that differentiates lawyers from doctors and some other professions is that lawyers operate in a more competitive environment. Competitive concerns would inhibit peer review and transparency initiatives. Lawyers would not willingly participate in a process that might disclose weaknesses in their practices to competitors who could use the information to solicit their clients. This obstacle is daunting but not insuperable. Insurers, regulators, and bar associations could construct a review process that minimized the risk of subjecting practitioners to review by competitors. Retired lawyers and judges might be good candidates for reviewers.

C. Confidentiality

Error detection and peer review raise two types of confidentiality concerns. First, there is the question of whether quality assessment information should be fully available to the client whose representation is being assessed. The disclosure of errors could lead to malpractice claims. Disclosure will sometimes be in the firm's self-interest. If the client is likely to discover the error anyway, it is better for the firm that the client learns from the firm itself. And disclosure will sometimes enable lawyer and client to take actions to mitigate the effects of the error. But no doubt there are some situations involving errors that are large, unlikely to be discovered in the absence of

34. David B. Wilkins, *Team of Rivals? Toward a New Model of the Corporate Attorney/Client Relationship*, 62 CURRENT LEGAL PROBS. 478, 478-557 (2009).

35. A. Russell Localio et al., *Relation between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III*, 325 NEW ENGL. J. MED. 245, 248-49 (1991) (estimating on basis of extensive empirical study that less than one in seven medical errors eventuate in malpractice claims).

disclosure, and irremediable where disclosure would be strongly against the firm's interest. Moreover, even where review does not disclose substantial errors, critical comments by reviewers, if disclosed, might undermine client confidence. Lawyers fearing such consequences would be reluctant to engage in review or to assess candidly.

It seems incompatible with fiduciary commitment to the client to exempt the lawyer from responsibility to disclose substantial errors, however painful that duty may become.[36] However, since that duty may inhibit quality efforts, some regulatory pressure—for example, mandated review processes and strong penalties for breach of disclosure duties[37]—may be necessary in some practice contexts, especially those involving unsophisticated clients. On the other hand, while the client's interest in learning about errors seems large, her interest in learning critical comments made in review processes seems much weaker. Here the case for a "privilege of self-critical analysis" and corresponding exemption from ethical disclosure duties seems plausible. Statutes provide some protections of this kind in the medical peer review context, and some states have enacted a "self-audit" privilege for insurance companies.[38]

The other set of confidentiality issues concerns the possibility that review might inadvertently waive client confidentiality vis-à-vis outsiders. Any peer review involving outsiders to the firm would require client consent, and there is a risk that such consent might be construed as a waiver of privilege with respect to the world at large, rather than just with respect to reviewers.[39] Again, the problem could be solved at little cost with an explicit exception from waiver doctrine for disclosures in connection with good faith peer review and quality control efforts.

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36. Benjamin P. Cooper, *The Lawyer's Duty to Inform His Client of His Own Malpractice*, 61 BAYLOR L. REV. 174, 175-79, 213-14 (2009).

37. An optimal sanction regime should generally set higher penalties for undisclosed than for disclosed malpractice. *See generally* Jennifer Arlen & Reinier Kraakman, *Controlling Corporate Misconduct: An Analysis of Corporate Liability Regimes*, 72 N.Y.U. L. REV. 687 (1997).

38. Marder et al., *supra* note 24, at 21-24; Christine A. Edwards & John E. Court, *Good Corporate Behavior Redux—The Federal Self-Evaluative Privilege*, METROPOLITAN CORP. COUNS., June 2007, at 13, *available at* http://www.winston.com/siteFiles/publications/GoodCorporateBehaviorRedux.pdf; *see also* Brendan F. Quigley, *The Need to Know: Law Firm Internal Investigations and the Intra-Firm Dissemination of Privileged Communications*, 20 GEO. J. LEGAL ETHICS 889 (2007) (discussing the extent to which lawyers can assert privilege against clients for intra-firm discussion of their responsibilities to the clients).

39. *See, e.g.*, *In Re Von Bulow*, 828 F.2d 94 (2d Cir. 1987) (client's consent to lawyer's disclosure can waive privilege beyond scope of intended disclosure).

The confidentiality obstacles to the more ambitious quality efforts are substantial as doctrine now stands. But it seems likely that the bar could obtain legislative changes that would resolve the problems if it had the inclination to do seek them.

CONCLUSION

Despite some notable initiatives and the increasing use of quality rhetoric, the bar has lagged in the embrace of the quality reforms that have transformed other professions. The inhibitions on reform protect clients and lawyers from the dangers that reform might compromise client interests or lawyer morale, but they also preclude the benign potential of reform, including the fostering of service that is more reflective, adaptive, and transparent to clients.