



2-1-2015

Introspection Through Litigation

Joanna C. Schwartz
UCLA School of Law

Follow this and additional works at: <http://scholarship.law.nd.edu/ndlr>

 Part of the [Civil Procedure Commons](#), and the [Commercial Law Commons](#)

Recommended Citation

Joanna C. Schwartz, *Introspection Through Litigation*, 90 Notre Dame L. Rev. 1055 (2015).

Available at: <http://scholarship.law.nd.edu/ndlr/vol90/iss3/3>

This Article is brought to you for free and open access by the Notre Dame Law Review at NDLScholarship. It has been accepted for inclusion in Notre Dame Law Review by an authorized administrator of NDLScholarship. For more information, please contact lawdr@nd.edu.

INTROSPECTION THROUGH LITIGATION

Joanna C. Schwartz*

ABSTRACT

This Article contends that there is a bright side to being sued: organizational defendants can learn valuable information about their own behavior from lawsuits brought against them. Complaints describe allegations of wrongdoing. The discovery process unearths documents and testimony regarding plaintiffs' allegations. And in summary judgment briefs, expert reports, pretrial orders, and trial, parties marshal the evidence to support their claims. Each of these aspects of civil litigation can bring to the surface information that an organization does not have or has not previously identified, collected, or recognized as valuable. This information, placed in the hands of an organization's leaders as the result of litigation, can be used to improve systems and personnel.

This Article considers the information generated by litigation, the gaps lawsuit data can fill in the information otherwise available to organizations, and possible reasons some organizations may gather and analyze litigation data more frequently than others. To illustrate these concepts, I draw on original research of police departments and hospitals and evidence from other organizational settings.

INTRODUCTION

No organization relishes the prospect of being sued. Lawsuits are costly and time consuming to defend against and can lead to negative publicity, increased government oversight, and other woes. But some organizations also see a bright side to being sued: through litigation, organizations can learn about their own behavior. These organizations review information developed during the course of litigation—complaints, depositions, documents exchanged in discovery, expert reports, briefs, and trial transcripts—to

© 2015 Joanna C. Schwartz. Individuals and nonprofit institutions may reproduce and distribute copies of this Article in any format at or below cost, for educational purposes, so long as each copy identifies the author, provides a citation to the *Notre Dame Law Review*, and includes this provision in the copyright notice.

* Assistant Professor of Law, UCLA School of Law. For helpful comments and conversations regarding this project, many thanks to Sam Bray, Devon Carbado, Ann Carlson, Sharon Dolovich, Ingrid Eagly, Allison Hoffman, Sung Hui Kim, Jerry López, Timothy Lytton, Timothy Malloy, Hiroshi Motomura, Jason Oh, Nicholas Parrillo, Margo Schlanger, Seana Shiffrin, Clyde Spillenger, Rebecca Stone, Alexander Stremitzer, Alex Wang, Stephen Yeazell, and Noah Zatz. Thanks also to Braden Holly, Tommy Huynh, Madeline Morrison, Vicki Steiner, and researchers at UCLA's Hugh and Hazel Darling Law Library for their excellent research assistance. Thanks, finally, to Mark Kubisch and the editors of the *Notre Dame Law Review*.

better understand weaknesses¹ in personnel, training, management, and policies. The process of organizational learning through information generated in lawsuits is what I call introspection through litigation.

Although introspection through litigation has not received sustained attention by scholars,² it operates at the intersection of two well-established concepts. The first is that organizations must understand their strengths and weaknesses in order to operate effectively and improve—a process that has been referred to as “organizational introspection.”³ Organizations may gather information about their own performance⁴ but also often seek out information from outsiders through customer surveys, audits, and manage-

1 For the purposes of this discussion, I use the term “errors” to refer to those events that may lead to litigation and “weaknesses” as those characteristics of personnel, training, management, and policies that may cause errors to occur. I use the term “performance improvement efforts” to refer to steps taken to reduce errors and weaknesses. I use these terms as a sort of shorthand, but recognize several ways in which they could be contested. First, organizations’ leaders will not always agree with these definitions and will differ in the ways that they understand their strengths and weaknesses. One police chief might consider a rise in lawsuits alleging the unconstitutional “stop and frisk” of pedestrians to be a troubling sign that his officers are exceeding the bounds of their constitutional authority, while another might view the same rise in suits as a positive sign that his officers are engaged in aggressive policing. *See infra* notes 183–85 and accompanying text (describing this possibility). In addition, the definitions are overly narrow to the extent that some cases without legal merit may nevertheless reveal information of interest and use to organizational leaders. *See infra* note 114 (describing this possibility). Finally, I recognize that suits do not always reveal useful information, and I describe the limitations of lawsuits as a source of information in Section I.D.

2 A handful of scholars have observed that defendants may learn something about their own behavior in the process of defending a suit, but have not paid sustained attention to this idea. *See, e.g.*, TIMOTHY D. LYTTON, *HOLDING BISHOPS ACCOUNTABLE: HOW LAWSUITS HELPED THE CATHOLIC CHURCH CONFRONT CLERGY SEX ABUSE* 14–17 (2008) (noting that bishops learned about some allegations of clergy sex abuse through lawsuits); Mark S. Hochberg et al., *Perspective: Malpractice in an Academic Medical Center: A Frequently Overlooked Aspect of Professionalism Education*, 86 *ACADEMIC MED.* 365, 367 (2011) (suggesting that malpractice cases be used for medical training); Margo Schlanger, *Operationalizing Deterrence: Claims Management (in Hospitals, a Large Retailer, and Jails and Prisons)*, 2 *J. TORT L.* 1, 31–35 (2008) (describing how researchers and hospitals review medical malpractice claims files as a means of improving performance).

3 *See, e.g.*, PAUL GLEN, *LEADING GEEKS* 88 (2003) (describing “organizational introspection” as the process of “understand[ing] honestly the capabilities of one’s own organization, including its technical and managerial strengths and weaknesses”); MICHAEL POWER, *THE AUDIT SOCIETY* 54 (1997) (“Gatekeeping mechanisms like auditing, and record keeping and disclosure requirements become important as ways of connecting the different layers and of encouraging a certain kind of organizational introspection.” (citations omitted)).

4 Organizations may conduct this internal analysis voluntarily. *See, e.g.*, Schlanger, *supra* note 2, at 20–23 (describing a large retailer’s claims management procedures that require employees to report and investigate accidents and possible wrongdoing both to manage claims and to improve performance). Regulatory requirements can also force organizations to gather information about their performance. *See generally* Louis Lowenstein, *Financial Transparency and Corporate Governance: You Manage What You Measure*, 96

ment consultants.⁵ Outsiders are believed to offer valuable insights because they have fresh perspectives, are disengaged from organizations' internal politics, and are not predisposed in favor of existing personnel and practices.⁶

The second is that lawsuits can unearth information about misconduct that organizations have hidden from regulators and the public at large.⁷ Outside auditors or regulators may not have the authority, tools, or motivation to pry the information from corporate executives' white-knuckled grip.⁸ But plaintiffs' attorneys, unencumbered by allegiances to the industry and driven by the financial and other associated benefits of a win, are highly motivated to seek out information supporting their claims. Liberal discovery rules, including rules empowering courts to compel production of evidence and sanction those who do not comply, pressure defendants to turn over information that they would prefer to keep secret.

Introspection through litigation combines the recognized value of organizational introspection with the observed power of litigation to unearth information. For organizations interested in learning about their performance, lawsuits are, in essence, unsolicited audits by deeply dissatisfied custom-

COLUM. L. REV. 1335, 1342–45 (1996) (describing how financial and environmental regulatory disclosure requirements cause organizations to pay closer attention to their behavior).

5 See, e.g., CHRISTOPHER D. MCKENNA, *THE WORLD'S NEWEST PROFESSION: MANAGEMENT CONSULTING IN THE TWENTIETH CENTURY* (2006) (describing widespread use of management consulting by corporations); Christopher Meyer & Andre Schwager, *Understanding Customer Experience*, HARV. BUS. REV., Feb. 2007, at 116 (describing the importance of understanding customer experiences and methods of collecting and measuring customer satisfaction); Stephen Wagner & Lee Dittmar, *The Unexpected Benefits of Sarbanes-Oxley*, HARV. BUS. REV., Apr. 2006, at 133, 136 (observing that outside auditors have helped corporations get better information about their performance).

6 See, e.g., THOMAS A. LIMONCELLI ET AL., *THE PRACTICE OF SYSTEM AND NETWORK ADMINISTRATION* 308 (2d ed. 2007) (recommending outside audits of an organization's information systems because outsiders have "distance from the work that is going on, and their approach will be unaffected by expectations and inside knowledge"); Marty Parker, *Know Thyself: Corporate Culture Begins with Introspection*, FIN. POST (Feb. 7, 2012, 12:28 PM), <http://business.financialpost.com/2012/02/07/know-thyself-corporate-culture-begins-with-introspection/> (advising that "[c]ultural assessments [of an organization] are best carried about by a third party who is sure to be objective, and will be perceived as such").

7 For scholarship examining how lawsuits publicly reveal useful information, see, for example, TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 162 (2005) (observing that high-profile medical malpractice lawsuits reveal information that may "energiz[e] government agencies to discipline doctors or order hospitals to take corrective action"); Timothy D. Lytton, *Using Tort Litigation to Enhance Regulatory Policy Making: Evaluating Climate-Change Litigation in Light of Lessons from Gun-Industry and Clergy-Sexual-Abuse Lawsuits*, 86 TEX. L. REV. 1837, 1843–58 (2008) (describing information revealed in gun litigation and clergy-sexual-abuse litigation); Wendy Wagner, *When All Else Fails: Regulating Risky Products Through Tort Litigation*, 95 GEO. L.J. 693, 711–27 (2007) (showing how gun litigation and breast implant litigation have unearthed previously unknown information and thereby supplemented regulatory efforts).

8 See Wagner, *supra* note 7, at 696–97 (describing information costs associated with agency regulation).

ers who are highly motivated to describe their claims in the strongest terms, uncover all evidence relevant to their case, and present that evidence in the most compelling light. Hearing from a deeply dissatisfied, highly motivated customer may be an unpleasant experience, but it can also be illuminating.⁹ Just as lawsuits can publicly reveal information hidden by corporate executives from outsiders, lawsuits can surface information that employees have purposefully or negligently failed to provide to management.

In prior work, I have studied the ways in which police departments and hospitals gather and analyze information from lawsuits brought against them and what both types of organizations learn from litigation data.¹⁰ This Article draws on my studies of police departments and hospitals—as well as evidence about information generated through litigation against airlines, auto manufacturers, correctional facilities, and the Catholic Church—to offer generalizable observations about this phenomenon.

Part I considers what organizations can learn from the lawsuits brought against them. Although organizations gather information about their performance from multiple sources, lawsuits can surface information that has fallen through the cracks of organizations' other information systems. Complaints may describe allegations of wrongdoing that employees never reported to their supervisors. During discovery, lawyers may unearth details about the plaintiff's allegations that other investigators did not have the time or fortitude to seek out. And in complaints, summary judgment briefs, expert reports, pretrial orders, and trial itself, parties marshal the evidence—meaning they interpret, organize, and present information to support their claims—in ways that may prove illuminating. Each of these aspects of civil litigation can draw attention to previously unknown or underappreciated information and insights that organizations can use to identify and correct weaknesses in personnel, training, management, and policies.

9 Of course, hearing from a deeply dissatisfied customer through a lawsuit can also be unpleasant and *unilluminating*. I discuss the limitations of lawsuits as a source of information in notes 109–25 and accompanying text.

10 In two articles, I studied the frequency with which police departments gather and analyze information from suits brought against them and their employees, and the ways in which litigation-attentive departments use lawsuit data to improve performance. See Joanna C. Schwartz, *Myths and Mechanics of Deterrence: The Role of Lawsuits in Law Enforcement Decisionmaking*, 57 UCLA L. REV. 1023 (2010) [hereinafter Schwartz, *Myths and Mechanics*] (studying the practices in twenty-six law enforcement agencies across the country and finding that law enforcement officials rarely collect information about lawsuits brought against their department and officers); Joanna C. Schwartz, *What Police Learn from Lawsuits*, 33 CARDOZO L. REV. 841 (2012) [hereinafter Schwartz, *What Police Learn*] (examining the practices in five law enforcement agencies that review lawsuits for lessons). In a third article, I examined the use of litigation data in hospital performance improvement efforts. See Joanna C. Schwartz, *A Dose of Reality for Medical Malpractice Reform*, 88 N.Y.U. L. REV. 1224 (2013) [hereinafter Schwartz, *A Dose of Reality*] (studying whether—and how—hospitals gather and analyze litigation data, based on thirty-five in-depth interviews and a survey of more than 400 risk managers and patient safety personnel).

To be sure, information generated during the course of litigation is flawed in several respects. Because very few people who have been harmed ever sue and damages awards are calculated based on the severity of the plaintiff's injury rather than the degree of the defendant's wrongdoing, lawsuit filings and outcomes are a poor indicator of the frequency and severity of organizational misconduct.¹¹ The adversarial nature of litigation can also cause parties to overclaim or shade the truth in their pleadings, briefs, and testimony.¹² These flaws do not, however, disqualify lawsuits as a source of useful information. All information is impacted by the manner in which it is produced, the interests of those producing the information, and its intended use. Organizations that engage in introspection through litigation do so in ways that take account of these limitations while still benefitting from the insights lawsuits can provide.¹³

Organizations that review lawsuits for lessons have learned about personnel and policy weaknesses and have used that information to prevent similar events from recurring in the future. Yet some organizations do not take advantage of the litigation information at their disposal. In my research, I found that most hospitals make some effort to learn from the lawsuits brought against them, but few police departments do so. Part II considers why some organizations might engage in introspection through litigation more often than others. It seems reasonable to assume that an organization will engage in introspection through litigation only if the organization wants to understand and improve its performance, views lawsuits as a source of valuable information about organizational errors and weaknesses, and has the infrastructure and personnel in place to analyze lawsuits for lessons. Hospitals generally meet each of these conditions, as do the few law enforcement agencies that analyze information from lawsuits. Most other law enforcement agencies, it seems, do not have the incentives, personnel, or favorable view of lawsuits as a source of information that would lead to introspection through litigation. By comparing the incentives and systems in place in hospitals and police departments, this Article identifies a variety of ways in which regulatory mandates, financial incentives, personnel, and evidentiary rules might be used to encourage police departments and other organizations to pay closer attention to the information in lawsuits.

I. WHAT ORGANIZATIONS CAN LEARN FROM LAWSUITS

The notion that an organization could learn anything about its behavior through the litigation process may be counterintuitive. After all, the organization, through its employees, engaged in the alleged misconduct and orga-

11 See *infra* notes 109–11 and accompanying text (describing the limitations of the volume of cases filed and the amount paid to plaintiffs as sources of information about organizational behavior).

12 See *infra* notes 113–16 and accompanying text (describing distorting effects of the adversarial system).

13 See *infra* notes 121–25 and accompanying text (describing the ways that organizations analyze lawsuit information).

nizational leaders will, one presumes, have access to the documents and witnesses that may prove revelatory. But that presumption ignores the facts of institutional life.

In complex organizations, information is decentralized and held by a number of different people and entities. It is the low- and mid-level employees who often have the most direct and immediate exposure to valuable information.¹⁴ Police officers or their direct supervisors may be the first to learn of an allegation of excessive force.¹⁵ Nurses attending to their patients may be the first to learn of medical errors.¹⁶ Store managers may be the first to learn of customer reactions to new products.¹⁷ In these settings, claims of possible wrongdoing will not come to a decisionmaker's attention unless she is somehow informed.¹⁸ Complex organizations may fashion systems to carry critical information from these front-line employees to higher levels of management, but gaps in design and implementation can frustrate information collection efforts.¹⁹ For any number of reasons, those at the highest levels of governance may not learn about incidents of wrongdoing or critical details of those incidents.

14 See, e.g., Donald C. Langevoort, *Organized Illusions: A Behavioral Theory of Why Corporations Mislead Stock Market Investors (and Cause Other Social Harms)*, 146 U. PA. L. REV. 101, 119–20 (1997) (“Information is highly decentralized in business organizations. Especially when we focus on information and inferences that are not readily quantifiable—for example, customer reactions to new products, how well products are proceeding through the research and development pipeline—relatively low- or mid-level managerial personnel will have the most immediate access to useful information.”); see also KENNETH J. ARROW, *THE LIMITS OF ORGANIZATION* 33–43 (1974) (discussing organizations and the flow of information).

15 See Wesley G. Skogan, *Why Reforms Fail*, 18 POLICING & SOC'Y 23, 24 (2008) (“Most police officers work alone or with a partner, and the top brass know little about what they do out there except what they report on pieces of paper that they sometimes fill out to document their activities.”).

