MEASURING THE QUALITY OF LEGAL SERVICES: AN IDEA WHOSE TIME HAS NOT COME

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There is a record of concern about the quality of legal services. And there is a record of the attempt to ensure quality through restricting the admission of persons to the practice of law. But beyond this, there is no "system" for, nor for that matter, any theory about, assuring the quality of legal services. This paper proposes such a system, and at the same time offers a theoretical framework for its development. And this is done despite the fact that it is highly unlikely that any such system will be utilized in the near future.

The paper develops its theoretical base, and its concrete proposals, from an extended examination of the systems of quality assurance which have been developed for medical care services. Given a sufficient degree of similarity between the medical care and legal service systems, analogical analysis is used.

The paper concludes that a quality assurance system can be fashioned for the provision of legal services, even though such a system is likely to remain a theoretical construct for the foreseeable future.

I. INTRODUCTION

This paper considers whether and to what extent consumers may participate effectively in evaluating the competence of lawyers and legal services in the context of prepaid and group plans. It is a pertinent issue, particularly given the consumer movement in the law and the rising interest in prepaid and group legal service plans. But there is a problem. There is a dearth of literature on the subject of the quality of legal services—the container for the narrower issue posed above. Not surprisingly, then, there is virtually no literature on the subject of practitioner competence. This paper must necessarily be largely conceptual.

There is another problem. Even conceptually the question of practitioner competence cannot be addressed until more is known about the purposes such competence should serve and about quality itself—a very elusive concept. And this at least initially requires an inquiry into a larger subject: the purposes of the law and the quality of the pursuit of those purposes. This subject will be explored, but only in order to set a context for the paper.

Finally, a personal note. I practiced law for about three and a half years, but I do not practice law now. I left the law nearly eight years ago. I haven't taught law either, but I have followed the debate about law and legal services with interest. In the last few

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years I have spent most of my time looking at the medical care system and, in particular, the relationship between medical care and health (see Carlson, 1974). In this exploration the issue of the "quality" of medical care services has been prominent. Since there is a provocative set of analogies between the medical care system and the legal system, and since the analogies hold fairly well at the level of quality, I will draw on my knowledge of medical care to enrich the analysis of legal services.

A. A Statement of the Problem

There are unmistakable signs that legal services as a subject of research has come of age, but what about the subject of quality? It is one thing to be concerned about the cost and distribution of legal services, but "quality" is quite another matter. Why? These reasons seem to be central

- From a logical perspective the issue of quality is necessarily a part of the larger subject of legal services.
- If someone pays for legal services furnished to another, as the government is doing to some extent and employers are being asked to do, then it is both logical and appropriate for each to inquire into the quality of those services.
- As commercial matters, and indeed most of life, become more complicated (no doubt due in part to lawyers themselves), lawyers and legal requirements have proliferated. In this climate corporate interests in particular have come to rely heavily on legal talent. The result is that those with the wherewithal to buy that talent can affort to shop for it and, accordingly, are interested in making discriminations among lawyers.
- The rise of prepaid group legal practice and the vitriol being spilled over the issue of advertising has floated the issue of quality to the surface, as it did in medicine, in part because those who oppose these innovations tend to argue against them in terms of quality.
- Watergate.

More on this last point. What we are experiencing is literally an "ecology of corruption." As news accounts proliferate about greed and hustling by the government and by many large corporations and institutions, the public soon stops believing those in power when they protest their innocence. The law and lawyers have not escaped the brush. As Irving Kaufman points out in a recent *Saturday Review* article, "No longer can [the lawyer] avoid impropriety by simple dedication to the judicial process or by adher-

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ence to principles of fairness in the conduct of litigation" (1975: 16). Kaufman notes a very typical example of the lawyer's dilemma:

> Dean Norman Redlich of New York University Law School poses the hypothetical case of a client who seeks advice on whether to offer a bribe to a foreign official in the hope of a favorable ruling. It is inconceivable to me that a lawyer who takes pride in the great tradition would restrict his advice to the legality of the bribe under American or foreign law . . . .
>
> Though the advice to be given may be readily spelled out, what should the lawyer's response be if his client indicates an intention to engage nonetheless in the bribery? [*Ibid.*]

It is well known which horn most lawyers would grab. And, as a result, most people simply don't believe that many lawyers are honest.[1]

B. A Restatement of the Problem

The point thus far is that the question of individual practitioner competence is only one way to deal with the question of quality. A number of levels of analysis might be pursued.

1. There is, first, the level of individual practitioner competence. This has two aspects: whether the lawyer is a crook, and, if not, can he or she do well at what he or she is supposed to do?

2. There is also a "corporate product" of legal services when there is a firm that provides the service—bridges fall down because of the interrelated and compounded errors of many.

3. Then there is the quality of the product the entire system delivers—the law that is made and practiced. This is analogous to the "amount" of health the medical care system produces and, similarly, the "amount" of knowledge the educational system produces.

4. Finally, there are the wider implications for the social structure generally. Do we have a healthy, vital, and free society; and what has been the contribution of law to that end?

For the balance of this paper I will look at levels one, two, and three, with an emphasis on level two. But since I will rely so heavily on the yield of health services research, more should be known about the relationships between the medical and legal systems—just how good is the analogy?

II. SOME DEVELOPMENTS IN THE MEDICAL CARE SYSTEM AND THEIR APPLICATION TO LEGAL SERVICES

Legal services are unique—they are different from engineering, dental, embalming, and medical services; but there are similarities

1. This may be a phenomenon peculiar to California. As Garry Trudeau points out in his comic strip "Doonesbury," 80 percent of the Watergate miscreants were from California. He adds comfortably or uncomfortably, depending on where you are from, that it is probably due to the drinking water. *Los Angeles Times*, November 16, 1975.

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as well, particularly with medical care. Legal services have been slowly expanding with population growth and affluence. But due to many factors, particularly group legal practice, a major market expansion may now be possible. This makes comparisons between medical care and legal services compelling. Medicine has confronted (unsatisfactorily to many) the challenges of market expansion and structural transformation largely posed by private and third-party financing. The legal system faces many of the same issues today.

A. A Rationale for Comparison, and Its Limitation

For most of the twentieth century the debate about providing medical care has been intense, even strident—far more so than the debate about legal services. This has been due to more vigorous and sustained public pressure; the struggle over Medicare began more than twenty years before its passage. And it is also due to an expanding governmental role in the financing and regulation of care. The organization of the firm—or delivery unit in medical care—has been amazingly resilient. But major changes in financing and regulating medical care have now occurred and have altered the structure of the medical care industry and also affected the style of medical practice.

The transformations of medical care might not be germane to the law if the similarities between law and medicine were fewer. There are differences but the likenesses are greater. Both systems provide services and, although medical care is more "essential" in a life and death sense, both services are vital and significant to large numbers of consumers. Both systems are highly—even exaggeratedly—professionalized. And both professions are tightly controlled by professional organizations, more so than any other profession, except perhaps the clergy (see, generally, Freidson, 1970; Lieberman, 1970; Lynn, 1963). Both possess great autonomy not only in professional matters, but also in the means by which they deliver services to the public. Both enjoy respectability, affluence, and political power disproportionate to their numbers. Finally, both exercise wide powers to perpetuate their franchise: they fix and maintain prices, although some limitations are slowly being imposed; they are ceded unmatched authority to determine entrance, practice, and "exit" standards for practitioners; and they can "create" demand for their product because of their pricing powers. But there are also limitations and differences which suggest caution in cavalierly applying the lessons learned in one field to the other.

Medical care is a more "critical" service; demand is less elastic —most people would do without legal services before risking the

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loss of medical care (although some, like the late Jack Benny, may value their wallets over their lives). The "politics" of the practitioners in the two systems are different—lawyers tend to be more "liberal" than physicians and are generally more comfortable in the legislative arena. And, historically, there has been more group practice in law than in medicine.

But the role of government is the most significant difference. It has cast a longer and more pervasive shadow over medicine. The governmental role in medical care is large—over 40 percent of all care is publicly purchased—and will necessarily grow with the passage of a national health insurance program.

On balance, however, since many of the transformations slowly remaking the legal system have previously occurred in medical care, and since there are many similarities of structure and practice, some carefully limited analogical analysis seems warranted.

B. The Evolution of Medicine as a Public Utility

Today medicine is very nearly a public utility. The government is the largest purchaser of care and, in this capacity, seeks to regulate the cost, distribution, and quality of services. The escalation of government involvement in medical care is germane to this paper because the government appears ready to increase its involvement in the provision of legal services and, if it does, it will soon address the question of quality.

Medicine opposed government intervention from the start—correctly perceiving that federal financing, even on a modest scale, was the camel's nose under the tent. But it fought a losing battle. Today the federal government proposes even wider implementation of major regulatory constraints on medicine, including cost and distribution controls and intricate programs of quality control.

The invasion of medicine by the public began forty to fifty years ago. The initial problems were cost and control: cost because medical care was expensive, and control because it was important. The problems galvanized consumer groups, and spawned the "Blues"—Blue Cross and Blue Shield insurance plans. Consumer groups sought prepaid practice to curb costs but, more importantly, to gain some control over what they perceived as an essential service. But their half-loaf was health insurance. Nevertheless, the creation of a private insurance market, first with the Blues and thereafter by large commercial concerns like Aetna Life and Casualty, failed to solve the problems that excited the controversy. Private insurance spread the costs but didn't reduce the total bill—groups like the elderly and the poor who couldn't afford medical care couldn't afford insurance either. And it failed to shift

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any real control to consumers. As medical care became steadily costlier, fewer consumers could afford to pay. The need for subsidization was becoming clearer. But given the political power of medicine and the impotence of consumer groups, more political muscle was necessary to transfer the social need into legislative reality.

After World War II the first serious pressure for a federal role in financing arose. There had been sparks just prior to the war, and a few continued to smolder through the conflict. The movement coalesced in the middle-1940s. Labor was involved. In 1948, for example, medical care was added to the list of subjects about which management must bargain (see McKiever, 1953: Section 1). Over the next twenty years the debate continued, reaching its apogee in the early sixties. The opposition of medicine was fierce. But despite the opposition, the proponents of Medicare and Medicaid finally prevailed in 1965 and 1966. A loose coalition of labor, the aged, and welfare rights groups (together with the fundamental equity of their claims) were responsible.

As soon as Medicare and Medicaid became law, the movement for wider coverage began. A substantial number of consumers—mostly lower and middle income—were still significantly impoverished by medical care costs. The logical solution was inclusion in the governmental subsidy. Organized labor again took the lead and formed the "Committee of Five Hundred" to promote a national health insurance program. Others were active as well: the radical health movement argued vehemently for a national program, spurred by the knowledge that only the United States, among the developed nations, lacked universal coverage for health care (see Babson, 1972). Employers' groups entered the field because employers were not being asked to assume appreciable costs for employee care and because they perceived the value of a healthy labor force (Reuther, 1972). In addition, provider organizations like the American Hospital Association proffered plans. Even the AMA pushed a plan, recognizing that it might be better to influence the debate constructively rather than oppose a program that was certain to be enacted in some form.[2]

Today all parties agree on one thing: there will be a national health insurance program, and soon. And all parties disagree on three things: first, the breadth and comprehensiveness of the program; second, the degree to which the program will compel or encourage changes in patterns of practice; and third, the degree to which the government will seek to assure the quality of medical care services.

2. For a comparison of the respective plans, including the AMA's, see Hodgson (1973).

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C. The Issues Today

In the thirties the main issues were cost and control, with distribution close behind. Today these remain issues, but two others have emerged: the structure of the system and the quality of services it provides.

The order in which these issues arose possesses a certain logic. The cost problem is clear. The control question is a function of the cost question, since consumer control presumably would lead to reductions in costs, but it connotes more. Consumers might reduce costs, but to the consumer the more important consideration is assurance of uninterrupted service. Thus, the depression created a cost squeeze, but it also threatened the availability of the supply, at any cost.

The distribution problem is also clear but is seemingly intractable. There is simply no easy way to compel a more equitable distribution of doctors. Hospital care can be redistributed and was—largely through the Hill-Burton legislation enacted in 1946, which provided ample funds for rural hospital construction (see Lave and Lave, 1974).

Issues of structural reform arose out of the debate on the first three. If costs couldn't be cut and providers couldn't be forced to relinquish some control, and if doctors couldn't be compelled to practice in places of need, then perhaps medicine could be structurally rearranged to accomplish the same ends. Incentives would be needed because the assault could not be direct.

The question of quality hadn't even been formulated in the thirties. Medical care had just acquired some new and powerful tools and the public was impressed. The issue didn't enter the public arena until evidence was amassed in the late 1960s and early 1970s that medical care was uneven and at times unmistakably poor (see Bunker, 1970; Starfield and Scheff, 1972). The government then (and now) took the position that it had the responsibility to assure the quality of the care it was buying. Initial efforts were modest but drew almost apoplectic responses from medicine. Recently, however, the Professional Standards Review Organization (PSRO) legislation was passed ("What Makes Doctors Sick," 82 *Newsweek* 94, December 17, 1973). The legislation is primarily designed to contain costs but has quality assurance as an important subsidiary objective. For example, medical justification for the use of certain procedures must be shown to ensure reimbursement under either Medicare or Medicaid. This legislation is generally recognized as the prototype of a more comprehensive program of quality assurance which will be linked with the passage of a national health insurance program.

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With the passage of the PSRO legislation and the threat of other, even more stringent quality control programs, quality has become a matter of public policy. But it has taken a long time for it to emerge as an issue. What are the prospects in the legal system?

D. Where is the Legal System Today?

Today the law faces many of the same issues and pressures that medicine has faced over the last three decades. And many of the same parties are involved. The government has been involved ever since the OEO legal services program was launched. Labor is involved because it desires to convert legal services from a "voluntary" into a "mandatory" subject for collective bargaining. Consumer groups are active but not as vociferous as they have been in medicine, perhaps because legal services are not perceived to be as vital as medical care. This is true of public employee organizations as well. Finally, there is a "radical" reform government, and the slow emergence of a private insurance market can also be seen.

The issues are largely the same, but the emphases are different. Cost is a problem but, because legal services are not as crucial to the public, cost controls by government and governmental financing are not the bellwether issues they were in medicine. Instead the issue appears to be the "means" by which legal services will be promoted among "publics" who are not customarily purchasers of legal aid. The issue of cost is related to this development because it is clear that middle income consumers will not buy legal services at a cost that competes with other needed goods and services—legal services may always be a luxury item to some. But if cost is not a pivotal issue, control is. Lawyers fear that much of standard legal practice could be deprofessionalized because the law is less technical than much of medical care. Means can more easily be developed to resolve disputes without the use of professional technicians. But even professional alternatives represent a threat. The group practice model in the law poses the clearest challenge to professional autonomy and control. The Bar Association recognizes this when it seeks to channel change through mechanisms of its own creation. The debate over "open" versus "closed" panels arises from this larger issue. In this sense then the early struggle in medicine over the growth of prepaid group practice is the issue most germane to the further development of the legal system. The more recent debate over governmental financing is material but of less immediate relevance.