16 See, e.g., Shuh-Jen Sheu et al., *Using Snowball Sampling Method with Nurses to Understand Medication Administration Errors*, 18 J. CLINICAL NURSING 559, 560 (2008) (“[N]urses are aware of more medication errors from private or colleagues' communications than nursing management is aware of from filed incident reports.”).

17 See, e.g., Jane E. Dutton et al., *Reading the Wind: How Middle Managers Assess the Context for Selling Issues to Top Managers*, 18 STRATEGIC MGMT. J. 407, 407 (1997) (“It is often middle managers rather than the top managers who have their hands on the ‘pulse of the organization’ . . .”).

18 See Langevoort, *supra* note 14, at 119 (“One subject on which there is substantial agreement over the full range of organization studies is that ‘upward’ information flow poses a challenge for coherent corporate decisionmaking.”).

19 These have been referred to as the problems of information acquisition, transmission, and aggregation. John Ferejohn, *The Lure of Large Numbers*, 123 HARV. L. REV. 1969, 1984 (2010) (book review). For foundational descriptions of these information problems, see, for example, ARROW, *supra* note 14, at 53 (“The information has to be coordinated if it is to be of any use to the organization. More formally stated, communication channels have to be created within the organization.”); RICHARD M. CYERT & JAMES G. MARCH, *A BEHAVIORAL THEORY OF THE FIRM* 109–10 (1963) (describing “routing rules” and “filtering rules” governing the communication of information in large organizations).

Lawsuits produce three types of information that can fill the gaps in organizations' other information systems. First, plaintiffs' complaints may announce allegations of wrongdoing that internal reporting systems did not collect. Second, during discovery, lawyers may unearth details about plaintiffs' claims that an organization's internal investigators did not search for or find. Third, throughout litigation, parties marshal the evidence—meaning they interpret, organize, and present information—in ways that may prove illuminating.

In Sections I.A–C, I show how information can be announced, unearthed, and marshaled during litigation with examples from suits against several different types of large organizations—police departments, hospitals, correctional facilities, the Catholic Church, airlines, and an auto manufacturer. My contention is not that organizations have learned from lawsuits in all of the examples I offer; in Part II, I describe the very limited information that is available about what organizations actually do with lawsuit information. Instead, my focus here is on the types of information that lawsuits generate that may be of use to organizations. In Section I.D, I describe the limitations of lawsuits as a source of information about organizational performance and the ways in which organizations learn from lawsuits despite these limitations. Section I.E concludes with observations about the value of lawsuit data to organizations interested in understanding and improving their performance.

A. *Announcing Harms*

Lawsuits may notify organizations about allegations of wrongdoing. When there is a high-profile event, such as a police shooting or an airplane crash, lawsuit complaints are likely unnecessary to notify an organization's leaders that the event occurred. The defendant named in the suit will almost certainly know a great deal about the case from the press and its employees long before a lawsuit is filed. Moreover, when alleged wrongdoing was committed or orchestrated by those at the very highest levels of governance, lawsuits are unnecessary to bring information about the event to organizational leaders' attention.²⁰ But there are many other types of incidents committed by low-level actors that do not garner press attention. Although organizations often have systems to capture information about harms when they

20 For example, information about products' dangers—the effects of asbestos, tobacco, and the Dalkon Shield—may well be known by those at the highest levels of corporate decisionmaking. See, e.g., PAUL BRODEUR, *OUTRAGEOUS MISCONDUCT: THE ASBESTOS INDUSTRY ON TRIAL* 117–19 (1985) (describing efforts by manufacturers to keep information about asbestos dangers from the public); PHILIP J. HILTS, *SMOKESCREEN: THE TRUTH BEHIND THE TOBACCO INDUSTRY COVER-UP* (1996) (describing efforts to hide the damaging effects of tobacco); MORTON MINTZ, *AT ANY COST: CORPORATE GREED, WOMEN, AND THE DALKON SHIELD* (1985) (describing efforts to hide information about the damaging effects of the Dalkon Shield). Lawsuits may reveal useful and previously unknown information about those decisions to the public. See *supra* note 7. Lawsuits will not, however, be illuminating to the executives who made those decisions.

occur,²¹ allegations of wrongdoing may fall through the gaps of these information systems.

Some gaps are the result of design flaws: internal reporting systems may not be suited to collect information about certain types of allegations that result in litigation. For example, almost all police departments require officers to file reports when they have used force.²² Yet departments generally do not require officers to report incidents that do not involve force—illegal searches or warrantless home entries, for example—that can be the basis for constitutional claims. Moreover, some departments do not require their officers to report all types of force; an officer will most likely be required to file a report after firing their gun, but may not need to fill out a report after handcuffing someone, striking someone with their flashlight, or assaulting someone with a police dog.²³ By reviewing lawsuits, police departments have learned of allegations of misconduct that officers were not required to report, including claims that officers engaged in improper vehicle pursuits, warrantless home entries, and illegal searches.²⁴

Hospitals have more comprehensive reporting systems than police departments: through incident reports, reports to risk management, patient complaints, and executive walk rounds, hospital information systems are designed to gather information about all types of errors as soon as they occur.²⁵ Yet hospitals' reporting systems are not well designed to capture information about incidents of medical error that are not immediately observable. Missed diagnoses, delayed diagnoses, and treatment errors may only be apparent months or years after a doctor has provided medical care. If, for example, a doctor misreads a chest x-ray as normal, neither the doctor nor the patient will know of that error until the patient develops lung cancer.²⁶ If a doctor fails to remove a sponge during surgery, no one may know

21 See Schlanger, *supra* note 2, at 10–13 (describing the ways in which organizations acquire information); *see also id.* at 19–48 (describing information systems and claims management more generally in three organizational settings).

22 See INT'L ASS'N OF CHIEFS OF POLICE, PROTECTING CIVIL RIGHTS 136 (2006), *available at* <http://www.cops.usdoj.gov/files/RIC/Publications/e06064100.pdf>.

23 See Schwartz, *What Police Learn*, *supra* note 10, at 868; *see also* CHARLES R. EPP, MAKING RIGHTS REAL: ACTIVISTS, BUREAUCRATS, AND THE CREATION OF THE LEGALISTIC STATE 251 (2009) (reporting, based on a survey of police departments across the country, that 93.7% of departments required a report when an officer used a baton against a civilian, 57.6% required a report after using a “twist lock or wristlock” on a civilian, and 32% required a report after using a “firm grip” on a civilian).

24 See Schwartz, *What Police Learn*, *supra* note 10, at 869–70 (describing allegations of police misconduct revealed through litigation). Departments could also learn about these types of incidents through civilian complaints. Yet a Bureau of Justice Statistics survey found that very few people who believe they have been mistreated file civilian complaints. *See id.* at 862–63 (describing civilian complaint policies and evidence that people infrequently file civilian complaints even when they believe they have been mistreated by the police).

25 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1235 (discussing hospital data collection practices).

26 *See id.* at 1280.

of this error until years later, when the patient undergoes another surgical procedure.²⁷ Lawsuits are better suited than hospitals' internal systems to reveal these types of claims with delayed manifestations. Consistent with this observation, studies have found that a significant number of missed and delayed diagnoses and allegations of improper treatment are revealed for the first time in lawsuits.²⁸

Federal reporting mandates governing airlines are even more extensive than those governing hospitals. The Federal Aviation Administration (FAA) requires reporting and investigation of any incident that takes place on an airplane causing serious injury or death or damage to the airplane.²⁹ Its reporting system captures thousands of errors and "near misses," events that could have—but did not—result in a crash.³⁰ Most, if not all, airlines also have their own internal systems to capture and analyze errors.³¹ Yet there are some types of incidents—including air turbulence, emergency descents, and inappropriate behavior by airline personnel—that do not need to be reported and so may only come to an airline's attention when described in a lawsuit.³²

Beyond information gaps resulting from the design of internal organization systems, organizations may also not know about wrongdoing because personnel do not report errors even when they are required to do so. Employees in a wide array of organizational settings—including police officers,³³ medical personnel,³⁴ clergy,³⁵ and airline employees³⁶—have all

27 See *id.* at 1280 n.277.

28 See *id.* at 1278 (noting that hospital risk managers and patient safety personnel "reported that when lawsuits reveal previously unreported claims, they most frequently concern diagnostic and treatment errors"); see also Osnat Levzion-Korach et al., *Integrating Incident Data from Five Reporting Systems to Assess Patient Safety: Making Sense of the Elephant*, 36 JOINT COMM'N J. ON QUALITY & PATIENT SAFETY 402, 402 (2010) (finding that malpractice claims are more likely to allege delayed and missed diagnoses and treatment errors than other types of reporting systems).

29 FAA Order No. 8020.11C, Aircraft Accident and Incident Notification, Investigation, and Reporting (Oct. 4, 2011), available at <http://www.faa.gov/documentLibrary/media/Order/8020.11C%20with%20Chg%201.pdf>.

30 See Alan Levin, *FAA Error-Reporting Program Reveals Hazards, Yields Fixes*, USA TODAY (Apr. 5, 2010, 9:38 AM), http://usatoday30.usatoday.com/news/washington/2010-04-04-faa-error-reports_N.htm.

31 See GLOBAL AVIATION INFO. NETWORK WORKING GROUP B, *ROLE OF ANALYTICAL TOOLS IN AIRLINE FLIGHT SAFETY MANAGEMENT SYSTEMS* vi (2d ed. 2004) ("[M]ost, if not all, airlines have established a process for collecting and analyzing air safety reports . . .").

32 See Telephone Interview with David Rapoport, Aviation Attorney (Jan. 30, 2012) (observing that many incidents involving injury—including injuries from turbulence and emergency descents—have not been found in National Transportation Safety Board (NTSB) and Federal Aviation Administration (FAA) reports).

33 See, e.g., U.S. DEP'T OF JUSTICE, CIVIL RIGHTS DIV., *INVESTIGATION OF THE NEW ORLEANS POLICE DEPARTMENT 14* (2011) [hereinafter *NEW ORLEANS*] (finding widespread underreporting of uses of force by its officers resulting in part from "poor understanding of what force must be reported" and in part from the "systemic failure to hold officers accountable for not reporting force"); Letter from Shanetta Y. Cutlar, Chief of Special Litig. Section of Civil Rights Div., to Roosevelt F. Dorn, Mayor, City of Inglewood, Cal., at 16–17 (Dec. 28,

been found to underreport mistakes and misconduct. Organizational sociologists have offered several observations that may explain low reporting rates: employees may not want to get themselves or their colleagues in trouble;³⁷ may intend to file a report but run out of time or forget to do so;³⁸ or may decide not to report because such incidents are part of the job and therefore cannot be prevented.³⁹

Even when an employee reports an incident, he may shade the truth in a way that protects himself or his colleagues.⁴⁰ An investigation of the Philadelphia Police Department's officers' use-of-force reporting found that reports were so vague as to be incomprehensible: "A 'head injury' could refer

2009) (describing use-of-force reporting in the Inglewood Police Department as "under-inclusive"); Letter from William R. Yeomans, Acting Assistant Att'y Gen., Civil Rights Div., U.S. Dep't of Justice, to Anthony Williams, Mayor, District of Columbia & Charles H. Ramsey, Chief of Police, Metro. Police Dep't (June 13, 2001), *available at* <http://www.justice.gov/crt/about/spl/documents/dcfndings.php> (finding that Metropolitan Police Department policies regarding use of force were inconsistently followed; although policies required officers to report "use of firearms, electronic stun devices, pepper spray (oleoresin capsicum), batons, carotid artery holds, and forcible frisks," only the use of firearms was regularly reported).

34 See, e.g., David C. Classen et al., 'Global Trigger Tool' Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured, 30 HEALTH AFF. 1, 4-5 (2011) (finding that ninety percent of adverse events were unreported in three hospitals recognized for patient safety initiatives); James A. Taylor et al., *Use of Incident Reports by Physicians and Nurses to Document Medical Errors in Pediatric Patients*, 114 PEDIATRICS 729, 729 (2004) (finding that over two-thirds of nurses and physicians reported medical errors less than forty percent of the time).

35 See, e.g., Madeleine Baran, *Number of Alleged Sex Abusers Greater than Archdiocese Has Revealed*, MPR NEWS (Feb. 19, 2014), <http://minnesota.publicradio.org/collections/catholic-church/2014/02/19/investigation-more-priests-accused-of-sexual-abuse-in-twin-cities-catholic-church/> (reporting that the Archdiocese of St. Paul and Minneapolis underreported abusive priests).

36 See, e.g., Associated Press, *Investigation Reveals Underreporting of Airplane Near Misses at Dallas-Fort Worth*, AVIATION PROS (June 24, 2005), <http://www.aviationpros.com/news/10434278/investigation-reveals-underreporting-of-airplane-near-misses-at-dallas-fort-worth>.

37 See ARROW, *supra* note 14, at 75 (describing the tendency to filter information); Langevoort, *supra* note 14, at 121 (observing that "employees with the most immediate access to basic information are almost always line personnel" whose "operational responsibilities and reporting duties create[] an obvious conflict of interest"); Taylor, *supra* note 34, at 729 (reporting that medical personnel underreport for fear of implicating others).

38 See A. Ian Glendon, *Accident Data Analysis*, 7 J. HEALTH & SAFETY 5 (1991) (describing time constraints).

39 Sharon Clarke, *Safety Culture on the UK Railway Network*, 12 WORK & STRESS 285 (1998) (attributing some underreporting to the inevitability of accidents).

40 For discussions of the way in which employees may filter information, see ARROW, *supra* note 14, at 75 ("The efficiency loss due to informational overload is increased by the tendency in that situation to filter information in accordance with one's preconceptions."); CYERT & MARCH, *supra* note 19, at 81-82 (describing biases in the communication of information).

to a scratch, sutures, a concussion, or a broken skull.”⁴¹ When a commission compared Los Angeles Sheriff’s deputies’ use-of-force reports with lawsuits filed regarding the same incidents, it found that deputies’ reports “almost always [were] at wide variance with the allegations made by the plaintiff in a lawsuit” such that “a deputy’s report alone could not have alerted a supervisor to a problem.”⁴²

Plaintiffs are likely to describe incidents of alleged wrongdoing in their lawsuit complaints with more detail than do employees internally reporting that same alleged wrongdoing. In contrast to the fear, embarrassment, and time constraints that can prevent employees from reporting—or fully reporting—possible misconduct, plaintiffs have good reasons to file detailed, compelling pleadings. For cases filed in federal court, the Supreme Court’s decisions in *Bell Atlantic Corp. v. Twombly*⁴³ and *Ashcroft v. Iqbal*⁴⁴ require plaintiffs to include facts sufficient to state a plausible claim for relief in their complaint.⁴⁵ Defense counsel have welcomed these rigorous pleading standards because they will, presumably, lead to more dismissals at an early stage of litigation.⁴⁶ These pleading requirements have an additional benefit for organizational defendants that review complaints for lessons: prudent plaintiffs’ attorneys are likely to vigorously investigate their claims before filing and to file detailed initial pleadings.⁴⁷

41 ELLEN H. CEISLER & JAMES B. JORDAN, INTEGRITY & ACCOUNTABILITY OFFICE, PHILA. POLICE DEP’T, THIRD REPORT 28 (1999).

42 See JAMES G. KOLTS ET AL., THE LOS ANGELES COUNTY SHERIFF’S DEPARTMENT 56 (1992), available at http://www.parc.info/client_files/Special%20Reports/3%20-%20Kolts%20Report%20-%20LASD.pdf.

43 550 U.S. 544, 555 (2007).

44 556 U.S. 662, 684 (2009).

45 For criticisms of these pleading standards and the burdens they impose on plaintiffs, see, for example, Arthur R. Miller, *From Conley to Twombly to Iqbal: A Double Play on the Federal Rules of Civil Procedure*, 60 DUKE L.J. 1, 43 (2010) (“It is uncertain how plaintiffs with potentially meritorious claims are expected to plead with factual sufficiency without the benefit of some discovery, especially when they are limited in terms of time or money, or have no access to important information that often is in the possession of the defendant, especially when the defendant denies access.” (footnote omitted)).

46 See, e.g., Leslie A. Gordon, *For Federal Plaintiffs, Twombly and Iqbal Still Present a Catch-22*, ABA J., Jan. 1, 2011 (“*Twombly* and *Iqbal* are widely cited by defense lawyers as a means of getting frivolous complaints dismissed before the costly factual discovery stage.”).