In sum, the issues now being debated in legal services circles are many of the same issues that have been debated (although not necessarily resolved) in medicine. And they seem to be arising in

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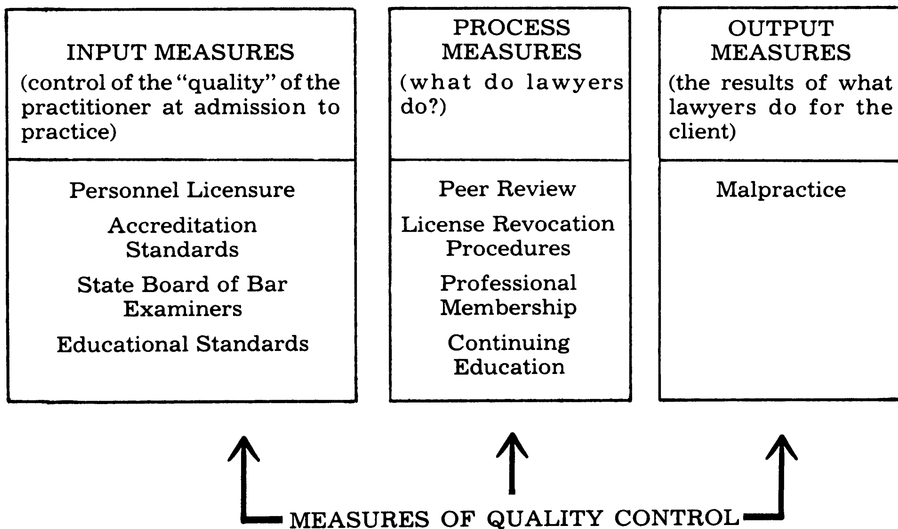
about the same order—cost and distribution first, followed by access questions, and then finally by structural and quality issues. If this is so, then the conceptualizations and indeed many of the approaches taken to each of the issues—especially that of assuring the quality of medical care—should be helpful in shaping a quality assurance program for legal services. This doesn't mean that quality can be measured in the same way in both systems; the methods and products differ too much. But it does mean that the general ways in which the problem has been approached and some of the techniques that have been or are being used might be transferable.

III. CAN THE QUALITY OF LEGAL SERVICES BE MEASURED?

A. The Method of Regulation

There are three fundamental approaches. They are represented in the figure below.[3]



Input measures, like licensure, assume that quality is assured (without seeking to measure it) because the resources entering the system met certain standards at the time of entry.

Process measures, like continuing education and professional membership (or in medicine, like most peer review programs), assume that quality will be achieved by insuring that the practitioner does certain things in the course of practice. For example, in medical care, if the practitioner follows Steps X, Y, and Z in rendering care to a given patient, then he or she has met quality assurance standards whether the patient lives or dies. In the case of

3. This figure has been adapted from Carlson (1970).

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law the same would be true if all of the instruments necessary to complete a transaction were properly executed and filed in a timely manner, irrespective of the outcome to the client.

Outcome measures, like the results of a medical malpractice claim, assume that quality will be achieved if the actual outcome to the client or the patient is satisfactory. The definition of the word "satisfactory," of course, is a very subtle matter.

Existing measures of quality assurance come in all shapes and sizes, although for both obvious and not so obvious reasons, there are fewer outcome measures. I'll return to this subject later.

B. Who Regulates?

Here again there are three options. First, the profession can take on the job, as is now widely the case. Second, following the pattern increasingly evident in medical care, the government can assume a regulatory role. Finally, the consumer can seek to regulate, principally by choice of practitioner, but also by participation on professional or governmental regulatory boards.

In the special instance of legal services all of these options—both the "how" and the "who"—are essentially open. Legal services are not now systematically regulated. Perhaps they will never be. But in the balance of this paper all such regulatory measures—actual and potential—will be discussed using the framework of this section.

C. The Regulation of Legal Services

1. *The Practice of Law Today*

This section has to be impressionistic because, without sensitive measures of quality, there is no way of knowing what the state of the legal art is. All we have are the results of a few malpractice actions against lawyers; some studies of lawyer adherence to or violation of legal ethics;[4] a few surveys which show that many people don't use legal services, which may be a partial reflection on the quality of those services (see, e.g., Christensen, 1970; Curran and Spalding, 1974); and the public remonstrances of a few knowledgeable people, most notably Chief Justice Burger, on the quality of the average lawyer. There are a few other odds and ends, but that's about it.[5]

4. These studies fall into two types: research focused on why lawyers deviate from ethical and professional standards, and research on why existing practices and procedures of disciplinary agencies fail to control even outrageous departures from community and professional standards. Examples of the first are Carlin (1966) and Handler (1967). An example of the latter is the Clark Committee report (American Bar Association, 1970). Both are discussed in Marks and Cathcart (1974).
5. This isn't the case with other fields. There is a very rich regulatory literature in medicine, some of which will be discussed in later sections of this paper, as there is in engineering and architecture.

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What views are generally shared by practitioners and clients? Two probably prevail. First, most practitioners (and, undoubtedly, all clerks of court) know how very uneven legal services are. The very poor, shoddy practitioners are all usually known, even in relatively large jurisdictions. But even respected practitioners and firms have their off days when they scatter about random blunders.

Then, too, there is probably a fairly high incidence of just plain screw-ups. After all, lawyers are awash in detail, mostly of their own making, and mistakes are bound to occur. They range from the obvious, like miscalculations and errors in the preparation and filing of instruments, to the very subtle, including poorly targeted appellate research and disastrous litigation strategy.

Since practitioner performance is uneven at best, and mistakes are probably quite common at worst, there is an understandable interest in trying to find out more about how lawyers perform and how to improve that performance. This interest is undoubtedly heightened by the fact that hordes of law school graduates are about to enter the market. And it is probably also a reflection of the thinness of existing input regulatory measures.

Simply put, clients are probably being injured today and, given the lack of measures of quality and the growing number of practitioners, there is a very real fear that more will be hurt in the future.

2. *How Effective Has Regulation Been?*

What has been done and what is being done to regulate the quality of legal services?

The method of regulation. A few years ago Lester Brickman compiled a bibliography on legal delivery systems (1973). Under the heading, "Regulation of the Practice of Law," he listed only the material on unauthorized and unethical practice. A review of the literature since that date reveals no significant breakthroughs. To commentators on law and legal services, regulation of quality means essentially the control of sharp practice. Of course, there's more to it than that.[6]

Some "input" controls are used in the law. Law school graduates are required to take bar exams and, assuming they pass, are thereafter required to be licensed. Licensure itself is almost a

6. The literature on "access" to legal services ultimately bears on the question of quality *if* the assumption is made that access to a lawyer is valuable to a client irrespective of the outcome to that client. But access is far from determinative. As Marc Galanter (1974) argues convincingly, access to legal services for certain socioeconomic groups is less important because their relative social and economic position renders them far less vulnerable.

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pure formality—a few affidavits are usually required testifying to the moral character of the applicant.

There are also movements for recertification and specialty certification. These differ in their objectives. Specialty certification is derived from the model of medical care, where thirty-three specialty groups are currently certified by the AMA and associated organizations, and is based on the ostensible need to assure the public that someone who claims a expertise actually has it (Mindes, 1975). Recertification, on the other hand, would apply to both general and specialty practitioners. Recertification movements are fairly common in other fields, particularly medicine and accounting (see Parker, 1974). They are premised on the simple idea that a practitioner's skill and knowledge might atrophy or become dated with time and, hence, should be reawakened by mandatory continuing education programs as a condition of recertification.

But this is about it, with the exception of malpractice actions against lawyers, which occur whether or not anyone characterizes them as regulatory measures. There are then a few "soft" input measures, a slight but perceptible trend toward some "process" controls like continuing education and recertification; and no outcome measures, with the possible exception of malpractice and sometimes the findings of disciplinary boards.

Who regulates. Today the profession itself does virtually all the regulating that occurs. State governments are involved as licensing bodies, but they are little more than messengers for the discriminations made by the profession. Otherwise, government has not yet sought to regulate legal services, except to the extent that its funding of legal services programs allows it to exercise authority. Similarly consumers, again with the exception of those who sat on the boards of Community Action Program agencies, have failed to try to influence the practice of law.

There is nothing inherently "wrong" with an unregulated industry—nature has shown no natural inclination to fill all regulatory vacuums. But some vacuums seem irresistable. Not surprisingly, then as legal services are perceived as increasingly central to the division of spoils in our society, a regulatory impulse has arisen. Part of the impulse is supplied by those who urge continuing education and reeducation. Others are trying to devise more rigorous input standards, particularly by relating input testing to actual practitioner performance. Finally some, who look to other delivery systems and see what wonderfully complex regulatory systems have emerged, conclude that the grass is greener over there. But how much greener is it?

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IV. THE REGULATION OF MEDICAL CARE: A CASE IN POINT

Before turning to the possibilities of further development of the regulatory apparatus for the law, what has been done to measure the performance of physicians, and how has their activity been regulated?

In medical practice, essentially four regulatory mechanisms have been used

- *utilization review* focused on the use of available facilities and services;
- *medical audit* of the quality of care received by patients;
- *claims review* of the appropriateness of services billed to a third-party payer; and
- *Professional Standards Review Organizations* (PSROs), which are legislatively mandated organizations charged with the responsibility to conduct utilization review and medical audits.

These measures have been designed to address two problems in the practice of medical care. The first, and probably the most important, is overutilization or overprovision of medical care and the contribution that makes to the high costs of care. Utilization review and claims review are directed towards uncovering it. The second problem, which has become slightly more important in recent years, is the low or at least uneven quality of medical care. Of these two problems, the second is more germane to this paper.

Of the basic regulatory measures listed above, the second and fourth, medical audit and PSROs, are most closely related to the quality of care. These measures are based upon a fairly thorough and provocative body of research. Although the research has been inadequate to develop definitive policy, far more has been done with respect to medical care than with respect to other human services. Given the close relationships between the provision of medical care and legal services, this research is worth looking at in some detail.

A. Methods of Regulating the Quality of Medical Care

There have been three major phases of regulation. The first consisted of informal self-regulation, with the exception of medical malpractice litigation, which is quasi-public in nature. It rested largely with organizations of providers such as medical societies and with provider units such as hospitals. In the latter case the regulatory sanction was the grant and denial of hospital privileges.

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Since the government did not finance the purchase of care, its regulatory role was correspondingly limited. However, in the early 1900s, about the time that the Flexner Report revealed rampant fraud and insufficient quality in medical education, the states took the initiative and enacted health manpower licensure laws (Carlson, 1970). This legislation represented the first public intervention into the performance of the medical care system.

The second phase of regulation featured a slowly expanding governmental role, which culminated in the passage of Medicare and Medicaid. But self-regulation continued and even increased during this period, largely because governmental intervention was premised on sustained and more vigorous provider self-regulation.

The third and final phase of quality regulation has recently begun. Heretofore, regulation of the quality of care, whether public or private, has focused on individual practitioners and the safety and hygiene standards of health care facilities. In recent years the emphasis has shifted in two respects. First, from a focus on individual practitioners and health care facilities to a more systematic approach tied to integrated provider units, such as Health Maintenance Organizations, delivering both physicial and hospital services. And second, to an emphasis on the "outcomes" of care to the patient as opposed to the qualifications of practitioners and the physical characteristics of the facilities for care (see Ellwood, 1972).

Cutting across these three phases is the consumer role. In the first phase of regulation when professionals largely regulated themselves, consumers were in a position to exercise relatively informed choices. Medical care was not then as sophisticated as it is now, and it was easier for consumers to make choices among various providers. However, with the increasing sophistication and fragmentation of medical care, the role of the consumer has diminished; it is marginal today.

B. Research on the Quality of Medical Care Services

The research can be broken into five categories (see generally Slater and Bryant, 1975), each with a different degree of relevance to the potential regulation of the quality of legal services. In each case the research is briefly summarized, and then some of the central implications for the regulation of legal services are suggested.

1. *Effectiveness Research*

Effectiveness research focuses on the relationship between the provision of a given medical care service and the outcome to the patient. Although it seems a logical question to ask, it has rarely

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been answered. This oversight has been remedied to some extent recently by the development of some sophisticated effectiveness research on a number of well-known medical procedures, including the pap smear, coronary bypass surgery, the use of cardiovascular care units for heart attack victims, anticoagulant drugs, and radical mastectomy for breast cancer. In almost every case the procedure not only failed to produce the results that everybody expected but, when compared to far less expensive treatments, was found to be no more effective.

The implications of this research for legal services are twofold. First, because the research designs were very simple—one simply assigns patients and/or clients randomly to one procedure or another and then measures the outcomes—similar studies could easily be developed for the measurement of the impact of various legal services. A second implication is that "error" in a system relying heavily on human labor is not so much a matter of individual mistake as it is a compound of many systemic failures. In almost all effectiveness studies in medical care an individual's error rarely led to the ineffectiveness of the procedure in question. Rather, there was failure by all the components of the medical care system which were deployed. This latter conclusion suggests that assurance of the quality of legal services is also more likely to succeed if its major focus is on systemic failures rather than upon individual competence.

2. *The Education of the Practitioner*

One of the classic input measures to assure the quality of medical care services has been the educational proficiency of the practitioner. The studies inquiring whether or not educational achievement is related to subsequent practitioner competence have yielded mixed results. Associations are apparently hard to derive because the attrition in knowledge over the life of a practitioner's work is likely to be very substantial, whether the practitioner is a physician or a lawyer. As a result, it would be unrealistic to expect that similar studies will produce different results in the legal services context.

3. *Utilization Review Programs*

The purpose of utilization review in medical care has been to save money. But that hasn't been easy. If cost containment measures are based on reducing fees, physicians somehow find a way to increase the number of "units" of services provided, thereby generating the same cash flow. Conversely, if the attempt is made to control the number of "units" of services rendered, physicians increase their fees. As a result, utilization review programs that

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attempt to control both rate structures and the number of "units" provided have been the most successful.

On the hospital side, there is some evidence that thorough review of the utilization of services, particularly the use of beds, can produce cost savings because of the inordinate costs of modern medicine. From 1974 to 1975 the gross cost jumped from 104 to 118 billion dollars, representing a leap from 7.5 to 8.3 percent of the Gross National Product (Social Security Administration, 1975).

On the assumption that providers of medical care enjoy incentives to overprescribe and overutilize costly facilities, attempts have been made to curb such practices. The data suggest that the review process succeeds in exposing numerous instances of overutilization, but that practitioner behavior is only slightly affected. This is especially true when there are no significant economic incentives for practitioners to change established practice patterns.