47 See Lori Andrus, *In the Wake of Iqbal*, 46 TRIAL 20, 22 (2010) (advising plaintiffs’ attorneys to “make every effort to include substantive factual allegations for every element of every claim in the complaint”). I recognize that these two benefits of *Iqbal* and *Twombly* to organizational defendants are in some tension with each other. If a plaintiff decides not to file a case because it would be too difficult to satisfy this pleading standard, the organizational defendant will not have the benefit of learning from that case. If a plaintiff does file a case but it is dismissed for failing to satisfy the pleading standard, the organizational defendant may still learn something from the complaint, but will not learn from any other aspect of the litigation process. Presumably, most defendants applaud *Twombly* and *Iqbal* not because the decisions require plaintiffs to file detailed complaints but because the decisions make it more difficult for plaintiffs to get to discovery; most would gladly forego

Apart from the demands of *Twombly* and *Iqbal*, parties may file factually detailed complaints for strategic reasons. A plaintiff may decide to file a detailed complaint so that the defendant must affirm or deny each of the plaintiff's allegations.⁴⁸ A complaint with a compelling narrative may attract the attention of the press; publicity about the case may pressure the defendant to change practices or settle.⁴⁹ A compelling complaint may also influence the opinion of the judge assigned to the case.⁵⁰

Not all complaints will be detailed. Attorneys may choose to keep allegations general so that they cannot be contradicted during discovery or may lack the skill or vision to present their clients' cases in the most compelling light.⁵¹ But even barebones pleadings offer some information about alleged harms and the parties involved that may have fallen through the cracks of other reporting systems.

B. *Unearthing Details*

Litigation can also unearth details about allegations of wrongdoing previously unknown to an organization's leadership. Organizations may have procedures to investigate incidents internally when they occur.⁵² Outside agencies also investigate some types of wrongdoing.⁵³ Yet, in multiple set-

the benefit of learning from their errors if it meant that a suit was never filed or was dismissed.

48 See, e.g., MARY BARNARD RAY & BARBARA J. COX, *BEYOND THE BASICS: A TEXT FOR ADVANCED LEGAL WRITING* 255 (2d ed. 2003) (advising that detailed complaints may "induce settlement negotiations and may require the defendant to admit or deny information that will assist you with discovery").

49 See Herbert A. Eastman, *Speaking Truth to Power: The Language of Civil Rights Litigators*, 104 *YALE L.J.* 763, 772 (1995) ("[T]hrough the media, the complaint speaks to the greater community. That community includes the defendants, the defendants' superiors, and possibly their friends and colleagues. That community may come to see hidden problems in a new light, consider change, and press for settlement."); William H.J. Hubbard, *A Theory of Pleading* 6 (Univ. of Chi., Coase-Sandor Inst. for Law & Econ. Research Paper No. 663, Univ. of Chi., Pub. Law Working Paper No. 446, 2014), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2360723 (observing that a plaintiff has "every incentive to *signal* the strength of her case [in her complaint] by communicating her facts to the potential defendant, if doing so will encourage the defendant to settle").

50 See Eastman, *supra* note 49, at 769–70 (arguing that pleadings should tell a compelling story because in many cases the complaint is "the first and perhaps the only means of communicating the client's story" to a judge who is responsible for "managing a complex discovery process, punctuated by scrimmages over various motions," and facilitating settlements).

51 See *infra* Section I.D (describing these and other characteristics of lawsuit complaints that may make them less useful sources of information).

52 See generally Schlanger, *supra* note 2 (describing internal investigations in hospitals, retailers, and jails and prisons).

53 See generally ANTON R. VALUKAS, JENNER & BLOCK, REPORT TO BOARD OF DIRECTORS OF GENERAL MOTORS COMPANY REGARDING IGNITION SWITCH RECALLS (May 29, 2014) (describing the investigation of an automobile defect by the National Highway Traffic Safety Administration (NHTSA)).

tings, organizations have learned important details about allegations of misconduct through litigation discovery.⁵⁴

One example of lawsuits' power to unearth critical details concerns the faulty ignition switch in Chevrolet Cobalts that has led to over a dozen deaths and the recall of millions of cars by General Motors.⁵⁵ The ignition switch, first installed in Cobalts in 2002, caused cars to stall and lose power.⁵⁶ In 2006, amid increasing reports of stalls and crashes, the company that manufactured the ignition switch proposed a redesign of the switch and a General Motors engineer approved the change.⁵⁷ The engineer reportedly did not tell others within General Motors about the switch redesign and no steps were taken to address faulty ignition switches in older cars.⁵⁸ Later model Cobalts, with the improved ignition switch, did not stall. General Motors' investigating engineers could not, however, figure out why different models of Cobalts performed differently.⁵⁹

The truth came to light during the litigation of a case brought by the parents of Brooke Melton, a woman who died after she lost control of her Chevy Cobalt, hit another car, and rolled off the road.⁶⁰ Her parents sued General Motors in 2011, and hired Mark Hood, a Florida engineer, to figure out why Melton's engine had suddenly shut off.⁶¹ Hood disassembled and examined the ignition switch in Melton's 2005 Cobalt and then compared it to a newer ignition switch purchased at a local dealership. Although both ignition switches had the same identification number, there were significant

54 See, e.g., Schwartz, *A Dose of Reality*, *supra* note 10, at 1287 (reporting that the vast majority of risk managers and patient safety personnel surveyed reported that the information that emerges during litigation discovery is "very useful" or "somewhat useful" in identifying safety and quality concerns, and that discovery "often" or "sometimes" reveals new and useful information); Schwartz, *What Police Learn*, *supra* note 10, at 872–73 (reporting that when auditors compared closed litigation files to internal affairs investigations in Los Angeles County, Seattle, Denver, and Portland, they found that litigation files were far more complete); see also David E. Rapoport & Michael L. Teich, *The Erosion of Secrecy in Air Disaster Litigation*, 10 ISSUES AVIATION L. & POL'Y 231, 232 (2011) (reporting that, despite the NTSB's sterling reputation, "pertinent facts are still often *first* discovered in *adversarial* pretrial discovery in air disaster litigation").

55 The most complete information to date about the ignition switch defect and General Motors' failure to correct the defect for over a decade can be found in the report by Anton R. Valukas, an attorney retained by the General Motors Board of Directors. See generally VALUKAS, *supra* note 53 (describing the investigation of an automobile defect by the NHTSA).

56 See *id.* at 1.

57 See *id.* at 100.

58 See *id.* at 100–01.

59 See *id.* at 3–4.

60 See Gregory Wallace et al., *How Brooke Melton's Death Led to the GM Recall*, CNN MONEY (June 4, 2014, 2:57 PM), <http://money.cnn.com/2014/06/04/autos/general-motors-melton-crash/>.

61 Bill Vlasic, *An Engineer's Eureka Moment with a G.M. Flaw*, N.Y. TIMES, Mar. 28, 2014, http://www.nytimes.com/2014/03/29/business/a-florida-engineer-unlocked-the-mystery-of-gms-ignition-flaw.html?_r=0.

differences in design; the design of the newer ignition switch made it more difficult for a driver to inadvertently cause a car to shut off power and disable its airbags.⁶²

Mark Hood's comparison of faulty and functioning switches was, according to Hood, "nothing extraordinary in scope"⁶³—it is just the type of thing that an expert retained in litigation is paid to do. Yet investigators for General Motors and for the National Highway Traffic Safety Administration (NHTSA) had never taken the "basic investigative step[]" of disassembling and comparing the ignition switches.⁶⁴ Hood's discovery of the changed ignition switch notified the public, for the first time, of the reason Cobalts and other cars were stalling.⁶⁵ It also appears to have informed General Motors management about the cause for the stalls; higher-ups in General Motors maintain that they were unaware of the change to the faulty ignition switch until it was discovered by Hood.⁶⁶

Hood's revelation is not unique; litigators in multiple settings have unearthed valuable, previously unknown information by taking seemingly straightforward steps overlooked by other investigators. For example, in 2006, a Portland man named James Chasse died after a confrontation with two Portland transit officers.⁶⁷ The police department conducted an internal investigation and Chasse's family filed a lawsuit; an outside expert then reviewed both the internal investigation and the litigation file for possible lessons.⁶⁸ The outside expert found that the internal affairs investigators had neglected to interview several officers who were at the scene and nurses who saw Chasse at the jail. The most significant deficiency, however, was the internal affairs division's failure to enhance a video taken the night of the man's death in which the involved officers were talking and reenacting the incident.⁶⁹ Although the audio portion of the recording was mostly unintelligible, internal affairs did nothing to improve the sound. Only during litigation did plaintiff's counsel improve the audio, at which point it became clear

62 *See id.*

63 *See id.*

64 VALUKAS, *supra* note 53, at 4 ("While stumped by the inability to determine why different model year Cobalts performed differently, the investigating engineers nonetheless failed to take certain basic investigative steps, such as taking apart both poorly and properly functioning switches to compare the two.").

65 *See Vlasic, supra* note 61.

66 *See VALUKAS, supra* note 53, at 4 ("While the issue of the ignition switch passed through numerous hands at GM, from engineers to investigators to lawyers, nobody raised the problem to the highest levels of the company. As a result, those in the best position to demand quick answers did not know questions needed to be asked.").

67 *See* MICHAEL GENNACO ET AL., OIR GROUP, REPORT TO THE CITY OF PORTLAND CONCERNING THE IN-CUSTODY DEATH OF JAMES CHASSE 1 (2010), available at www.portlandonline.com/auditor/index.cfm?a=310291&c=54263.

68 *See generally id.* (investigating the death of Mr. Chasse in a report completed by an outside group commissioned by the city auditor).

69 *See id.* at 25–26.

that the officer's statement the night of Chasse's death contradicted his statement to internal affairs.⁷⁰

The National Transportation Safety Board (NTSB) has been described as the "the world's gold standard in terms of accident investigation."⁷¹ Yet, despite its sterling reputation, the NTSB has overlooked key evidence unearthed only during the litigation process. After a Cessna aircraft crashed in December 2004, the NTSB conducted an investigation but could not determine the cause of the crash.⁷² When, in 2006, the NTSB released the plane to the parties to a lawsuit filed by the family of the deceased pilot, two experts examining the plane discovered a small hole in an oil line.⁷³ Further testing by the experts confirmed that the oil hose had been improperly mounted and maintained, causing the oil hose to leak and the engine to stall.⁷⁴ The NTSB subsequently adopted the findings of the experts, concluding that the improperly placed and maintained oil hose had caused the crash.⁷⁵

There are at least three reasons why plaintiffs may unearth information that has gone unnoticed by other investigators. First, plaintiffs' attorneys may have more resources than other investigators to conduct a complete investigation. Commentators report that a wide range of investigations—including those conducted by the NHTSA, police internal affairs divisions, and the NTSB—have been compromised because investigators are underpaid, understaffed, and overworked.⁷⁶

70 See *id.* at 27.

71 Christopher A. Hart, Vice Chairman, Nat'l Transp. Safety Bd., Remarks at His Swearing-In Ceremony (Dec. 17, 2009), available at http://www.nts.gov/news/speeches/CHart/Pages/Hart_091217.aspx; see also Bob Wachter, *The Crash of Air France 447: Lessons for Patient Safety*, WACHTER'S WORLD (Dec. 31, 2011), <http://community.the-hospitalist.org/2011/12/31/the-crash-of-air-france-447-lessons-for-patient-safety/> (describing data collection about errors in aviation as the "true north" for hospital patient safety efforts).

72 See Michael Slack, *Slack & Davis Attorneys Credited with Helping Determine Cause of Airplane Crash*, SLACK & DAVIS (June 19, 2014), <http://www.slackdavis.com/slack-davis-credited-helping-determine-airplane-crash>.

73 *Id.*

74 *Id.*

75 *Id.* In other instances, the NTSB has not adopted information unearthed during litigation discovery that has proven convincing to judges and juries. A study by *USA Today* of NTSB's investigations of small plane and helicopter crashes found "21 verdicts totaling nearly \$1 billion against manufacturers that the NTSB exonerated." Thomas Frank, *Unchecked Carnage: NTSB Probes Are Skimpy for Small-Aircraft Crashes*, USA TODAY (June 12, 2014), <http://www.usatoday.com/longform/news/nation/2014/06/12/unfit-for-flight-part-2/10405451/>.

76 See, e.g., CYNTHIA C. LEBOW ET AL., SAFETY IN THE SKIES: PERSONNEL AND PARTIES IN NTSB AVIATION ACCIDENT INVESTIGATIONS 45–46 (1999) (finding that the NTSB's investigations are compromised by underfunding, understaffing, and outdated investigatory techniques); G. Flint Taylor, *A Litigator's View of Discovery and Proof in Police Misconduct Policy and Practice Cases*, 48 DEPAUL L. REV. 747, 756 (1999) (observing that, among other limitations of police internal affairs investigations, "[t]he salaries paid may not be sufficiently competitive to attract competent investigators . . . [t]he agency may be understaffed for the volume of work at hand, and the resultant backloads may be a cause of shoddy, pro forma investi-

Plaintiffs' attorneys are more likely to have the time and money to uncover all evidence that might help win their clients' cases. As Peter Schuck has observed, "lawyers have every incentive to demand as much existing information from the defendants as the discovery rules, the judge or discovery master, and their photocopying budgets will allow."⁷⁷ Plaintiffs' attorneys' may not uncover every relevant piece of evidence that exists; as Schuck's comment about the limits of an attorney's photocopying budget implies, lawyers and clients may well make cost-benefit analyses about how aggressive to be during discovery.⁷⁸ But competent counsel⁷⁹ will only pursue cases in which they have the resources to unearth the evidence necessary to prove their client's claims. Shifts in litigation finance mean that both sides are more likely to be evenly matched: Although the defense bar has long had a financial advantage, the increasingly well-financed plaintiffs' bar is better able than ever before to engage in lengthy and costly discovery.⁸⁰

Second, plaintiffs' attorneys may be more motivated than other investigators to uncover evidence of misconduct. Internal investigators may conduct perfunctory investigations in order to protect⁸¹ or avoid retribution

gations"); Christopher Jensen & Matthew L. Wald, *Carmakers' Close Ties to Regulator Scrutinized*, N.Y. TIMES, Mar. 30, 2014, <http://www.nytimes.com/2014/03/31/business/carmakers-close-ties-to-regulator-scrutinized.html> (observing that the NHTSA may be less effective than it could be because of a shortage of investigators).

77 Peter H. Schuck, *Why Regulating Guns Through Litigation Won't Work*, in *SUING THE GUN INDUSTRY* 225, 233 (Timothy D. Lytton ed., 2005).

78 See, e.g., Bryant G. Garth, *Two Worlds of Civil Discovery: From Studies of Cost and Delay to the Markets in Legal Services and Legal Reform*, 39 B.C. L. REV. 597, 605 (1998) (observing that "lawyers in the ordinary cases have learned how to manage time and expense" because "their clients will not pay for scorched earth tactics").

79 Less competent counsel may fail to make these types of cost-benefit calculations before taking the case. See *infra* Section I.D (describing these and other reasons that not all lawsuits generate valuable information).

80 See, e.g., Elizabeth J. Cabraser & Katherine Lehe, *Uncovering Discovery*, 12 SEDONA CONF. J. 1, 26 (2011) (describing how plaintiffs' lawyers work together "essentially as *ad hoc* law firms" and, by doing so, "overcame the limitations of the contingent fee economic model (small firm size/litigation underfunding) to achieve economies of scale, and amass a sizeable costs fund with which to counteract attrition tactics"); Stephen C. Yeazell, *Re-Financing Civil Litigation*, 51 DEPAUL L. REV. 183, 195 (2001) (observing that the modern plaintiffs' bar has "recapitaliz[ed] themselves to the point where they could take cases deep enough into discovery to realize some of the potential gain from such pretrial preparation"); *id.* at 198–205 (describing in detail factors that have recapitalized the plaintiffs' bar).

81 See ROBERT M. WACHTER & KAVEH G. SHOJANIA, *INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA'S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES* 322 (2004) (suggesting that hospitals may sometimes "protect their own . . . at the expense of patients"); Samuel Walker, *The New Paradigm of Police Accountability: The U.S. Justice Department "Pattern or Practice" Suits in Context*, 22 ST. LOUIS U. PUB. L. REV. 3, 34–35 (2003) (observing that police "[i]nvestigations have been compromised by too intimate a relationship between investigators and officers, a failure of the department to respond to force incidents in a timely fashion (which may result in the loss of witnesses or physical evidence), the failure to report incidents to the top command or other authorities, the collusion of officers for the

from⁸² their fellow employees. Outside investigators, like those employed by the NHTSA to investigate stalls in Chevrolet Cobalts or those employed by the NTSB to investigate the 2004 Cessna crash, may have allegiances to the industry that they are employed to regulate.⁸³ Senator Claire McKaskill, in a recent hearing about the General Motors defect, despaired that the NHTSA was “more interested in singing ‘Kumbaya’ with the manufacturers than being a cop on the beat.”⁸⁴ As a result, information generated through internal investigations or investigations by regulators can be geared toward protecting organizational interests at the expense of a full and fair examination of the event. Plaintiffs’ attorneys, in contrast, have no allegiances to those they are suing. Instead, they are highly motivated to uncover all material that supports their position—and harms that of the defendants—both to defeat any motion for summary judgment and to prevail at trial.