4. *The Medical Audit*

The medical audit differs from utilization review in one significant respect: it is a locally controlled peer review program focused on the extent to which practitioners conform to sets of process measures for given procedures. There are two overall conclusions to be drawn from the work that has been done. When applied in a circumscribed setting, such as a hospital, and directed by an informed, interested individual, this approach is likely to be successful in changing physician behavior and improving performance. But when it is replicated on a broad scale, it does not necessarily produce equally salutary results.

One major implication is that assurance of the quality of legal services through an "audit" procedure is likely to be more successful in those locales where both practitioners and auditors are highly motivated and are not constrained by personal or institutional loyalties, as is often the case. Nevertheless, translation of success at a local level to a regional or national setting may be very difficult, as has been the experience in medical care.

5. *Miscellaneous Structural Considerations*

Leaving aside the method of quality review, what evidence is there that the organization of medical care delivery systems influences the results of quality assurance programs? The studies that have been done on various structural considerations relating to the quality of care suggest the following

- Nonprofessionals can be successfully utilized in quality-screening programs where there is substantial professional agreement on the criteria to be applied. Of course, where the

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nuances of legal services are the subject of the review, it is less likely that nonprofessionals will be able to perceive differences in performance.

- There are definite trade-offs that follow from the rigidity of the standards used: if the standard allows little discretion in its application, the amount of overall change in practitioner performance is likely to be greater, but the system may suffer because of the lack of equity.
- Programs of quality assurance in medical care are much more likely to be effective if they focus on gross provider incompetence than if they attempt to distinguish fine gradations in performance among those practitioners who are at least minimally proficient.
- And finally, quality assurance programs have a greater likelihood of success if they are integrated into a practice setting as early as possible; a quality assurance program instituted in a new hospital is far more likely to succeed than one that is superimposed upon an older facility.

C. What Does All This Mean?

This all-too-brief survey of some of the quality assurance research in medical care presents some obvious lessons for the regulation of the quality of legal services. I will return to some of these points, but for now the following implications seem valid.

First, the problem of quality is not necessarily one of individual error; it is partially that, but is more a matter of system failure.

Second, efforts to change practitioner behavior are ineffective unless they are implemented at the local level and coupled, to the extent possible, with economic incentives or at least credible peer pressures.

Third, outcomes assessment, though much more difficult than process assessment, is vastly preferable because, among other things, effective outcomes assessment allows us to improve our process criteria.

Fourth, certain structural factors do influence the success of quality assurance efforts, although the legal system may be sufficiently different in these respects to warrant caution in applying the findings drawn from medical care.

With all of this in mind, what are the prospects for assurance of the quality of legal services?

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V. PROSPECTS FOR REGULATION OF THE QUALITY OF LEGAL SERVICES

Early in this paper I suggested that there are four "levels" of regulatory focus: the individual, the firm, the system, and the wider impacts that the law and its practitioners have on social and cultural phenomena. In this section my intention is to discuss the prospects for the regulation of the competence of the individual legal practitioner (and the firm where appropriate). But before doing so, I want once more to stress the importance of looking as well at the competence of the legal services system.

The record of regulation in medical care illustrates the dangers of an exclusive focus on individual practitioner competence. It is possible that uniformly optimal individual practitioner performance will not necessarily produce health in the population. Health is a function of many variables other than medical care. Yet in our pursuit of health we have been seduced by medicine to the point where virtually all of our health-related resources are lavished on medical care. The result is that we starve all of the other programs and approaches that might generate better health. Cancer research is an example. Estimates vary at the margin, but most commentators know and can increasingly demonstrate that 80 to 90 percent of all cancers (cancer is not a disease but a series of disorders with common properties) are "caused" by environmental contaminants. Yet we spend almost all of our cancer research monies to develop and refine techniques designed to cure the organism whose environment is destroying him (see, e.g., Cairns, 1975).

The point can be put more sharply so that the analogies to the law can be seen. In late November of 1975 I participated in a high level conference on medical care organized under the auspices of a health services research center affiliated with Boston University Medical Center. The conference was funded by the Robert Wood Johnson Foundation, the world's second largest foundation, whose resources are wholly devoted to the improvement of the medical care system. The conference had as its focus the regulation of the delivery of medical care services. A number of regulatory devices were examined, including licensure, malpractice, peer review, medical audit, etc., most of which are analogous to regulatory mechanisms in the law. In a paper I prepared I sought to depict the significance of the subject of licensure with respect to the larger systemic objective: the production of health. I excerpt from that paper:

Picture a bar graph that represents health:[7]

7. I am aware that this use of schematics is unsophisticated and subject to criticism for the lack of adequate representation of coordinates. Nevertheless, I am trying to sketch the ideas visually and graphically, leaving questions of statistical nicety to those who wish to ask them.

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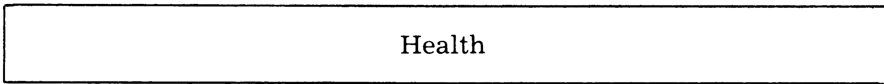
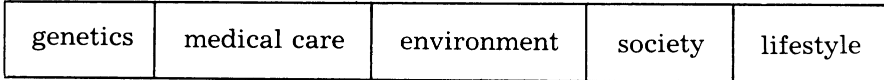
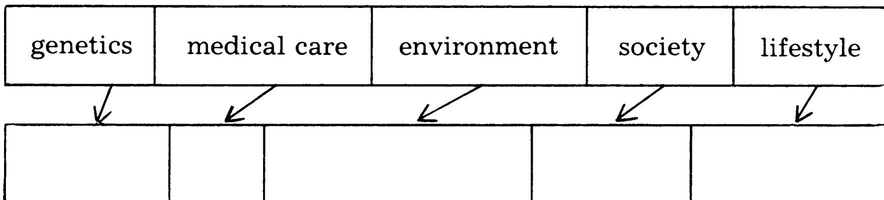


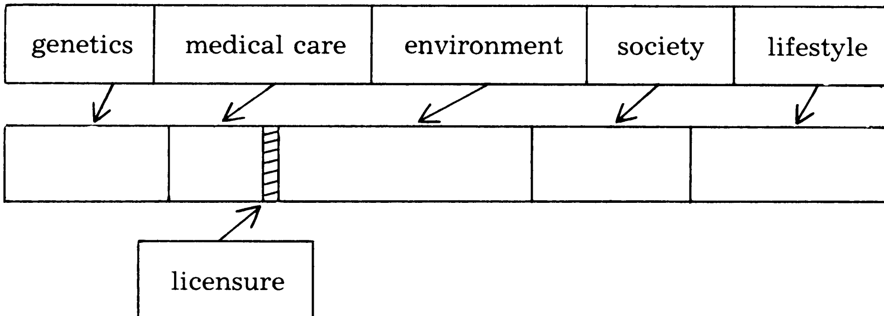
And picture above it five major clusters of variables that influence health:



Then plot the influence of these sets of variables on the dimension of "health," given what current evidence there is (admittedly poor):



If medical care makes the contributions suggested above, what part of that contribution is owed to licensure? If we are generous and say 25 percent, then what we are saying is that this much of health is conceivably due to licensure controls:



The same sort of argument can be made about the law. If health is or at least should be the objective of the medical care system, then what is the objective of the legal system? This is a difficult question to answer, however simple it is to state. Nevertheless, as a working definition (with which many would disagree), the following will do: the legal system should provide the just, expeditious, and parsimonious resolution of disputes. A cold, hard look at the legal system today suggests that by any measure the system is failing to meet that objective. The issue of justice, of course, is always difficult to argue, and people will differ about matters of degree; but a

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system that lavishes its resources on the wealthy and creates a federally funded legal services program solely for the poor can hardly be said to be a system that meets the needs of everyone. Moreover, the system is hardly speedy. It is perhaps true that large corporate interests buy legal help as much to gain time as to lose it, but it simply isn't true that the dispute-resolution needs of the rest of the population are met by a system that rewards dilatory tactics. And finally, as if it isn't obvious, the cost of legal services has escalated to the point where they simply can't be afforded by any but the rich.

Despite fairly widespread agreement with these assertions, the danger still exists that zeal to measure the competence of the practitioner will blind us to the need to measure the competence of the system. Having said this, there are three large questions left. What technology is required by a regulatory system for the quality of legal services? Based upon the state of the technology, what type of regulatory measures can be used to look at practitioner performance? And finally, who should do it?

A. Criteria, Standards, and Quality Assurance

The first issues to be decided are what standards and criteria for measurement will be used. Quality can provisionally be defined as "adherence to a standard." There can, of course, be input, process, or outcome standards, or a mixture thereof. Whatever the type of standard, criteria are needed to determine whether adherence did or did not occur in a given instance. Both standards and criteria can be established by either the profession or the public, or responsibility can be shared. And criteria can be either "preset" or ad hoc, though standards are almost by definition preset.

Within these parameters, a regulatory system for a given service can be established. Naturally, the standards and criteria will depend on the service to be provided. A concert pianist might be asked to play a score and be judged by her peers in terms of technical competence, phrasing, etc. A mathematician might be asked to solve a representative sample of difficult mathematical equations. A carburetor repairman might be asked to correct five common carburetor deficiencies. To a great degree, then, a quality assurance system must first address itself to what performance is desired. Quality assurance systems for manufactured products can involve consumer reports, tests of the quality of the item, etc.; a television, for example, can be judged by its audio and video qualities and by its frequency of repair record. But the evaluation of the quality of services, particularly legal and medical services, is necessarily softer.

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Given these problems, can a quality assurance system for legal services be conceived; and how would it work? In wrestling with these questions, it would be helpful to know how the technology is used in medical care.

As noted earlier, the regulatory approach in medical care has long been a mixture of input and process standards. In the last few years, however, there has been a perceptible shift towards outcome measures. This has been facilitated by the development of evaluative criteria, and in some cases has been legislatively mandated, as in the PSRO program. An example of recent work is a celebrated and controversial study done in the United Kingdom. Using a "randomized clinical trial" technique (assigning patients with common disabilities randomly either to a group receiving the care in question or to a control group not getting that care), it was found that heart attack victims had a better prognosis if treated at home than if carted off to the hospital and placed in a cardiovascular care unit (see Cochrane, 1972). Analogous randomized "trials" could be used in the law to assess the dispute resolving efficiency of a variety of dispute resolving mechanisms, including the use of lawyers.

Ideally an outcome oriented system would feed back patient outcome data to permit a retooling of the processes used in care. But such data do not insure retooling. In the case of the heart attack study referred to above, it is doubtful that medical practice in the U.K. or elsewhere will be radically altered to encourage the home treatment of patients, despite the results. Moreover, the studies necessary to construct such a regulatory system are costly, and often raise ethical dilemmas—it is difficult to randomize patients when a treatment is available that is either known or believed to work.

With respect to these sorts of issues, regulatory thinking about the law is profoundly primitive. This means the initial task is conceptual. Standards must first be established for what a legal practitioner is supposed to do before the decision is made to use any of the regulatory mechanisms discussed here.

B. What are Lawyers Supposed to Do?

Answering this question is a large undertaking, but the necessary steps can be suggested

- First, the types of services that lawyers perform must be specified in detail, on an "episode of service" basis. (If outcomes are even to be measured, whole cases have to be examined along with their constituent parts).
- Second, standards should be fixed for each such episode of

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service, i.e., what things must be done just to advance the case toward a resolution.

- Third, criteria must be established with which to determine whether the standards have been met; e.g., in a real estate transaction, purchaser titles should be free of defects that could have been anticipated, etc. These criteria should be preset whenever possible.
- The means by which the criteria will be applied must be decided, i.e., will episodes be randomly selected and reviewed by boards with shifting membership, or will all episodes be reviewed by a board with a more permanent representation, etc.?
- Fifth, a decision must be made whether outcomes will be considered or just processes, unless the processes are themselves dispositive, as in the timely filing of an appeal.
- Sixth, decisions must be made about the use of the results, i.e., whether they will only be used to educate practitioners, or whether sanctions will be applied.

These are the necessary first steps in the construction of a legal practitioner quality assurance system. Two questions remain: what type of measure should be used—input, process, or outcome—and who should evaluate.

C. What Measures of Lawyer Quality Should We Use?

1. *Input Measures*

First and most obviously, input measures don't fit into the schema just presented. They are not performance related. They could be if data on subsequent performance were used to modify the design of input controls. But this is unlikely. So these measures should be understood for just what they are—barriers designed to preserve the lawyers' monopoly. One of the inevitable effects of input control is to homogenize supply and grant the suppliers something approaching monopoly power. This means that legal needs can only be met by card-carrying members of the monopoly. Many legal needs will therefore fail to be met—particularly those of the middle and lower socioeconomic strata—because those allowed to practice have been trained to deal with the problems of only some persons who need help, principally those with substantial assets to protect or exploit.

There is more to it. It is not just that lawyers have practice preferences that match their capabilities; the very institutions of the law are structured to reflect their biases. Leon Mayhew (1975: 406) puts the argument this way:

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> (1) There exists in the population an aggregate of interests and claims and potential problems; some are well understood by the members of the population, while others are perceived dimly or not at all. (2) The legal system is institutionally organized and includes a set of institutions of representation. An institution of representation is an organized, established, routinized method of providing advocacy representation or other legal services to those who have legal needs, interests, and claims. (3) Each institution of representation possesses a peculiar set of biases; it is more likely to stimulate and provide for the representation of some claims than others. The biases are not random but structured. They reflect the social organization of the various institutions of representation of the legal system and of the larger society.

Input controls both create and reinforce these tendencies. And that, at least in major part, is why they are used. They are not and really cannot be used to insure competence throughout the careers of those practitioners who pass the initial screening. They can be used to keep a few of the most degenerate and incompetent out of practice, but this is done as much to protect the reputation of the profession as a whole as it is to protect an unsuspecting public.

Continuing education and recertification programs offer some slender hope of upgrading competence, but only if they are somehow related both to actual performance and outcomes. A lawyer could easily sit through four hundred hours of continuing education and gain nothing except some added tax breaks (see Rosenthal, *supra* 261).

The second obstacle is even more formidable. Input measures do not have the assurance of quality as their purpose. They can be (and historically have been) used to restrict the supply of services to insure a sufficient demand for the services of those who have already run the gauntlet. It may be possible to bend them a little to capture some performance-related criteria, but if their ultimate purpose would be diluted, there will be dogged resistance.[8]

In short, input measures are the least useful in regulatory terms and will not be easily transformed into quality assurance tools.