The third reason that litigants may unearth previously unknown information during discovery is because litigation discovery rules allow for the production of a broader range of information. Some investigative bodies are limited in the types of information they can seek and the manner in which they can seek that information. Police department internal investigations, for example, may be constrained by state and local laws, union agreements, and department policies. Some departments suspend internal affairs investigations if a lawsuit is filed regarding the alleged misconduct.⁸⁵ Some departments limit the amount of time that can be spent conducting an investigation: Louisiana state law requires that most police internal investigations be completed within sixty days.⁸⁶ Some departments limit the ways in which employees can be questioned: the Chicago Police Department’s internal affairs investigators give officers a week or longer to respond to questions

purpose [sic] agreeing on a common and exculpatory version of the incident, and the lack of supervisory attention to critical incidents”).

82 See Myriam E. Gilles, *Breaking the Code of Silence: Rediscovering “Custom” in Section 1983 Municipal Liability*, 80 B.U. L. REV. 17, 85 (2000) (observing that a 1992 study of the Boston Police Department found that “investigators refused to volunteer for the Internal Affairs Division ‘because they fear[ed] retribution once they [got back on the street]’” (alterations in original) (quoting another source)).

83 See, e.g., Jensen & Wald, *supra* note 76 (describing the fear that the “revolving door between the [NHTSA] and the automotive industry” may cause the agency to be less aggressive in its investigations); Nicholas Schmidle, *Crime Fiction*, THE NEW YORKER, Aug. 4, 2014, available at <http://www.newyorker.com/magazine/2014/08/04/crime-fiction> (observing that the Illinois State’s Attorney’s Conviction Integrity Unit, charged with investigating claims of false convictions, may “resist rigorous reviews” because of “‘relationship issues’ flowing from the office’s ‘heavy reliance’ on the testimony of officers”).

84 Hilary Stout & Aaron M. Kessler, *Senators Take Auto Agency to Task over G.M. Recall*, N.Y. TIMES, Sept. 16, 2014, <http://www.nytimes.com/2014/09/17/business/senate-hearing-on-nhtsa-and-recalls.html>.

85 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1049 (describing this practice in Philadelphia).

86 NEW ORLEANS, *supra* note 33, at 80.

and allow officers to respond to those questions in writing.⁸⁷ Investigators may also lack the power to compel information they seek; if a witness refuses to disclose documents or feigns ignorance in an interview there may be little an investigator can do.⁸⁸

In contrast, litigation discovery allows parties to seek out any information that “appears reasonably calculated to lead to the discovery of admissible evidence.”⁸⁹ While a police officer may be allowed to respond to an internal investigator’s questions in writing, the officer, once named as a defendant in a civil suit, will be required to respond to questions in a day-long deposition where he is sworn and attorneys cannot—except under very limited circumstances—intervene. When a party refuses to disclose relevant evidence during litigation, opposing counsel can seek a motion to compel.⁹⁰ When a party suppresses or destroys evidence, opposing counsel can seek sanctions.⁹¹ Internal investigators are less likely to have (or use) comparable powers to overcome and punish obstructionist behavior. For any of these reasons, an important document sitting in a dusty file cabinet may be unearthed only when a discovery request demands its production.

C. *Marshaling the Evidence*

Throughout litigation, parties marshal and interpret available evidence in ways that can prove illuminating. When drafting a complaint, plaintiffs gather relevant evidence and frame defendants’ conduct as a violation of the law.⁹² After discovery, attorneys scour incident reports, emails, internal memos, and deposition transcripts for facts that support or undermine (or, at times, transform) their legal theories. Attorneys evaluate the strength of the inferences connecting those unearthed documents and statements to the legal propositions they are trying to prove. Then, in summary judgment motions, settlement letters, pretrial orders and arguments before the jury, each side shows how their curated collections of facts support their legal claims and defenses. Experts also perform a marshaling function, evaluating documents and deposition transcripts to form an opinion about the extent of liability or harm.⁹³

87 Craig B. Futterman et al., *The Use of Statistical Evidence to Address Police Supervisory and Disciplinary Practices: The Chicago Police Department’s Broken System*, 1 DEPAUL J. SOC. JUST. 251, 275 (2008).

88 See Wagner, *supra* note 7, at 699 (observing that many agencies do not have subpoena power and those that do may not use it because “[t]he fear of political backlash, the agencies’ limited resources, and more invisible political pressures all likely work to temper the agencies’ use of these information-production authorities”).

89 FED. R. CIV. P. 26(b)(1).

90 See FED. R. CIV. P. 37(a)(3).

91 See FED. R. CIV. P. 37(b).

92 See Stephen C. Yeazell, *Convention, Fiction, and Law*, 13 NEW LITERARY HIST. 89, 92 (1982) (observing that, by “sorting complaints into contract, negligence, fraud, battery, and the like,” a lawsuit “helps the reader to organize the story”).

93 For evidence about the prevalence of experts in civil litigation, see Samuel R. Gross, *Expert Evidence*, 1991 WIS. L. REV. 1113. Professor Gross found that experts testified in 86%

Organizations may also analyze information available to them to determine whether they are meeting internal goals or legal standards. This process might occur as part of the organization's risk management efforts or regulatory protocols. Yet, an organization's internal analyses may be focused on answering questions different than those posed in litigation. And even when internal analyses and litigation address the same issues, the plaintiff may interpret the evidence in a manner more sympathetic to her position.⁹⁴ As a result, when litigants marshal evidence, they may be reflecting that information back to the defendants in novel ways.

Take, for example, a recent case brought against the Los Angeles Sheriff's Department by three individuals arrested at different times and locations by deputies for taking photographs in public spaces.⁹⁵ The Department presumably knew about each of the arrests from the reports deputies filled out in each case. And the Department—or the district attorney's office—presumably began some manner of investigation based on these reports. But the civil complaint created a connection between the arrests, framed these arrests as violations of the plaintiffs' First Amendment rights, and contended that the Los Angeles Sheriff's Department had a policy of infringing on artists' constitutional rights. In bringing a single civil case on behalf of the three plaintiffs, the complaint alleged a connection between these events and framed the wrongdoing as a violation of the First Amendment.

Organizations, named as defendants in civil litigation, can also learn valuable information in the process of marshaling evidence they already possess. One such example comes from research by Timothy Lytton about the sex abuse scandal in the Catholic Church.⁹⁶ Lytton credits clergy sex abuse litigation with publicly revealing “hidden (or merely hard to access) information” about the extent of the abuse and framing the abuse as an institutional failure.⁹⁷ Clergy sex abuse litigation also appears to have marshaled diffuse information previously unknown to church officials. As part of a mediation process with plaintiffs' attorneys, the Archdiocese of Los Angeles in 2004 compiled a report detailing 244 sexual abuse allegations against priests that marked a turning point in its response to sexual abuse allegations.⁹⁸ As Lytton writes, “[i]t is highly unlikely that this information would have been collected, organized, and disclosed in the absence of litigation.”⁹⁹

of the civil trials sampled from California state courts in 1985 and 1986, with an average of 3.3 experts per trial. *Id.* at 1119.

94 See Timothy D. Lytton, *Clergy Sexual Abuse Litigation: The Policymaking Role of Tort Law*, 39 CONN. L. REV. 809 (2007) (describing this as the “framing” function of litigation).

95 See Complaint, *Nee v. Cnty. of L.A.*, No. CV11-08899DDP(JCGx), 2011 WL 5121137 (C.D. Cal. Oct. 27, 2011).

96 See generally LYTTON, *supra* note 2, at 175 (2008) (arguing that “[i]nformation generated by litigation may prove crucial” to efforts by the Vatican to screen candidates for the priesthood).

97 *Id.* at 138.

98 See *id.* at 155 (describing the report).

99 See *id.*

Expert reports can also marshal evidence that defendants possess but have not previously analyzed. Take, for example, the expert reports in *Ingles v. Toro*, a class action lawsuit filed against the New York City Department of Corrections (DOC) in 2002, alleging widespread, excessive force against prisoners and inadequate supervision and discipline of officers.¹⁰⁰ Twenty-two individual plaintiffs sought damages for injuries received at DOC facilities and sought systemic reform of officer training, supervision, investigation, and discipline on behalf of a class of prisoners.¹⁰¹

Plaintiffs hired two corrections experts to evaluate whether there was a pattern of excessive force applied against DOC prisoners.¹⁰² To answer this question, the experts reviewed thousands of use of force reports, hundreds of use of force investigations, and department manuals and policies, all of which were produced by defendants. Plaintiffs' experts also reviewed deposition transcripts of DOC employees. In addition, plaintiffs' experts visited the corrections facilities at issue in the case.¹⁰³ Plaintiffs' experts found several patterns in DOC use-of-force incident reports: officers repeatedly used force against prisoners in isolated areas of the jail facilities; officers disproportionately used force against mentally ill prisoners; and officers often unnecessarily hit prisoners in the face. Plaintiffs' experts analyzed patterns in the narratives in officer-reported uses of force and found that officers justified uses of force with "recurring boilerplate scenarios" that suggested not only improper uses of force but also false reporting.¹⁰⁴ The reports also suggested inadequate supervision; supervisory staff should have but did not intervene, both to address officers' use of excessive force and their blatant false reporting.

Although the use-of-force reports and investigation files relied upon by plaintiffs' experts were in defendants' possession, the DOC had never engaged in this type of analysis. DOC leadership had monthly and yearly records of the total numbers of use-of-force events and injuries, divided (by severity) into "use of force A" events and "use of force B" events, and class A and B injuries. But the DOC did not track information about the precise nature of injury, the location of use-of-force events, or the type of force used.¹⁰⁵ Even when one facility did start using a pushpin map to identify where use-of-force incidents occurred, they took down the pins each month with no effort "to retain or analyze the information."¹⁰⁶ Although the DOC analyzed security-related data to identify patterns of wrongdoing by prison-

100 See Fourth Amended Complaint at 5, *Ingles v. Toro*, No. 01 CIV 8279 (S.D.N.Y. Aug. 11, 2003).

101 See *id.*

102 See generally Report of Plaintiffs' Expert Steve J. Martin, *Ingles v. Toro*, No. 01 CIV 8279 (S.D.N.Y. Sept. 27, 2004) [hereinafter Martin Report]; Report of Plaintiffs' Expert Vincent M. Nathan, *Ingles v. Toro*, No. 01 CIV 8279 (S.D.N.Y. Sept. 27, 2004) [hereinafter Nathan Report].

103 See Martin Report, *supra* note 102, at 9.

104 See Nathan Report, *supra* note 102, at 10.

105 See *id.* at 23, 24, 240.

106 See *id.*

ers,¹⁰⁷ it did not use these same techniques to uncover patterns in force used against prisoners.¹⁰⁸ It was only through the litigation process that these patterns were revealed.

D. *The Limits of Litigation Information*

By announcing previously unknown allegations of wrongdoing, unearthing details of allegations, and marshaling evidence, litigants can bring information to the attention of organizational leaders and cause them affirmatively to know something previously unknown, ignored, or unappreciated. I do not, however, mean to suggest that lawsuits are an ideal medium through which to understand organizational performance. Lawsuits—like all other sources of information—have limitations and flaws.

The volume of lawsuits filed is, for example, a poor indicator of the frequency with which defendants engage in misconduct. Although proponents of tort reform may argue that there are too many lawsuits,¹⁰⁹ the weight of empirical evidence indicates that very few people who have been harmed ever sue.¹¹⁰ In addition, the amount that a plaintiff recovers may depend more on the degree of her injury than the severity of the defendant's miscon-

107 See *id.* at 35–36 (observing that the Department of Correction's statistical reports "contain information relating to drug discovery locations, weapon discovery locations, escape contraband locations, and place of occurrence for infractions" but do not contain information "with respect to the location of reported or alleged uses of force . . . in stark contrast to the collection of a host of other security-related data the department maintains").

108 See *id.* ("I am at a loss to understand why none of this information [regarding uses of force by staff] so readily available from reports prepared at the jail is collected, reviewed, and used by central office managers to identify problematic trends in use of force in the jails.")

109 See Marc Galanter, *Real World Torts: An Antidote to Anecdote*, 55 MD. L. REV. 1093, 1095 (1996) (describing the prevailing view that "there are too many tort claims: Americans sue too readily, 'at the drop of a hat'; egged on by avaricious lawyers, they overwhelm our congested courts with mounting numbers of suits, including many frivolous claims").

110 See, e.g., PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 23–24 (1985) (finding that ten percent of victims of medical malpractice sued); MATTHEW R. DUROSE ET AL., *BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, CONTACTS BETWEEN POLICE AND THE PUBLIC: FINDINGS FROM THE 2002 NATIONAL SURVEY* 16–20 (2005) (finding that the police had used force against 664,500 people, 87.3% of whom (580,108) believed that the police acted improperly, and just 1.3% of whom (7416) filed a lawsuit regarding the alleged misconduct); DEBORAH R. HENSLER ET AL., *RAND INST. FOR CIVIL JUSTICE, COMPENSATION FOR ACCIDENTAL INJURIES IN THE UNITED STATES* 121 (1991) (finding that lawsuits were filed in 44% of vehicle injuries, in 7% of work injuries, and less frequently in other types of claims); 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 ENG. J. MED. 245, 249 (1991) (reporting that "the fraction of medical negligence that leads to claims is probably under 2 percent"); Richard E. Miller & Austin Sarat, *Grievances, Claims, and Disputes: Assessing the Adversary Culture*, 15 LAW & SOC'Y REV. 525, 544 (1981) (showing that 5% of grievances became filed lawsuits).

duct.¹¹¹ Accordingly, the volume of lawsuits filed likely understates the frequency with which defendants commit errors, and damages awarded to a plaintiff may overstate or understate the severity of defendants' conduct, depending on the nature of the plaintiff's injury.

The inaccuracies of filing rates and disposition amounts can be attributed to the dynamics of modern civil litigation. Because plaintiffs generally pay their lawyers by the hour or on contingency, a plaintiff will decide to sue—and a lawyer will decide to take her case—only when the likely benefits of a remedy exceed the costs of pursuing the case. If a person's injuries are minimal, she would be an unsympathetic plaintiff, or if the legal claim would require extensive discovery, a person who has been wronged or her lawyer might conclude it is not financially viable to bring her case.¹¹² And because compensatory damages are calculated based on the extent of plaintiffs' injuries, settlements and judgments may not reflect the severity of defendants' misconduct. Egregious malpractice that shortens the life of an elderly patient by one day will garner a low settlement (if the case is brought at all). A far higher settlement is likely in a case with professionally marginal conduct that causes a severely compromised child to need lifetime care.

Some of the flaws in lawsuit data are caused by litigants who—intentionally or inadvertently—distort the information generated during litigation. A lawyer might file a complaint that includes few details, either to preserve the opportunity to pursue multiple theories during discovery and trial, or because he lacks the skill, time, or motivation to tell the plaintiff's story in a compelling manner.¹¹³ A lawyer might, alternatively, overstate the wrongs

111 See, e.g., Janet Cooper Alexander, *Do the Merits Matter? A Study of Settlements in Securities Class Actions*, 43 STAN. L. REV. 497 (1991) (finding that awards are calculated based on plaintiff's injuries); David A. Hyman, *Medical Malpractice and the Tort System: What Do We Know and What (if Anything) Should We Do About It?*, 80 TEX. L. REV. 1639, 1642–44 (2002) (describing studies in malpractice and other contexts that show “the best predictor of the size of an award is the severity of disability, not whether there was negligence or an adverse event”).

112 Scholars have offered these and other reasons to explain why wronged plaintiffs may decide not to pursue litigation. See, e.g., Galanter, *supra* note 109, at 1099 (hypothesizing that people are unlikely to file lawsuits if “they think the injury is de minimis; they want to get on with their lives; they are wary of the cost of pursuing claims; or they simply do not know how to pursue the matter”); Daniel J. Meltzer, *Deterring Constitutional Violations by Law Enforcement Officials: Plaintiffs and Defendants as Private Attorneys General*, 88 COLUM. L. REV. 247, 284 (1988) (suggesting that people who are victims of police misconduct might not sue because of “ignorance of their rights, poverty, fear of police reprisals, or the burdens of incarceration” (footnotes omitted)); Miller & Sarat, *supra* note 110, at 540 (hypothesizing that “people do not make claims unless they feel confident that something can be done should the claim be accepted”).

113 See, e.g., CHARLES R. CALLEROS, *LEGAL METHOD AND WRITING* 366 (5th ed. 2006) (advising that lawyers should draft their complaints with “the maximum generality allowed” in order to avoid allegations that “might prematurely commit the plaintiff to a particular factual theory of the case”); Jack B. Weinstein & Daniel H. Distler, *Comments on Procedural Reform: Drafting Pleading Rules*, 57 COLUM. L. REV. 518, 518–19 (1957) (“Adept pleaders are reluctant to reveal their position in too precise a form early in the litigation—

suffered by his client in the complaint or file a meritless case.¹¹⁴ A lawyer may not hire a key expert because he did not think to do so, or because he did not have the money to do so. During a deposition, an attorney may ask questions that distort the witness's testimony, or may fail to ask a critical question that would unearth key information. In his summary judgment brief, an attorney may marshal evidence in ways that misconstrue the record. Our adversarial system is premised on the notion that a neutral factfinder is best equipped to determine the truth after hearing from equally matched, zealous advocates.¹¹⁵ Yet when adversaries have unequal amounts of money or skill, the information generated during litigation may well favor the party with the most resources regardless of the underlying merits of the case.¹¹⁶

Critics of lawsuits as a mode of regulation have raised a number of additional concerns about lawsuit data. Lawsuits may not focus on the issues most relevant to an organization interested in understanding and improving its performance.¹¹⁷ Because each case takes so long to resolve, lawsuits may generate out-of-date information.¹¹⁸ Finally, some fear that the threat of litigation will cause employees to hide relevant information.¹¹⁹ Commentators

often because it is not then clear what evidence will be produced at the trial—and inept pleaders may be unable to do so.”).