2. *Process Measures*

The prospects for innovation are brightest here for reasons that will be clear after I have discussed outcome measures. It should be easy to develop a series of process measures for legal services based on the technologies available for quality assurance. One example will serve. The incorporation of a small business can be systematically broken down into its constituent parts, each of which represents a process. From the first meeting with the client, the steps are

8. There is a fairly substantial literature to support these points; ranging all the way from Milton Friedman's purely theoretical arguments (1971), to Robert Derbyshire's thorough survey of the failure of input controls as quality regulating devices (1969).

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- preparation of the incorporation papers (based upon boiler-plate);
- a check (with the Secretary of State in many jurisdictions) to insure that the corporate name is available;
- finally, a check of trade names if necessary, etc.;
- holding of the first meetings of the incorporators and of the first board of directors;
- preparation of the minutes of those meetings; and
- the recordation of the appropriate documents to effect the incorporation.

Each step in the episode is subject to standardization based on present criteria. Then the entire episode can also be judged in terms of its rapidity, cost, inconvenience to client, thoroughness, etc. As noted earlier, some process measures may also be outcome measures. For instance, failing to check or erroneously checking on the availability of the corporate name when incorporating a business.

Almost all legal work can be broken down this way. Medical practice has been subjected to this sort of delineation, even though it is a more complex, multidimensional undertaking. Nevertheless, in the law, as in medicine, some of what practitioners do will not fit very well. Take a corporate merger. The steps in the merger can be readily identified in process terms, but a good outcome to the client is not so much a function of procedural crispness as it is a matter of negotiation tactics, including bluff, intimidation, withdrawal, poker-facedness, and "chutzpa." These qualities cannot be easily measured. And although they are processes they go to outcome.

3. *Outcome Measures*

In medical care outcome measurement is still in its infancy. In part this is due to decades of neglect. But it is also attributable to the deucedly difficult nature of the problem. Patients get well without physicians, and with them, or in spite of them; and they die for the same reasons. In large measure medicine is like a black box: things are done to patients for the ostensible objective of curing them, but few of those things can be definitively correlated with the outcome to the patient. A cure might have had more to do with the fullness of the moon. Nevertheless, research is underway, and unless physician resistance becomes even more shrill, many of the processes inflicted on patients will be outcome-tested.

In legal services there is neither outcome measurement, with the exception of malpractice litigation, nor are there many ideas on how it would work. What are the possibilities?

Legal services must be divided into two major categories for outcome measurement purposes. The first contains all legal services

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for which little negotiation is required. Lawyer performance can more easily be measured when the lawyer functions like a clerk. If you go to get your next year's license plates, you have to fill out a form, stand in line, receive the plates and attach them to the car—all before a certain date if you wish to avoid a fine. Most legal practice is just like that,[9] and the way lawyers handle the many steps from A to F is measurable in both process and outcome terms because the processes logically and promptly yield an acceptable outcome. If corporation X gets incorporated with all of the right papers filed within the time set by law, the corporation has been well served and the outcome can be said to be acceptable. If corporation X prefers to obtain same result from a well-manicured lawyer in an office where the carpet is nine inches deep, rather than from a hungry young recent law school graduate working out of his basement, that is the client's choice and may indirectly be a measure of quality (in terms of client satisfaction) but should not be central to a quality assurance system linked to results.

This sounds too good—and it is. An appreciable part of legal practice cannot be measured this way. F. Lee Bailey, Edward Bennett Williams, and Clark Clifford are hired not because they fastidiously follow steps one through nine. A lot of legal practice, although probably the lesser part, is dependent upon skills of advocacy married to some natural savvy and winsomeness. These skills simply are not easily amenable to either process or outcome evaluation. If the pharmaceutical companies were about to be forced by the FDA to sell generically labeled drugs, *any* delay, however achieved, would be a good result—to the client (the public, or course may be damned, which is why the third level of quality—the consequences of legal services for society—must be considered). If lawyer X ignores all of the procedural steps, leaving that to his legal secretary (or even botches some of them himself), but a phone call secures a delay for the client, that is an outcome for which a client will pay. The phone call won't even show up in a list of processes.

The result is that those legal services that entail tactical negotiating and rhetorical skills are simply not as amenable to evaluation by process measures (or in most cases, outcome measures), since adherence to a process is not determinative. Such skills, however, may be amenable to crude outcome measures, in terms of cases won, mergers successfully completed, pharmaceutical companies made happy, etc.

9. By this I don't necessarily mean that most of client fees go for this type of service. As in the case of medical care, the brain surgeon makes more money per unit of time than the pediatrician; but the pediatrician renders far more units of service.

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This means at least three things: (1) process and outcome are more nearly the same thing in legal services than in medical care because many of the processes used in legal practice are equivalent to outcomes; (2) some of legal practice, because it is based on nuance, cannot be process evaluated and, hence, must be measured by rough outcome if anything; and (3) much of the law, whether or not involving nuance, may produce outcomes acceptable to clients but, at the same time, be socially destructive.

A few clarifications. First, data collection will be a challenge. Whether process or outcome is the measure, it is unrealistic to expect to monitor a lawyer's interview with a client, or a bargaining session between counsel. But the same is true in medicine. Quality investigators do not literally oversee a physician's manual dexterity. But medical audits of records, reviews of files, and examination of removed tissues, etc., will yield the data necessary for both process and outcome review.

Second, it is true that many legal service episodes will involve both routine and nuance. For example, in a major real estate transaction, there is a bewildering array of routine requirements, and yet at the closing the millions of dollars shifted back and forth depend upon the lawyer's negotiating skills. But this is no objection to the scheme. Those aspects that are routine can be subjected to process review and the nuance to outcome measurement, if any. The same is true of medicine. Patients die despite slavish adherence to process (perhaps because of it) and some physicians, despite their medical ignorance, may coax patients into health through the use of psychosocial skills.

Finally, a few more words on points two and three. Legal services that are not amenable to process evaluation may still be judged by crude outcome measures. Some lawyers win cases and some lose. When the case in question can be judged by a discrete result, like a defeat of legislation, winning or losing a lawsuit, avoidance of tax fraud charges through negotiation, or a graceless retirement to San Clemente, the results are outcome measures, whether or not anyone likes them. Accordingly, a system of quality assurance could incorporate such measures if desirable. I leave the determination of desirableness to those who will make that decision.

As to point three, it is already made. If outcomes are only evaluated in terms of success for the client, the product of the system will not necessarily be successful for society at large. Medicine may cure individuals but, because of its mystique and oversell, may also foster a dependency in the population which strips it of the capacity to care for itself. Similarly, the law may

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serve individual interests and yet be as iatrogenic as much of medical care.

So where are we? Three questions remain: who should regulate; and what is the optimal mix of measures and regulators?

D. Who Should Regulate?

As noted, there are three alternatives, which may be combined: the profession, the government, and the consumer. Today the profession tries to take care of itself. Most agree that it does not regulate itself well enough. Hence other options are being considered. What are the basic advantages and disadvantages of each?

1. *The Professions*

The legal profession, like others, tends to take care of itself by protecting its hegemony and engages in self-regulation only to rid itself of total losers (those convicted of felonies, or of bad taste, e.g., appearing before the state Supreme Court costumed as a chicken)—and occasionally with more vigor when public pressures mount, as in the case of Watergate. Moreover, the profession tried very hard to keep information about the practice of law and the performance of lawyers quiet (see, e.g., Lieberman, 1970).

Are there any advantages to professional self-regulation? A few, maybe. The profession is in the best position to educate those bunglers who are educable; and the profession itself, if it could act objectively, would be the best judge of technical performance. In sum, though, professional regulation, particularly with respect to the quality of services, will only result in minimal policing and rarely, if ever, launch programs that seriously threaten its economic base.