114 Note, however, that even a case without legal merit may reveal information of interest and use to organizational leaders. See, e.g., Schwartz, *A Dose of Reality*, *supra* note 10, at 1283 (describing the value to hospitals of lawsuits that do not meet the standards for medical negligence).

115 For descriptions of this conventional view of the role of the adversarial system, see DEBORAH L. RHODE, IN THE INTERESTS OF JUSTICE 15 (2000); Sharon Dolovich, *Ethical Lawyering and the Possibility of Integrity*, 70 *FORDHAM L. REV.* 1629, 1634 (2002).

116 See Schwartz, *What Police Learn*, *supra* note 10, at 876–77 (describing the distortions that may result when adversaries in litigation are not evenly resourced or skilled).

117 See, e.g., Jennifer Arlen, *Contracting over Liability: Medical Malpractice and the Cost of Choice*, 158 *U. PA. L. REV.* 957, 987–88 (2010) (“Although many errors are attributable to hospitals’ administrative systems, patients generally cannot recover for injuries resulting from systems problems unless they can identify an individual act of negligence. As a result, hospitals do not have adequate incentives to make systemic investments to reduce the risk of error.”); Schuck, *supra* note 77, at 235 (noting that a regulator “might want to know about the industry’s revenues, costs, and profits in order to assess the feasibility of alternative policy interventions, yet this kind of economic information might be inadmissible in a tort case where the issue is whether and how the defendant harmed the plaintiff”). Note, however, that this is not always the case; lawsuits sometimes concern allegations of wrongdoing highly relevant to policymakers that internal systems simply are not designed to collect. See *supra* notes 22–32 and accompanying text.

118 For discussions of these critiques and the value of lawsuit data despite the time delay, see Schwartz, *What Police Learn*, *supra* note 10, at 883–84. Note, also, that the time delay inherent in the litigation process can sometimes be a benefit. See Schwartz, *A Dose of Reality*, *supra* note 10, at 1281 (observing that the time delay inherent in litigation makes lawsuits better suited to capture allegations of delayed treatment, delayed diagnoses, and misdiagnoses).

119 See ATUL GAWANDE, *COMPLICATIONS: A SURGEON’S NOTES ON AN IMPERFECT SCIENCE* 57 (2002) (describing the negative effects of litigation on the openness and transparency needed to improve patient safety); Schuck, *supra* note 77, at 233–34 (“[I]t is quite plausible

have debated the strengths of these criticisms of lawsuits as a source of information about organizational performance.¹²⁰ Further research could endeavor to pinpoint the manner and extent to which each of these limitations of lawsuit data influence the information lawsuits generate. We can accept, for the purpose of discussion, that lawsuit data has each of these flaws to at least some degree.

It would, however, be a mistake to disregard lawsuit data altogether because of these limitations. All information is impacted by the manner in which it is produced, the interests of those producing the information, and the intended use of the information. Prudent review of information therefore recognizes and accommodates those effects. Notably, the organizations I have studied that gather and analyze litigation data appear to do so in two ways that take account of the limitations of lawsuits as a source of information. First, organizations that gather and analyze litigation data discount the information most prone to distortion. For example, both hospitals and police departments distrust payouts as a source of information about organizational behavior. To be sure, organizations may take note when clusters of settlements and judgments indicate problematic practices, personnel, and units.¹²¹ But those charged with improving performance are skeptical of lawsuit outcomes as an indication of the severity of misconduct.¹²²

Second, organizations gather information from multiple sources—not only lawsuits—when identifying problem personnel, practices, and units and

to suppose that litigation, or the prospect of it, may actually *discourage* the gun industry from undertaking new risk-related research [because] . . . any new information that the research might yield . . . would likely be used by gun control groups to press for expanded civil liability or government regulation”); Schwartz, *What Police Learn*, *supra* note 10, at 885–87 (describing the blaming culture allegedly created by litigation). *But see* BAKER, *supra* note 7, at 97 (reviewing available research about medical injuries and finding “no research testing the conventional wisdom that medical malpractice lawsuits drive medical mistakes underground”); Schwartz, *A Dose of Reality*, *supra* note 10, at 1230 (finding evidence that lawsuits do not necessarily inhibit open discussion and transparency in hospitals). Note that lawsuits may also contribute to the creation of policy-relevant information. *See generally* Schlanger, *supra* note 2 (observing that the threat of litigation can cause organizations to implement claims management procedures, including the collection and assessment of information, that can lead to performance improvements).

120 *See supra* notes 117–19 (describing literature that both sets out and challenges these criticisms of lawsuits).

121 *See, e.g.*, Schwartz, *A Dose of Reality*, *supra* note 10, at 1274–75 (describing closed claims reviews across multihospital systems to identify settlement trends); Schwartz, *What Police Learn*, *supra* note 10, at 854–55 (describing an analysis by the Los Angeles Sheriff’s Department indicating that two stations were responsible for sixty percent of settlement dollars paid over a six-month period, and the resulting in-depth investigation of the underlying causes for those payouts).

122 *See* Schwartz, *A Dose of Reality*, *supra* note 10, at 1293 (describing hospital risk managers’ skepticism about lawsuit payouts as a source of information about medical errors); Schwartz, *What Police Learn*, *supra* note 10, at 882–83 (reporting that those engaged in police department performance improvement efforts pay little attention to lawsuit outcomes).

determining how best to address the problems they identify.¹²³ Scholars have long recognized that it is valuable to gather information from redundant or overlapping sources.¹²⁴ By reviewing data from multiple sources, organizations can get a fuller picture of their strengths and weaknesses; if a problem is reported through an internal information system but not a lawsuit, the organization will still have a record of the alleged problem.¹²⁵ Organizations can also use multiple data sources to check the integrity of information generated by each system; if previously unknown details of a doctor's wrongdoing emerge during a medical malpractice lawsuit, the hospital can assess whether internal reporting systems should have captured this information—or whether the details of the doctor's behavior have been distorted by the litigation process. Either way, the organization's review of data from multiple sources can improve the integrity of information ultimately relied upon when making personnel and policy decisions intended to reduce future harms.

E. The Case for Introspection

Thus far, I have shown that litigation data can fill gaps in organizations' internal information systems and that the weaknesses of litigation data can be addressed through thoughtful collection and analysis. I now take the short leap from descriptive to prescriptive and make the case for organizations interested in learning about and improving their performance to engage in

123 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1292–93 (describing the various sources of data gathered and analyzed by hospital risk managers); *id.* at 1262–63, 1269 (describing investigations of medical errors that are prompted by, but independent of, medical malpractice lawsuits); Schwartz, *What Police Learn*, *supra* note 10, at 877 (describing the multiple sources of data analyzed in police early intervention systems); *id.* at 878 (describing a review of a Los Angeles Sheriff's Department station that was prompted by a series of lawsuits but focused on staffing and management issues that went beyond the allegations in the suits).

124 See, e.g., JAMES Q. WILSON, *BUREAUCRACY: WHAT GOVERNMENT AGENCIES DO AND WHY THEY DO IT* 274 (1989) (“In some governmental systems as in many mechanical ones, redundancy is useful. Overlapping agencies, like back-up computers on the space shuttle, can detect errors; duplicating functions is not always wasteful, it can lead to more flexible responses and generate alternatives.”); Martin Landau, *Redundancy, Rationality, and the Problem of Duplication and Overlap*, 29 *PUB. ADMIN. REV.* 346 (1969) (describing the benefits of overlapping and redundant systems in complex organizations); Matthew C. Stephenson, *Information Acquisition and Institutional Design*, 124 *HARV. L. REV.* 1422, 1463 (2011) (“Redundant systems are thought to act as a form of insurance: if one agent fails in her task, another agent's contributions may compensate. Furthermore, if agents' contributions are partial rather than perfect substitutes (that is, if the agents' functions overlap but are not fully redundant), then the contributions from multiple agents may add value to the final outcome even if none of them shirk.”).

125 See *supra* text accompanying note 124 (describing the benefits of redundant or overlapping information collection); see also Levtzion-Korach et al., *supra* note 28 (describing the importance of collecting information about medical error from multiple sources to counteract the weaknesses of each data source).

introspection through litigation. It is, however, as this discussion will make clear, a relatively modest case and one that is qualified in several respects.

The case for introspection is straightforward: when organizations review lawsuits for lessons they can better understand weaknesses in personnel, management, and policies, and craft interventions to address those weaknesses. In multiple organizational settings, lawsuits have announced previously unknown allegations of wrongdoing, unearthed critical details about those events, and marshaled evidence in illuminating ways. Examples abound of instances in which information revealed during litigation has led to reductions in errors and improvements in care. When one hospital tracked lawsuits, it discovered that it had a cluster of pulmonary embolism cases and implemented several interventions that the hospital risk manager reported were “hugely effective” at reducing injuries and claims.¹²⁶ When one police department tracked lawsuits, it found a cluster of excessive force cases involving head injuries brought against officers working the night shift at one station.¹²⁷ Following retraining and closer supervision, head strikes—and associated lawsuits—declined.¹²⁸ The discovery by an engineering expert in a suit against General Motors that the Chevrolet Cobalt’s ignition switch had been surreptitiously changed to reduce the likelihood of stalls “set in motion G.M.’s worldwide recall of 2.6 million Cobalts and other cars, and one of the gravest safety crises in the company’s history.”¹²⁹

Although introspection through litigation has undoubtedly helped different types of organizations understand and address their weaknesses, I cannot calculate with any precision the contribution that lawsuits have made to these performance improvement efforts. Organizations that analyze lawsuits for lessons consider that information in connection with information from multiple other sources. Given the flaws of lawsuits as a source of information about organizational performance, and the flaws of the other types of data available to organizations, it makes good sense for organizations to seek out information from overlapping and redundant sources.¹³⁰ It does, however, make it difficult to determine the precise value added by lawsuits.

Moreover, the value of lawsuit data to organizational improvement efforts likely differs from organization to organization and depends on the types of harms caused by its employees, the types of claims that can be brought in court, the other types of information collected by the organization, and the strength and integrity of those other information systems. Presumably, organizations with the weakest internal information systems—like police departments—will benefit most from introspection through litigation. Yet lawsuits have also surfaced information of value to organizations with more comprehensive information systems, like hospitals. Lawsuits have revealed valuable information even to the auto and aviation industries, each

126 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1285–86.

127 See Schwartz, *What Police Learn*, *supra* note 10, at 854–55.

128 See *id.*

129 Vlastic, *supra* note 61.

130 See *supra* notes 123–25 and accompanying text.

of which have government-run investigative bodies overseeing their conduct. Accordingly, even organizations with robust systems for collecting and investigating possible misconduct learn lessons from lawsuits that can contribute to organizational performance improvement efforts.

In encouraging organizations to engage in introspection through litigation, I do not mean to suggest that litigation is the only way for organizations to learn about and address their weaknesses. Organizations can work to improve their other information systems. Indeed, organizations can endeavor to adjust their information systems so that they capture some of the same information generated by lawsuits. Such adjustments could, conceivably, reduce the value of lawsuit data to those organizations. If, for example, hospitals created incident reporting systems better designed to identify delayed and missed diagnoses, hospitals would less frequently learn about such claims through litigation. If the NTSB reduced their investigators' caseloads, critical evidence about aviation accidents might not surface for the first time during discovery. Yet litigation has several qualities that would be difficult for an organization to replicate: plaintiffs and their attorneys are completely independent of the organizations they sue, have strong financial and other incentives to unearth damaging information about those organizations, and can use discovery rules to ensure they will get the information they seek. Given these unique qualities of litigation, it is difficult to imagine that organizations' other information systems can be adjusted so dramatically that they eliminate the value of lawsuit information altogether.

Litigation is also an economical means of learning about organizational behavior. To be clear, I do not mean to suggest that litigation itself is inexpensive.¹³¹ But the current structure of our civil litigation system already requires parties to spend the money necessary to announce claims of wrongdoing, unearth critical details of those claims, and marshal the evidence they find. These costs will be borne by the parties to a suit regardless of whether the information is also used for performance improvement efforts. After spending the time and money necessary to defend against a suit, it is relatively inexpensive for a defendant to review the information generated during that suit for lessons.

II. WHY SOME ORGANIZATIONS ARE INTROSPECTIVE (AND OTHERS ARE NOT)

Although lawsuits have revealed previously unknown, useful information in multiple, varied organizational settings, not all organizations review lawsuits for lessons. There is very limited research—beyond my studies of police

131 There are, of course, ongoing debates about whether lawsuits are too expensive and time-consuming, whether procedural reforms are necessary to address the pathologies of modern civil litigation, and what those reforms should be. I do not intend to engage here in those ongoing debates. For the purposes of this Article, I focus on what organizations can learn from the information generated by our civil litigation system as it is currently structured.

departments and hospitals—examining the frequency with which organizations gather and analyze lawsuits for lessons.¹³² Yet, even in these two organizational settings, there is wide variation in this regard.

Police departments have highly flawed internal information systems—and could, therefore, one imagines, learn a great deal from lawsuits—yet very few police departments appear to systematically gather and analyze lawsuit data. High profile cases may capture the attention of law enforcement officials, but run-of-the-mill cases are largely ignored: most departments make little effort to gather and analyze data about which officers are sued, what claims are alleged, what evidence is unearthed, whether plaintiffs prevail, and how much they recover.¹³³ A growing number of police departments have computerized systems to track problem police officers, but do not necessarily include lawsuit claims in those systems.¹³⁴ And departments rarely use lawsuits to identify problem practices or stations, rarely analyze information gathered during discovery, and rarely review closed cases for lessons.¹³⁵

In contrast, hospitals—despite more extensive internal systems for reporting and analyzing error—report reviewing lawsuits for lessons far more often than do police departments.¹³⁶ Thirty years ago, few hospitals viewed medical malpractice cases as a source of information relevant to patient

132 For one study that does touch on this topic, see GEORGE EADS & PETER REUTER, *DESIGNING SAFER PRODUCTS: CORPORATE RESPONSES TO PRODUCT LIABILITY LAW AND REGULATION* 107 (1983) (observing, in a study of the effects of product liability litigation, that “firms viewed product liability litigation as essentially a random influence” and that “two firms with the largest volume of litigation took steps to insulate design decisions from the influence of litigation”). For additional scholarship that considers this question, see *supra* note 2.

133 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1041–52 (describing these findings); see also SAMUEL WALKER, *POLICE ACCOUNTABILITY: THE ROLE OF CITIZEN OVERSIGHT* 100–01 (2001) (“One of the notable failures of both police departments and other city officials has been their neglect of modern concepts of risk management and in particular their refusal to examine incidents that result in litigation and seek to correct the underlying problems.”).

134 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1059 n.214 (observing that, as of 2003, two-thirds of law enforcement agencies in jurisdictions with populations over 50,000 did not have early intervention systems, and those that did may not have included lawsuits in the data they collect).

135 See SAMUEL WALKER & CAROL A. ARCHBOLD, *THE NEW WORLD OF POLICE ACCOUNTABILITY* 48 (2d ed. 2014) (observing that some of the practices described in *What Police Learn*, including early intervention systems, “are already being done” but others, “such as revisiting closed cases for relevant information about officers’ conduct, are not known to be currently done but are a creative suggestion for the future”); Schwartz, *Myths and Mechanics*, *supra* note 10, at 1058–59 (describing the infrequency with which departments analyze trends in suits, review litigation discovery, or review closed cases); Schwartz, *What Police Learn*, *supra* note 10, at 847 (observing that the five police departments that gather and analyze litigation data are outliers, in that they “review litigation data most extensively as a matter of policy and most consistently as a matter of practice” (footnote omitted)).

136 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1252 (reporting that fewer than five percent of participants in my survey of hospital risk managers and patient safety personnel reported “never” or “rarely” using litigation data for patient safety and quality purposes).

safety. Today, however, hospitals gather and analyze information from every stage of litigation to help understand weaknesses and improve the quality of care. The vast majority of hospitals investigate the allegations in malpractice complaints not only to prepare a defense but also to identify possible patient safety issues.¹³⁷ Most hospitals analyze lawsuit claims in the aggregate to identify case trends that might signal weaknesses in personnel or protocols.¹³⁸ Hospital risk managers, medical providers, and other personnel receive updates about pending malpractice cases, and information unearthed during the course of discovery may inform patient safety initiatives.¹³⁹ Most hospitals also report reviewing closed malpractice claim files—containing both litigation documents and internal records—for lessons.¹⁴⁰

Why do most police departments ignore lawsuits as a source of information while most hospitals integrate litigation data into their patient safety efforts? The very nature of this question, as I have posed it, demands that any answer rely heavily on generalities.¹⁴¹ Nevertheless, this Part offers some preliminary answers to this question. It seems reasonable to assume that an organization would only engage in introspection through litigation if three conditions were met. First, the organization must have incentives to learn about errors and weaknesses in its operations and improve its performance. Second, those in positions of leadership must view lawsuits as a source of valuable information about organizational performance. And, third, the organization must have the infrastructure and personnel in place to gather and analyze information from lawsuits. Hospitals generally meet each of these conditions, as do the few law enforcement agencies that review lawsuits for lessons. Most other law enforcement agencies, it seems, do not have the incentives, personnel, or favorable view of lawsuit data that would cause them to review lawsuits for lessons. After comparing the incentives and systems in place in hospitals and police departments, this Part concludes with suggestions about how to encourage introspection through litigation in law enforcement agencies and other organizational settings.

A. *Incentives for Introspection*

Before engaging in introspection through litigation, an organization must want to improve its performance. An organization might want to improve its performance for any number of reasons: to improve the quality of the services it provides, reduce the costs or frequency of litigation, or improve outsiders' views of the organization. Hospitals, generally speaking,

137 *Id.* at 1268–69 (describing the analysis and investigation of legal complaints).

138 *See id.* at 1260–70 (describing trend analysis).

139 *See id.* at 1270–72 (describing review of discovery while cases are pending).

140 *See id.* at 1272–75 (describing hospitals' closed claims reviews).

141 Far more could be done to explore the differences and similarities of hospitals and police departments. Far more could be done to plumb the depths of the explanations that I offer. And far more could be done to explore the practices in those hospitals and police departments that do not fall within these broad categories. Further research should consider all of these questions in greater depth.

have financial and norms-based incentives to improve performance. Police departments, generally speaking, have neither. The few law enforcement agencies that do review lawsuits for lessons appear to have done so in response to external pressures or mandates to improve.

1. Financial Incentives

Economic theories of deterrence predict that the threat of financial sanctions will cause organizations to take steps that will reduce the likelihood of future suits.¹⁴² Consistent with that prediction, organizations might review lawsuits as a means of reducing the likelihood of future legal claims and associated expenses.

Hospitals have multiple financial incentives to reduce the types of errors that lead to malpractice suits. A majority of hospitals self-insure their doctors for medical malpractice claims, which should motivate them to reduce malpractice litigation costs whenever possible.¹⁴³ Even insured hospitals benefit financially when they reduce errors and suits, as hospitals' medical malpractice insurance premiums are generally tied to past litigation costs.¹⁴⁴ Hospitals also have financial incentives to reduce errors more generally. For example, Medicaid reimbursements are tied to whether hospitals track and

142 For foundational descriptions of this theory, see, for example, GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* (1970); WILLIAM M. LANDES & RICHARD A. POSNER, *THE ECONOMIC STRUCTURE OF TORT LAW* (1987); STEVEN SHAVELL, *ECONOMIC ANALYSIS OF ACCIDENT LAW* (1987). Although we expect that organizations will take steps to reduce the likelihood of future harms, an organization might choose to reduce litigation costs by engaging in harms that are less likely to result in civil liability. For a discussion of this possibility, see generally Margo Schlanger, *Second Best Damage Action Deterrence*, 55 DEPAUL L. REV. 517 (2006). Such organizations would still, presumably, review information from lawsuits to determine which behaviors result in the greatest liability exposure. See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1037–40 (describing the types of information and information systems organizations would need in order to make informed decisions intended to reduce financial liability).

143 Annual reports by Aon Risk Solutions in conjunction with the American Society for Healthcare Risk Management report that 74% of hospitals insure their providers through self-insurance. See Joe Carlson, *Systems Study Med-Mal Self-Insurance*, MODERN HEALTHCARE (Oct. 25, 2011), <http://www.modernhealthcare.com/article/20111025/NEWS/310259966>. This is consistent with my survey of hospital risk managers and patient safety personnel. Of the 392 respondents who provided information about their hospitals' insurance status, 65% (294) reported that they were self-insured, 21% (83) reported they had outside insurers, and 14% (55) reported "other," which appeared in some instances to include captive insurers.

144 See Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1598 (2002) (explaining that experience rating can "create a financial incentive to improve quality and safety in order to reduce the number of injuries"); see also Tom Baker & Rick Swedloff, *Regulation by Liability Insurance: From Auto to Lawyers Professional Liability*, 60 UCLA L. REV. 1412, 1434–35 (2013) (observing that individual doctors' malpractice insurance is not generally experience rated, but that "insurers use experience rating and consider loss prevention efforts when selling professional liability insurance policies to larger group practices and hospitals").

analyze errors, and whether patients are readmitted as the result of errors.¹⁴⁵ Hospitals must gather and analyze error data or lose accreditation and state certification—either of which would have significant financial ramifications.¹⁴⁶ Malpractice insurers may also provide financial incentives for hospitals to reduce error rates.¹⁴⁷

For-profit hospitals presumably have the strongest motivation to reduce error and improve their performance, as improved care could lead to more patients and increased profits. There is some evidence to support this hypothesis. When I surveyed hospital risk managers and patient safety personnel, for-profit hospitals reported reviewing lawsuits for lessons with slightly more frequency than nonprofit and government hospitals.¹⁴⁸ But almost all hospitals—regardless of their financial status—review lawsuits to some degree, suggesting that hospitals’ profit status does not determine *whether* hospitals gather and analyze lawsuits, but may influence how significant a role lawsuits play in patient safety and performance improvement efforts.

Law enforcement agencies have fewer financial incentives to reduce the types of behaviors that lead to civil litigation. Although governments—not individual officers—pay approximately 99.98% of the dollars that plaintiffs recover in police misconduct suits,¹⁴⁹ law enforcement agencies bear limited financial responsibility for those costs. In many jurisdictions, the money to satisfy settlements and judgments is paid out of general government funds,

145 See Robert Pear, *Report Finds Most Errors at Hospitals Go Unreported*, N.Y. TIMES, Jan. 6, 2012, http://www.nytimes.com/2012/01/06/health/study-of-medicare-patients-finds-most-hospital-errors-unreported.html?_r=0 (describing Medicaid requirements).

146 See Barry R. Furrow, *Regulating Patient Safety: Toward a Federal Model of Medical Error Reduction*, 12 WIDENER L. REV. 1, 18 (2005) (reporting that accreditation and government reporting requirements “strive to create a state of ‘forced mindfulness’ by providers, as the data allows for feedback as to sources of bad outcomes and the resulting ability to fix problems”). Note, however, that some commentators believe the Joint Commission—the hospital accreditation body—is “notoriously gentle in its approach, slow to develop meaningful standards and reluctant to develop enforcement mechanisms other than the unlikely threat of withdrawal of accreditation.” *Id.* at 7.

147 For example, Blue Cross Blue Shield of North Carolina advertises that it “provide[s] financial incentives for hospitals to reduce their preventable infections and error rates.” BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, <http://connect.bcbsnc.com/lets-talk-cost-2013/solutions/posts/solutions-rewarding-lower-error-rates/> (last visited Jan. 1, 2015).

148 Those responding to the survey were asked whether they “never,” “rarely,” “sometimes,” or “often” reviewed complaints, litigation discovery, claim trends, and closed claims data. To determine a hospital’s tendency to use litigation information for their patient safety and improvement efforts, I assigned their responses to each question in a range from a low of 1 (indicating that the litigation information was never used) to 4 (indicating that the litigation information was often used). Accordingly, a respondent who reported that all four types of litigation data were often used would receive a 16; a respondent who reported that all four types of litigation data were never used would receive a four. The 101 respondents employed by for-profit hospitals had an average score of 14.30. The 305 nonprofit and government hospitals had an average score of 12.89.

149 See generally Joanna C. Schwartz, *Police Indemnification*, 89 N.Y.U. L. REV. 885 (2014) (reporting study findings).

not police department budgets.¹⁵⁰ These departments have no financial incentives to reduce suits. Some law enforcement agencies do pay settlements and judgments from their budgets, and some contribute to city- or county-wide funds that pay these claims.¹⁵¹ But even when agencies bear some financial responsibility for litigation payouts, the impact of this responsibility on police operations may be limited; departments receive their budgets from jurisdictions' general funds, and jurisdictions may be wary to burden departments' budgets too significantly, as it might impair their ability to fight crime.¹⁵²

In addition, there are no financial pressures for police departments to reduce errors more generally. Law enforcement agencies receive money from states and the federal government, but state and federal funding is not tied in any way to the collection or assessment of data about police error.¹⁵³ And while hospitals stand to lose patients and profits if they provide substandard care, there is a far more tenuous relationship between police budgets and police performance. Police departments get their money from the government, not the individual civilians they are charged with protecting. A person dissatisfied with his police department can complain to government officials but cannot take action that will have any direct financial effect on that department. Moreover, government officials may not view allegations of police misconduct as a reason to reduce police department budgets. Instead, some believe that an increase in the number of lawsuits against a department

150 See HUMAN RIGHTS WATCH, SHIELDED FROM JUSTICE: POLICE BRUTALITY AND ACCOUNTABILITY IN THE UNITED STATES 80 (1998) (“[I]n most cities . . . civil settlements paid by the city on behalf of an officer usually are not taken from the police budget but are paid from general city funds.”); Marc L. Miller & Ronald F. Wright, *Secret Police and the Mysterious Case of the Missing Tort Claims*, 52 BUFF. L. REV. 757, 781–82 (2004) (“[T]he monetary cost of judgments against police are not always fully or directly born by police departments or by individual officers. Civil judgments come out of city or county funds, or perhaps from insurance policies that the local government purchases—i.e., from taxpayers.”); Schwartz, *Myths and Mechanics*, *supra* note 10, at 1047–48 (describing New York City’s practice of satisfying settlements and judgments out of the city’s general budget).

151 See, e.g., Email from Scott. M. Huizenga, Budget Officer, Budget Div., City of Kansas City, Mo., to author (Sept. 8, 2014) (on file with author) (“[J]udgments and settlements against KCPD [Kansas City Police Department] are paid from the KCPD budget.”); Email from Michelle Allersma, San Francisco Controller’s Office Budget and Analysis Dir., to author (Sept. 5, 2014) (on file with author) (“Each year, the Police Department’s General Fund operating budget includes an amount to pay for claims.”).

152 In ongoing research, I am examining the ways in which jurisdictions across the country pay for police misconduct litigation, and the ways in which these budgeting arrangements influence lawsuits’ financial effects on law enforcement agencies. See generally Joanna C. Schwartz, *How Governments Pay: Lawsuits, Budgets, and Police Reform* (unpublished manuscript) (on file with author).

153 Federal funding is formally tied to prohibitions on discrimination on the basis of race, color, national origin, sex, or religion, although this prohibition “is rarely used with notable effect against police departments.” Rachel Harmon, *Limited Leverage: Federal Remedies and Policing Reform*, 32 ST. LOUIS U. PUB. L. REV. 33, 53 (2012). Moreover, there are no “analogous statutes that condition federal funds for police departments on abstaining from forms of misconduct other than discrimination.” *Id.* at 52.

may result in a *larger* budget for the department because “the political returns for higher police funding and appearing tough on crime may be worth the budgetary cost.”¹⁵⁴ In sum, it appears that most law enforcement agencies appear to enjoy few if any financial gains when they reduce the frequency of lawsuits, and face few if any financial sanctions when they fail to do so.

2. Organizational Norms

Hospitals and police departments have different norms regarding the importance of detecting, understanding, and reducing the types of errors that lead to litigation. This difference in perspective likely influences the frequency with which each type of organization reviews lawsuits for lessons.¹⁵⁵

Thirty years ago, malpractice was generally considered rare and the result of errors by individual medical providers, and limited information was gathered and analyzed about medical errors. In its watershed report, *To Err Is Human*, published in 1999, the Institute of Medicine argued that medical error was far more frequent than the public had previously believed; that medical error was caused primarily by system-wide weaknesses in policy, organization, equipment, and technology; and that gathering and analyzing information about error was key to addressing these systemic weaknesses.¹⁵⁶ Although patient safety advocates had made these arguments long before the Institute of Medicine’s report, *To Err Is Human* has been credited with shifting the perspectives of the public and policymakers about the frequency of medical error, the causes of medical error, and the importance of gathering and analyzing data about error.¹⁵⁷

154 Miller & Wright, *supra* note 150, at 772; see also PETER H. SCHUCK, *SUING GOVERNMENT: CITIZEN REMEDIES FOR OFFICIAL WRONGS* 125 (1983) (“The political environment may countenance or even reward lawbreaking that appears to advance important programmatic or ideological goals such as crime control, intelligence-gathering, or preservation of neighborhood schools.”).

155 A larger discussion could be had comparing and contrasting police department and hospital cultures. For work discussing the culture of medicine, see, for example, David A. Hyman & Charles Silver, *Healthcare Quality, Patient Safety, and the Culture of Medicine: “Denial Ain’t Just a River in Egypt,”* 46 *NEW ENG. L. REV.* 417, 421–28 (2012). For work discussing the culture of police departments, see, for example, Barbara E. Armacost, *Organizational Culture and Police Misconduct*, 72 *GEO. WASH. L. REV.* 453, 495 (2004). For work on organizational culture and norms more generally, see, for example, JOHN P. KOTTER & JAMES L. HESKETT, *CORPORATE CULTURE AND PERFORMANCE* (1992); EDGAR H. SCHEIN, *ORGANIZATIONAL CULTURE AND LEADERSHIP* (4th ed. 2010); Diane Vaughan, *Rational Choice, Situated Action, and the Social Control of Organizations*, 32 *LAW & SOC’Y REV.* 23 (1998).

156 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1232–34 (describing the Institute of Medicine’s report).

157 See generally Lucian L. Leape & Donald M. Berwick, *Five Years After To Err Is Human: What Have We Learned?*, 293 *JAMA* 2384 (2005) (describing the effects of *To Err Is Human* on perceptions and policies regarding medical error).

In the years following the Institute of Medicine's report, hospitals have significantly increased the extent to which they gather and analyze data about their performance.¹⁵⁸ State and federal regulations and the Joint Commission, hospitals' accreditation body, have mandated increased data collection; hospitals have also developed patient safety programs on their own initiative.¹⁵⁹ Hospitals have hired patient safety personnel charged with implementing their patient safety and healthcare quality responsibilities,¹⁶⁰ and hospitals' risk management staff report that they have embraced patient safety as a goal of their work.¹⁶¹

The shifting perspective about the frequency of medical error and the importance of collecting and assessing information about errors when they occur appears to have encouraged the assessment of information in lawsuits. Patient safety advocates believe that key to reducing error is being transparent with patients and "sharing information about injuries with systems that facilitate analysis and learning."¹⁶² Although hospital risk managers historically discouraged the discussion of errors in an effort to reduce malpractice liability, my research suggests that the culture of openness and transparency encouraged by patient safety advocates appears to be influencing hospital risk managers' response to litigation risk.¹⁶³ Risk managers are increasingly encouraging medical providers to be transparent with patients when errors occur, and are encouraging and participating in internal discussion about errors—including discussions about lawsuits and the information learned from pending and closed cases.¹⁶⁴

Although I contend that norms have shifted regarding the importance of detecting and reporting medical errors, I do not mean to suggest that medical providers' conduct is always consistent with these norms. One study found that 96% of doctors surveyed believed they should report impaired or incompetent colleagues, but 45% had failed to do so.¹⁶⁵ A study of risk man-

158 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1232–37 (describing patient safety efforts implemented in recent years).

159 See *id.* at 1235–36 (describing increased data collection in hospitals after the Institute of Medicine's report).

160 See *id.* at 1236–37 (describing risk management and patient safety personnel charged with implementing patient safety requirements and goals).

161 See *infra* Section II.C (describing the views of risk managers and patient safety personnel).

162 Michelle M. Mello et al., "Health Courts" and Accountability for Patient Safety, 84 *MILBANK Q.* 459, 472 (2006).

163 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1294–95 (describing the findings of the study).

164 See *id.* at 1254–55 (describing risk managers' efforts to encourage providers to be transparent with patients); *id.* at 1260–63 (describing increasing discussions between risk managers, patient safety personnel, and medical providers about medical error).