2. *The Government*

There is a monumental literature on the subject of government regulation, which can be summed up in this way

- The government can establish, and has established, more stringent performance standards than some industries would set for themselves (there are exceptions, e.g., airlines).
- The government, because of its interpenetration with the regulated industries (legal services is an extreme example, since so many legislators are lawyers), has rarely sought to do more than reduce disruption, inequity, and abuses; it has not attacked the economic base of an industry except in truly outrageous cases like safety regulation in the coal industry, child labor laws, and the manufacture and sale of demonstrably dangerous products.

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- The government is less adept at setting performance standards because it only infrequently knows enough about the regulated industry, but is far better at setting criteria by which performance will be evaluated and in insuring more even-handed enforcement.
- The government can sanction more vigorously than can the industry, and occasionally does, but is often just as reluctant to punish (the federal government has been loath to shut down unsavory nursing homes because this would deprive some people of the only care they have).
- And finally, the government has stronger sanctions available when it also pays for its services since it then can restrict the flow of reimbursement to the provider.

All of these points show up in an examination of the regulation of medical care. On the whole, the delivery of medical care is far more regulated today as a result of governmental incursion than it would be had regulation been left to the profession. Yet it is doubtful that regulation has had much impact. Costs continue to soar; physicians still practice when and where they please and are rarely, if ever, disciplined by public licensing boards. And virtually no quality assurance has yet left the drawing boards.[10]

3. *The Consumer*

In classical laissez-faire capitalism the consumer is the ultimate regulator who acts by making choices in an unfettered marketplace. The most important reason why this doesn't happen, according to economists, is that the consumer is poorly informed. And ignorance about professional services is particularly great because the profession jealously guards the information that could enlighten the consumer.

This is certainly true of medical care. Even though medicine has very little to do with health, if a randomly selected group of consumers were given the responsibility to fix resource allocation priorities for health, they would probably choose to spend more on medical care, not less.

The accusation is not so obviously correct when made about legal services for at least four reasons. First, many corporate consumers are very knowledgeable—they direct lawyers as instruments in their larger commercial symphonies.

Second, the public is more realistic about the powers of lawyers than about those of doctors. In medicine the consumer expects the

10. Legal services is, of course, subject to one unique regulation. The quality of law itself is dependant upon the quality of the bench. This is a public function. Perhaps, then, the major governmental regulatory role today is to select and maintain the judiciary.

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doctor to be able to cure all of life's ills. But in the law consumers expect the lawyer to fight and sometimes to cheat—to do someone else in (and that's a lot of what lawyers do)—but they also know that there are always winners and losers.

Third, if there is continued progress in the movement to make legal services a negotiable item in collective bargaining agreements, some of the consumers of legal services will soon be large corporate interests and large labor unions. Such entities, especially because of the volume of their purchases, are very likely to be smart buyers. Even though these same consumers also buy medical care, and even though it costs them more, they show little sophistication because they have been taken in by the medical mystique.

Fourth, consumers have more alternatives available for the resolution of legal problems than they do for medical problems. When someone is sick it may be that relaxation, quiet, and time are the best healers; but most sick people don't know that and, hence, panic and run to the doctor. But with a legal problem, if a lawyer isn't available, many people, even those poorly informed, don't just gnash their teeth and give up. Rather, they ignore their bills, put up spite fences, bash their afflictors on the head, withhold the rent, skip town, use political pressure, hire thugs to enforce their rights, change their names, and so on. Sometimes they even try to resolve the mess directly themselves. Of course, this isn't always true. Many people do get ground up by bureaucracies, creditors, and landlords because they don't know their rights or because they are timid. But in contrast to sick people (or even well people who think they ought to feel better), people with legal problems are on the whole, better informed and less passive.

But even without information, do consumers make choices that produce regulatory results? I think the answer is yes. Knowledgeable buyers of legal services can shop; they probably hire and fire lawyers more frequently than doctors, and they insist on competent performance and probably get it most of the time.

Middle income consumers sometimes utilize the law, but arguably not as much as their numbers and problems would warrant. Yet by their very refusal to enter the marketplace they influence the law by causing it to adapt to serve them. Most lawyers are well aware that if their burgeoning ranks are to be kept busy, middle class demand has to be tapped. The result is that the institutions of law are being slightly reshaped to accord better with the ostensible needs of the vast middle income market.

The poor, here as elsewhere (except possibly in medical care because of the Medicaid program), have had little influence on the quality of legal services, though they have affected the distribution

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of legal services through their role in the implementation of the OEO legal services program. This isn't to say that they have no effect on quality. The exposure of OEO lawyers to the conditions of poverty has politicized many, and these in turn have exerted pressure on the profession at large to improve the quality and quantity of legal representation for the poor. Nevertheless, on the whole the poor have exercised the least regulatory authority.

4. *So Who Should Regulate?*

The real world has to be considered. As a practical matter the government is not about to leap into the regulation of legal services with both feet. It may eventually if the regulatory trajectory described in medical care is followed in legal services, but this is only likely to happen when and if the government becomes a major purchaser of such services—and that is highly unlikely in the short run. It is also true that the profession will strenuously resist a larger consumer regulatory role. A profession just doesn't like to have consumers messing around in its monopoly.

As a consequence, the profession will continue to be the major regulator, along with some large corporate and union interests if they become bigger buyers. But, of course, even if this is so, it doesn't necessarily preclude the development of a relatively sophisticated quality assurance system along the lines suggested here. Yet to be realistic, unless pressure mounts substantially, the profession has little incentive to monitor itself. Thus far the interest in quality assurance is essentially theoretical.

VI. AN OPTIMAL SYSTEM

The fact that it is unlikely to occur doesn't mean that we cannot speculate about an optimal approach to quality assurance for the law. It would be based on the following principles

- It should be heavily process oriented but should stress the monitoring, on a sample basis, of those processes that will result in discrete outcomes depending on whether they are bungled or handled well.
- It should initially be based upon standards and criteria designed to eliminate the most egregious errors in the system because to focus on those lawyers who are occasionally sloppy, but not necessarily reckless, will engender too much practitioner resistance.
- It should insure continuous feedback of the results of the evaluation (especially to the individual and firm practitioners) so that processes can be retooled in light of the evidence

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about outcomes (this might even allow for some simplification of the law).

- It should allocate resources to develop outcome measures of the part of legal practice that is not readily amenable to process measurement and, meanwhile, should use such indirect and approximate measures as client retention rates, speed in handling routine matters, cost-effectiveness, avoidance of repetitive corrections, etc.
- It should systematically publicize aggregate information regarding performance data, like that desired by the above indices, as well as data on individual practitioners and firms, such as cost of services, access to services, and cost-effectiveness.
- It should also feedback all quality-related information to aid in the construction and implementation of continuing education programs and to allow input testing to be validated against actual practitioner performance.
- It should be consumer controlled but should utilize lawyers as monitors.
- And it should be used to simplify the law and to establish for the poor and middle income groups, dispute-resolution systems that do not require sophisticated lawyering and provide quick, inexpensive solutions for common disputes.

What all of this means is that it is possible to construct a quality assurance system for legal services. It will have to be essentially process based, at least at first. It will work fairly well for those aspects of legal services that do not require unique skills. And it will work best if it is cybernetic in structure and consumer controlled.

It only remains to be said that *all* of the imperatives in the system, except good intentions, run the other way.

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