165 See Eric G. Campbell et al., *Professionalism in Medicine: Results of a National Survey of Physicians*, 147 *ANNALS INTERN. MED.* 795 (2007). This phenomenon is what some have called a "conspiracy of silence." See, e.g., Alex Stein, *Toward a Theory of Medical Malpractice*, 97 *IOWA L. REV.* 1201, 1212 (2012). Notably, commentators have used this same phrase—"conspiracy of silence"—to describe police officers' disinclination to report misconduct by

agers reported similar findings; although the majority of risk managers surveyed asserted that it was their hospital's practice "always" to disclose errors to patients or their families, hospital records indicated patients were not always informed of errors.¹⁶⁶ Doctors, risk managers, and other personnel do not always practice what they preach. But norms—and at least some behaviors—regarding the importance of detecting and reporting error have shifted over the past few decades.

The world of policing looks much like the world of medicine did in the years before the Institute of Medicine's report. Instead of recognizing police error as a significant and systemic concern, law enforcement officials often dismiss allegations of police misconduct, or acknowledge wrongdoing but place the blame on "bad apple" officers.¹⁶⁷ In contrast to hospitals' focus on systems-level weaknesses that lead to error, less attention is paid in law enforcement to system-wide weaknesses in policy, organization, equipment, and technology.¹⁶⁸ In contrast to the culture of transparency promoted by patient safety advocates, police officers and police department leadership are believed to follow a "code of silence" that values "silence and loyalty" to fellow officers over the disclosure of misconduct or corruption.¹⁶⁹

There are ongoing efforts to shift norms about police error and the culture of policing more generally. Advocates have long argued, based on available data, that police misconduct is widespread;¹⁷⁰ scholars have long called for better collection and assessment of data about police behavior so that policymakers can understand the extent of police misconduct;¹⁷¹ and a grow-

their peers. See, e.g., Howard B. Klein, *Fighting Corruption in the Philadelphia Police Department: The Death Knell of the "Conspiracy of Silence,"* 60 *TEMPLE L.Q.* 103 (1987).

166 See Rae M. Lamb et al., *Hospital Disclosure Practices: Results of a National Survey*, 22 *HEALTH AFF.* 73, 75, 79 (2003).

167 Armacost, *supra* note 155, at 455 (arguing that "[t]he primary defect in these explanations" offered for police violence "is that they view police misconduct as resulting from factual and moral judgments made by officers functioning as individuals, rather than as part of a distinctive and influential organizational culture"); Gilles, *supra* note 82, at 31 ("Municipalities generally write off the misconduct of an individual officer to the 'bad apple theory,' under which municipal governments or their agencies attribute misconduct to aberrant behavior by a single 'bad apple,' thereby deflecting attention from systemic and institutional factors contributing to recurring constitutional deprivations.").

168 For some exceptions to this rule, see *infra* notes 177–79 and accompanying text.

169 JEROME H. SKOLNICK & JAMES J. FYFE, *ABOVE THE LAW: POLICE AND THE EXCESSIVE USE OF FORCE* 111–12 (1993); see also Gilles, *supra* note 82, at 63–64 (observing that the police "code of silence"—meaning "the refusal of a police officer to 'rat' on fellow officers, even if the officer has knowledge of wrongdoing or misconduct"—"has existed, to varying degrees, for as long as there have been organized police forces").

170 See generally HUMAN RIGHTS WATCH, *supra* note 150 (describing police misconduct across the United States).

171 Rachel Harmon, *Why Do We (Still) Lack Data on Policing?*, 96 *MARQ. L. REV.* 1119, 1133–45 (2013) (describing limited state and federal data collection requirements for law enforcement agencies and institutional constraints on more robust data collection); Matthew J. Hickman, Alex R. Piquero & Joel H. Garner, *Toward a National Estimate of Police Use of Nonlethal Force*, 7 *CRIMINOLOGY & PUB. POL'Y* 563, 565 (2008) ("[L]ocal, state, and federal

ing number of cities have appointed police auditors, civilian complaint review boards, police advisory commissions, and other civilian-run entities charged with improving police accountability.¹⁷² Within police department ranks, tides appear to be shifting to some degree as well: departments are finding ways to engage cooperatively with the communities they patrol and the increasing diversification of police forces has “decreas[ed] the insularity of police forces as well as their monolithic solidarity.”¹⁷³ Over the past twenty-five years, departments have increasingly adopted early intervention systems to track problem officers and other reforms to increase professionalism and accountability.¹⁷⁴ Some departments are also apologizing for errors when they occur¹⁷⁵—an approach that has reduced the incidence and costs of medical malpractice litigation.¹⁷⁶

Those with an interest in improving policing also appear increasingly to be examining system-level weaknesses that lead to error. For example, the Force Science Institute has been applying human factors research, common in aviation and medicine, to law enforcement.¹⁷⁷ The Department of Justice has, in recent years, focused attention on systems-level weaknesses that may lead to error, including the lack of assistance for officers suffering from stress, the effects of off-duty assignments on officer fatigue, and the need for training about interactions with mentally ill arrestees.¹⁷⁸ And the National Institute of Justice recently issued a report reminiscent of *To Err Is Human*, calling on law enforcement to follow the model adopted by medicine (and

governments actually collect and report very little information about police use of force, much less than about police behavior in general.”).

172 The National Association for Civilian Oversight of Law Enforcement (NACOLE) works to bring these organizations and entities together to improve police accountability practices. For a list of police departments with some form of civilian oversight, see *U.S. Oversight Agency Websites*, NAT’L ASS’N FOR CIVILIAN OVERSIGHT OF LAW ENF’T, <http://nacole.org/resources/u-s-oversight-agency-websites/> (last visited Jan. 1, 2015).

173 David Alan Sklansky, *Is the Exclusionary Rule Obsolete?*, 5 OHIO ST. J. CRIM. L. 567, 578 (2008); see also *id.* at 575 (describing the rise of community policing, and describing activities that fall under that rubric).

174 See generally EPP, *supra* note 23 (describing the growth of what Epp calls “legalized accountability” in policing and other areas).

175 See, e.g., Alphonse Gerhardstein & David Krings, *Uncomfortably True Police Misconduct Cases: Keys to Appropriate Methods of Resolution*, 94 PUB. MGMT. 10, 11 (2012), available at <http://web.law.columbia.edu/sites/default/files/microsites/policing-litigation-conference/files/Professional%20Manager%20magazine%20-%20settling%20police%20misconduct.pdf> (describing mediation and apology efforts in Lockland, Ohio following two police incidents, and concluding that “[a] sincere effort by a local government manager to make amends for a public safety situation that went horribly wrong can lead to a far better emotional and financial outcome for all parties involved”).

176 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1256–58 (describing the effectiveness of hospital disclosure and apology programs at reducing medical malpractice claims and costs).

177 Studies can be viewed at FORCE SCI. INST. LTD., <http://www.forcescience.org> (last visited Jan. 1, 2015).

178 See generally NEW ORLEANS, *supra* note 33 (describing these and other recommendations to improve the department).

aviation before it) and analyze law enforcement errors and “near misses” to identify systemic weaknesses.¹⁷⁹ These developments may mark the beginning of a shift in law enforcement norms. But, as of now, despite these pockets of reform, there has been no seismic shift in the way in which law enforcement views the importance of detecting, understanding, and reducing error.¹⁸⁰

It may, in fact, be more difficult to shift law enforcement responses to information about error than it has been to shift norms in medicine. Doctors and hospitals strive to make their patients healthy;¹⁸¹ collecting and analyzing information about medical error is consistent with this goal. To be sure, doctors historically resisted collecting data about error, but they are hypothesized to have done so because they “view an error as a failure of character” and, therefore, feel “a strong pressure to intellectual dishonesty, to cover up mistakes rather than to admit them.”¹⁸² In other words, doctors are so committed to doing no harm that they may not admit harms when they occur.

Although doctors’ and hospitals’ interests in improving patients’ health are consistent with the collection and assessment of data about medical error, police departments’ and officers’ efforts to reduce crime and maintain order may be seen to conflict with the collection and assessment of information about police error.¹⁸³ Police department officials may believe that some constitutional violations are a necessary by-product of aggressive policing, and aggressive policing is necessary to deter future crime and secure

179 See James M. Doyle, *The Paradigm Shift in Criminal Justice*, THE CRIME REPORT (Mar. 4, 2014, 10:55 AM), <http://www.thecrimereport.org/viewpoints/2014-03-the-paradigm-shift-in-criminal-justice> (calling on law enforcement to “adapt the core insights of safety reformers in aviation, medicine and other fields to criminal justice”). See generally NAT’L INST. OF JUSTICE, MENDING JUSTICE: SENTINEL EVENTS REVIEWS (2014), available at <https://ncjrs.gov/pdffiles1/nij/247141.pdf>.

180 See Samuel Walker, *Institutionalizing Police Accountability Reforms: The Problem of Making Police Reforms Endure*, 32 ST. LOUIS U. PUB. L. REV. 57, 71 (2012) (observing, despite some organizational shifts, “the difficulty of getting the rank and file to support innovation—accountability-related reforms in particular”).

181 See Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851, 1851 (1994) (“For years, medical and nursing students have been taught Florence Nightengale’s dictum—first, do no harm . . . Physicians are socialized in medical school and residency to strive for error-free practice. There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable.” (footnote omitted)).

182 *Id.* at 1851–52.

183 See, e.g., Margo Schlanger, *Offices of Goodness: Influence Without Authority in Federal Agencies*, 36 CARDOZO L. REV. 53, 54 (2014) (illustrating Philip Selznick’s “precarious values”—in which doing “‘the right thing’ means executing not only a primary mission but also constraints on that mission”—by describing the police: “[W]e want police to prevent and respond to crime and maintain order, but to do so without infringing anyone’s civil rights”).

order.¹⁸⁴ Officials who hold such beliefs will also likely believe that gathering and analyzing information about claims of police misconduct—and changing policies and practices as a result—will undermine effective policing. At the very least, gathering and analyzing data about police misconduct will take time and money away from other crime control efforts.¹⁸⁵ To the extent that law enforcement officials consider officers' crime control efforts to be compromised by efforts to respect civilians' constitutional rights, officials will have little incentive to gather and analyze information about police error from lawsuits and other sources.

3. External Pressures

Although hospitals typically have financial and norms-based incentives to improve their performance, not all hospitals are adequately motivated by these incentives to improve. At least some hospitals have endeavored to improve the medical care they provide only after negative press coverage, government investigations, and other external pressures.¹⁸⁶

The few police departments that do gather and analyze lawsuits and other data about police performance appear to have been pressured to do so through the legal or political process. The Department of Justice has recommended or required most of the law enforcement agencies it has investigated to gather and analyze lawsuits for performance lessons.¹⁸⁷ For those jurisdictions under court supervision, monitors have worked to ensure that information from lawsuits and other sources is actually collected and analyzed.¹⁸⁸

Other jurisdictions began reviewing lawsuits as a response to political pressures. For example, Los Angeles County appointed an independent commission to evaluate the Los Angeles Sheriff's Department after a series of

184 See, e.g., Armacost, *supra* note 155, at 475 (observing that police departments may accept police misconduct lawsuits as the costs of aggressive policing).

185 Rachel A. Harmon, *Promoting Civil Rights Through Proactive Policing Reform*, 62 STAN. L. REV. 1, 8 (2009) ("Police departments do not exist to promote civil rights. Instead, they exist to prevent crime, protect life, enforce law, and maintain order. Promoting civil rights can sometimes interfere with these primary objectives because assessing misconduct and identifying, implementing, and monitoring appropriate reforms is difficult and consumes resources.").

186 The press coverage and congressional investigations of VA hospitals, for example, have caused the VA to address shortcomings in its services. For descriptions of the government investigations, and an example of the press coverage, see, for example, Curt Devine, *Bad VA Care May Have Killed More than 1,000 Veterans, Senator's Report Says*, CNN (June 24, 2014, 5:35 PM), <http://www.cnn.com/2014/06/24/us/senator-va-report/>. For a description of the changes announced by the VA, see Kimberly Leonard, *Massive VA Health Overhaul Announced*, U.S. NEWS & WORLD REP'T (Nov. 10, 2014, 3:51 PM), <http://www.usnews.com/news/articles/2014/11/10/robert-mcdonald-announces-massive-va-health-overhaul>.

187 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1052–57 (describing the types of policies recommended in Department of Justice technical assistance letters and required in Department of Justice consent decrees).

188 See *id.* at 1084 (describing the importance of court monitors and external auditors in police departments' efforts to implement policy changes).

high-profile shootings, a series of articles in the *Los Angeles Times*, and a series of large settlements and judgments against the Department.¹⁸⁹ It was that commission that recommended the appointment of outside observers who decided, as part of their oversight, to analyze lawsuits as one means of risk management.¹⁹⁰ High-publicity incidents involving police officers were also the apparent cause for other departments' decisions to hire auditors who evaluate performance by reviewing information from lawsuits and other sources.¹⁹¹

B. *Belief in Lawsuits' Informational Value*

Even if an organization is incentivized to improve behavior, it will not engage in introspection through litigation unless organizational leaders believe that lawsuits would offer useful lessons. Although outside researchers have convincingly shown that medical malpractice lawsuits are a source of valuable information about medical error, no comparable research about police lawsuits exists.

In 1983, long before the Institute of Medicine's report, the president of the American Society of Anesthesiologists (ASA) began a study of closed malpractice cases as a way of identifying the causes of anesthesiology injury.¹⁹² The ASA recruited thirty-five insurance companies to make their claims files available; volunteer anesthesiologists coded the files and investigators reviewed the claims for consistency before submitting them to the database.¹⁹³ Analysis of the closed claims revealed previously unknown causes of injury in anesthesiology patients.¹⁹⁴ Ten years after the ASA study began, anesthesiology error had dropped precipitously, and the ASA Closed Claims Study was credited with improving the safety of the practice. Researchers, citing the ASA's success, have used closed claims to identify

189 See KOLTS ET AL., *supra* note 42, at 1 (observing that the appointment of a commission to review the Department was the result of “[a]n increase over the past years in the number of officer-involved shootings,” “[f]our controversial shootings of minorities by LASD deputies in August 1991,” and the fact that “Los Angeles County . . . paid \$32 million in claims arising from the operations of the LASD over the last four years”).

190 See Schwartz, *What Police Learn*, *supra* note 10, at 849–50 (describing the commission's report and recommendations, including the appointment of special counsel to report to the County about the Department).

191 See *id.* at 850–52 (describing high-profile incidents in Seattle and Chicago that caused each city to appoint civilians to oversee aspects of their departments and who began to review litigation data as part of that oversight).

192 See Frederick W. Cheney, *The American Society of Anesthesiologists Closed Claims Project: What Have We Learned, How Has It Affected Practice, and How Will It Affect Practice in the Future?*, 91 ANESTHESIOLOGY 552 (1999), available at http://journals.lww.com/anesthesiology/Citation/1999/08000/The_American_Society_of_Anesthesiologists_Closed.30.aspx (describing the impetus for the ASA Closed Claims Project).

193 See *id.* at 553.

194 *Id.* at 554.

causes of error in other practice areas.¹⁹⁵ Even in the early days of the patient safety movement, researchers recognized that—although lawsuits were poor indicators of the frequency of error and lawsuit outcomes were poor indicators of the extent of a defendant’s wrongdoing—medical malpractice claims “may hold lessons the medical profession ought to learn.”¹⁹⁶ Accordingly, the groundwork was laid for malpractice lawsuits to play a role in hospital patient safety efforts.

Lawsuits have played a less significant role in scholarly work examining the causes of police misconduct. Although scholars have studied section 1983 cases as a way of understanding how many cases are filed and their rate of success,¹⁹⁷ scholars have largely overlooked closed section 1983 cases as a way of identifying trends in policies and practices that lead to misconduct allegations. Perhaps insurance providers have been less willing to share closed claims data with researchers.¹⁹⁸ Or, perhaps, those who study the police have not considered lawsuits a valuable source of information about the nature and causes of misconduct.

Although many law enforcement officials are skeptical of lawsuits as a source of useful information,¹⁹⁹ this view may slowly be shifting. The value of lawsuits as a means of understanding and improving police practices has been advocated by a small number of people, and illustrated in a small but growing number of departments. Merrick Bobb, who served as special counsel for the Los Angeles County Board of Supervisors, and was charged with reviewing the Los Angeles Sheriff’s Department, was among the first and

195 See, e.g., M. Ennis & C.A. Vincent, *Obstetric Accidents: A Review of 64 Cases*, 300 BRIT. MED. J. 1365 (1990) (using closed claims to study obstetric errors); Allen Kachalia et al., *Missed and Delayed Diagnoses in the Emergency Department: A Study of Closed Malpractice Claims from 4 Liability Insurers*, 49 ANNALS OF EMERGENCY MED. 196 (2007) (using closed claims to study emergency room errors); Selwyn O. Rogers, Jr. et al., *Analysis of Surgical Errors in Closed Malpractice Claims at 4 Liability Insurers*, 140 SURGERY 25 (2006) (using closed claims to study surgical errors).

196 Richard L. Kravitz et al., *Malpractice Claims Data as a Quality Improvement Tool*, 266 JAMA 2087, 2087–88 (1991).

197 See, e.g., David K. Chiabi, *Police Civil Liability: An Analysis of Section 1983 Actions in the Eastern and Southern Districts of New York*, 21 AM. J. CRIM. JUST. 83 (1996); Theodore Eisenberg, *Section 1983: Doctrinal Foundations and an Empirical Study*, 67 CORNELL L. REV. 482 (1982); Theodore Eisenberg & Stewart Schwab, *The Reality of Constitutional Tort Litigation*, 72 CORNELL L. REV. 641 (1987); Stewart J. Schwab & Theodore Eisenberg, *Explaining Constitutional Tort Litigation: The Influence of the Attorney Fees Statute and the Government as Defendant*, 73 CORNELL L. REV. 719, 728–30 (1988).

198 See Candace McCoy, *How Civil Rights Lawsuits Improve American Policing*, in HOLDING POLICE ACCOUNTABLE 111, 119, 151 n.13 (Candace McCoy ed., 2010) (observing that “insurance company records [as they relate to police misconduct suits] are private and seldom released to researchers” with the exception of “one small database from an insurance source, covering the years 1974 to 1984” that was released to McCoy only because the company “is now defunct”).

199 See Schwartz, *What Police Learn*, *supra* note 10, at 874 n.184 (describing officials’ criticisms of police misconduct lawsuits as a source of information).

most vocal advocates for lawsuits as a source of valuable information.²⁰⁰ The Office of Independent Review (OIR), another oversight agency for the Los Angeles Sheriff's Department, also began reviewing lawsuits when it was formed in 2001.²⁰¹ A former staff attorney for OIR then served as the civilian auditor of the Chicago Police Department, and incorporated review of lawsuits into her analysis.²⁰² Richard Rosenthal, the police auditor who caused the Portland Police Department to begin looking at lawsuits in 2004, then became the police auditor in Denver and imported his litigation review practices to that jurisdiction.²⁰³

In July 2014, inspired by the effective uses of lawsuit data in Seattle, Portland, and the Los Angeles Sheriff's Department, the New York City Comptroller, Scott M. Stringer, introduced ClaimStat, a program to track and analyze lawsuit claims against the New York City Police Department and other city agencies.²⁰⁴ New York City's CompStat system has been at the forefront of data collection efforts to reduce crime in law enforcement agencies across the country.²⁰⁵ Time will tell whether New York City's ClaimStat approach is adopted by other jurisdictions with the same enthusiasm.

C. Personnel

Even if an organization wants to improve its performance, and its leadership believes that reviewing lawsuits is one way to do so, an organization will not engage in introspection through litigation unless the professional personnel who would be directly responsible for analyzing lawsuits for lessons are willing to do so.²⁰⁶ Hospital risk managers and defense counsel appear to have increasingly accepted the importance of gathering and analyzing

200 See *id.* at 872–73.

201 See *id.* at 848 n.34.

202 See *id.* at 852.

203 See *id.* at 851–52.

204 See OFFICE OF THE N.Y.C. CONTROLLER, CLAIMSTAT: PROTECTING CITIZENS AND SAVING TAXPAYER DOLLARS 14 (2014), available at <http://comptroller.nyc.gov/wp-content/uploads/2014/07/ClaimStat.pdf> (describing the program and citing examples from Seattle, Portland, and Los Angeles County, drawn from *What Police Learn*, of the benefits of reviewing lawsuits for lessons).

205 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1071–72 (describing CompStat and its adoption in police departments around the country and around the world).

206 Organizational sociologists have long recognized that professional personnel can shape the practices and norms in their organizations. See Schlanger, *supra* note 2, at 14–16; see also Schlanger, *supra* note 183 (describing what Schlanger calls “offices of goodness,” offices within larger agencies charged with furthering some extrinsic mission, and possible factors leading to the success of such agencies). In the workplace, for example, professional personnel have translated broad prohibitions of discrimination into policies and practices and thereby are responsible for putting the law into action. See generally FRANK DOBBIN, *INVENTING EQUAL OPPORTUNITY* (2009); Lauren B. Edelman et al., *Diversity Rhetoric and the Managerialization of Law*, 106 AM. J. SOC. 1589, 1591 (2001); Lauren B. Edelman et al., *Internal Dispute Resolution: The Transformation of Civil Rights in the Workplace*, 27 LAW & SOC'Y REV. 497, 497–98 (1993); Susan Sturm, *Second Generation Employment Discrimination: A Structural Approach*, 101 COLUM. L. REV. 458, 462 (2001).

information about error, including information from lawsuits. Police departments, in contrast, generally do not have risk managers, and available evidence indicates that defense attorneys representing police officers are reluctant to share information from lawsuits with police leadership.

1. Risk Managers

Since the malpractice crisis in the 1970s, hospitals have had risk managers focused on reducing litigation risk. After *To Err Is Human* was published in 1999,²⁰⁷ hospitals began hiring patient safety and quality personnel focused on reducing error in hospitals.²⁰⁸ Although risk managers and patient safety advocates originally worked separately, they have become more connected in recent years.²⁰⁹ Risk managers have increasingly seen improving patient safety as a key aspect of their work.²¹⁰ Risk managers and quality improvement personnel report working closely together to identify litigation and safety risks and design interventions. And risk managers report tracking and analyzing claims, keeping abreast of discovery uncovered during litigation, and reviewing closed claims as means of reducing risk and improving safety.

Police departments, in contrast, rarely have personnel dedicated to understanding and reducing error in policing. Government, insurance, and law enforcement organizations have long encouraged police risk management as a means of addressing police risk and reducing litigation costs.²¹¹ Yet, in 2004, when Carol Archbold surveyed 354 law enforcement agencies with over 200 employees, she found that just 14 of the agencies—fewer than 4%—had risk managers in their departments to address liability issues.²¹² When police departments implement systems to gather and analyze data, it is often police sergeants and other supervisors who are charged with these responsibilities.²¹³ Yet computerized data entry and analysis are skills that “often ‘lie outside the traditional roles for which they were selected and

207 INST. OF MED., *TO ERR IS HUMAN* (1999).

208 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1226–27.

209 See *id.* at 1261–62.

210 See *id.* at 1253–54.

211 See WALKER & ARCHBOLD, *supra* note 135, at 218–20 (observing that “several professional groups and publications have identified the need for the use of risk management in police organizations” including the Public Risk Management Association, the Commission on Accreditation for Law Enforcement Agencies, and the Intergovernmental Risk Management Agency); Carol A. Archbold, *Managing the Bottom Line: Risk Management in Policing*, 28 POLICING 30, 34–36 (2005) (describing various publications promoting law enforcement risk management).

212 Archbold, *supra* note 211, at 38 (describing study findings); see also CAROL A. ARCHBOLD, POLICE ACCOUNTABILITY, RISK MANAGEMENT, AND LEGAL ADVISING 38–39 (2004) (describing the same study).

213 See Walker, *supra* note 180, at 76 (observing that early intervention systems are “an entirely new way of conducting police supervision” that involve “changes in the traditional work habits of police sergeants”).

trained' and in which they have much experience."²¹⁴ Moreover, police line and command staff may not have the time²¹⁵ or motivation²¹⁶ to make sure that these new tasks are done correctly—much less to innovate and improve.

Departments are also relatively rarely overseen or guided by city officials or other outsiders. Charles Epp surveyed practices in over 800 police departments across the country and found that, in almost 60% of departments, command-level officers never or almost never communicate with city attorneys or city-wide risk managers about officer use-of-force issues.²¹⁷ Approximately 115 departments across the country²¹⁸ have independent auditors who oversee police departments in some manner—a model that police accountability expert Samuel Walker has described as the best way to ensure lasting police reform.²¹⁹ And at least some of these auditors—including those in each of the five litigation-attentive police departments I studied—gather and analyze information about police performance from lawsuits and other sources. But the vast majority of the over 18,000 law enforcement agencies across the country have no outside reviewers to assist with accountability efforts.²²⁰

Hospital risk managers and patient safety personnel have been critically important to the translation of patient safety goals into policies and procedures that reduce error. Without comparable personnel in most law enforcement agencies and limited oversight by outsiders, it should come as no surprise that police departments less frequently review lawsuits for lessons.

214 *Id.* at 71 (quoting Skogan, *supra* note 15, at 26).

215 See POLICE EXEC. RESEARCH FORUM, CIVIL RIGHTS INVESTIGATIONS OF LOCAL POLICE: LESSONS LEARNED 20 (2013) (describing time constraints on sergeants and advising that police executives should not “burden sergeants with excess paperwork if you want them to supervise officers on the streets”).

216 See *supra* subsection II.A.2 (describing organizational norms that can limit introspection); see also *supra* Section I.B (describing some reasons that supervisors may be disinclined to investigate line officers’ misconduct).

217 Epp asked: “How frequently do command-level officers in your department consult about issues related to the use of force with your city’s risk management officials or legal staff other than prosecutors?” and 4.7% responded “daily or weekly”; 7.7% responded “monthly”; 28.6% responded “several times a year”; 41.2% responded “[a] few times over several years”; and 17.2% responded “never or almost never.” Epp, *supra* note 23, at 254.

218 The website of the National Association for Civilian Oversight of Law Enforcement lists 115 American cities and counties with civilian oversight. See *U.S. Oversight Agency Websites*, *supra* note 172; cf. LaDoris Cordell, *Policing the CHP: Beating Shows Officers Need Independent Oversight*, SAN JOSE MERCURY NEWS (July 9, 2014), http://www.mercurynews.com/opinion/ci_26105353/policing-chp-beating-shows-officers-need-independent-oversight (reporting that “200 cities and counties across this nation have oversight agencies”).

219 See Walker, *supra* note 180, at 84–85.

220 See Schwartz, *What Police Learn*, *supra* note 10, at 887 (describing the role of auditors in identifying and addressing implementation problems).

2. Defense Counsel

Introspection through litigation is near impossible without the cooperation of defense counsel. Assuming the organization is named as a defendant, it should have access to the complaint. But organizational leadership will not have access to the details unearthed during discovery, the evidence marshaled in expert reports and briefs, or the closed case file unless defense counsel shares this information.

Hospitals that engage in introspection through litigation report getting information about suits from their attorneys.²²¹ Hospital risk managers describe regular communications with defense counsel about lawsuits as they progress; defense lawyers may share depositions and other documents with the risk manager or provide regular reports about the status of discovery.²²² In some hospitals, defense counsel periodically present information about open cases to larger groups including risk management, medical staff, and patient safety personnel.²²³ Although these meetings are intended to help defense counsel assess the merits of the case, information learned by hospital staff during these meetings is also used to further patient safety objectives.²²⁴

In contrast, those few police departments that do seek to gather and analyze litigation information have reported significant opposition by defense counsel. The Kolts Commission, which evaluated the Los Angeles Sheriff's Department in 1992, observed that defense lawyers learned valuable information during litigation but that information "did not make its way systematically to the Department and was not used for risk management purposes."²²⁵ Ten years later, the Los Angeles County OIR, charged with overseeing the Department's investigations, reported that the Office of Los Angeles County Counsel had refused to share litigation information with the oversight agency.²²⁶ Although the OIR received information about lawsuit complaints from the Department, "County Counsel . . . blocked OIR from acquiring any further documents or information generated by the civil litigation process."²²⁷

Police auditors have faced similar roadblocks to information sharing in other jurisdictions. After Richard Rosenthal, the former police auditor in Portland, was given authorization to investigate claims made in lawsuits, the city attorney refused to turn over the notices of claim he needed to start his

221 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1270–71.

222 See *id.*

223 See *id.* at 1271 (describing these meetings).

224 See *id.*

225 L.A. SHERIFF'S DEP'T, FIFTEENTH SEMI-ANNUAL REPORT 83–84 (2002).

226 See OFFICE OF INDEP. REVIEW, CNTY. OF L.A., FIRST REPORT 55 (2002), *available at* http://shq.lasdnews.net/shq/LASD_Oversight/report1.pdf.

227 *Id.* Note, however, that in subsequent years, the relationship between OIR and the Office of Los Angeles County Counsel improved: it began sharing litigation materials and allowed OIR to participate in discussions of pending litigation. See MICHAEL Gennaco et al., Office of Indep. Review, Cnty. of L.A., Second Annual Report 79 (2003).

investigations.²²⁸ After three years of struggling with the city attorney's office for these claims, he found another city agency that would provide him with the claims.²²⁹ When Rosenthal became the auditor in Denver, the city attorney again did not provide him with copies of the lawsuits filed against the department and its officers.²³⁰ He only began receiving copies of the suits after a new deputy was hired as chief of litigation who agreed to cooperate with Rosenthal.²³¹

Although more study is necessary to understand why malpractice defense counsel are more willing than city counsel representing the police to share information about errors, the remainder of this Section suggests two possible causes for this phenomenon. First, defense counsel may share litigation information more often with hospital administrators because hospitals have a more direct financial stake in the outcome of malpractice suits. For the hospitals that are self-insured, defense counsel share information about pending suits with hospital personnel while seeking guidance about what course of action to take—whether to settle (and if so, for how much) or whether to take a case to trial.²³² Hospitals with outside insurers also consult with hospital executives about litigation strategy.²³³ Police departments, as previously described, often do not pay litigation costs out of their budgets. Moreover, it tends to be the city or county attorney, city council, or police commissioner who decides whether to indemnify an officer in a lawsuit, and the city or county council, treasurer, or comptroller who decides whether to approve a settlement.²³⁴ If a police department does not control its litigation costs, defense counsel has less reason to inform police executives about the details of ongoing litigation or seek their guidance about what course to take.

Second, defense counsel in malpractice cases may share more litigation information with hospital administrators because there are greater evidentiary protections for internal discussions of medical error. Hospital and police department personnel both report fearing that internal analysis of errors might be discoverable in litigation. For this reason, police departments may suspend internal investigations once lawsuits are filed. Even when

228 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1065–66 (observing that in 2008, the Portland police auditor “had the authority to investigate claims made in lawsuits for three years, but the city attorney’s office continue[d] to refuse to provide him with the notices of claim he need[ed] to begin the investigations”).

229 See Telephone Interview with Richard Rosenthal (June 9, 2011).

230 See *id.*

231 See *id.*

232 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1271 (describing periodic meetings with defense counsel and a hospital committee including risk managers, medical staff, and executives, during which defense counsel would describe the strengths and weaknesses of cases and the committee would decide whether to settle the case).

233 See *id.* at 1271 n.234 (describing similar meetings with hospital personnel led by the insurer instead of by defense counsel).

234 See Schwartz, *supra* note 149, at 904 (describing review of city and county council minutes in which settlements and judgments were approved); *id.* at 907 (describing who makes indemnification decisions).

cities require that lawsuit allegations be internally investigated, city attorneys have refused to turn over the complaints, citing the fear that an internal investigation will harm the defense of the case.²³⁵ Hospital personnel share the concern that internal discussions might be discoverable; as a result, hospital risk managers report tailoring internal communications so that they fall within the confines of available evidentiary privileges.²³⁶

Although police and hospital personnel share concerns about disclosure, existing law protects internal communications in hospitals far more than in police departments. Every state protects information from peer reviews of medical errors, most states protect the information in morbidity and mortality conferences, and at least twenty-one states protect information from internal error reports.²³⁷ If a hospital is designated as a patient safety organization, it can collect and analyze error information from multiple hospitals without that information being subject to disclosure during litigation.²³⁸ With such protections, defense counsel, risk management, and medical providers can discuss the details of pending litigation with the assurance that all discussions will be protected from discovery.

Law enforcement agencies' internal discussions have significantly less protection from discovery. Twenty-one states provide that internal affairs documents and civilian complaints are public record.²³⁹ In the other states, defense counsel in police misconduct litigation can argue that several privileges shield internal affairs reports and other internal documents from disclosure.²⁴⁰ Yet, despite defendants' assertions of privilege, internal affairs investigations are routinely produced during discovery.²⁴¹ Attorneys defend-

235 The Los Angeles Sheriff's Department's special counsel has repeatedly despaired that attorneys for the Department do not share damaging information in suits with the Department. See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1065–66; see also *supra* notes 228–31 and accompanying text (describing city attorneys' refusals to share information with police auditors in Portland and Denver).

236 Schwartz, *A Dose of Reality*, *supra* note 10, at 1264–66.

237 See *id.* at 1264.

238 See *id.* at 1264–66.

239 See Jenny Rachel Macht, *Should Police Misconduct Files Be Public Record? Why Internal Affairs Investigations and Citizen Complaints Should Be Open to Public Scrutiny*, 45 CRIM. L. BULL. 1006 (2009).

240 Privileges invoked by defense counsel in police misconduct litigation include the self-critical analysis privilege, the executive privilege, and the deliberative process privilege. See Josh Jones, *Behind the Shield? Law Enforcement Agencies and the Self-Critical Analysis Privilege*, 60 WASH. & LEE L. REV. 1609, 1612–13 (2003).

241 See, e.g., *Carillo v. Las Vegas Metro. Police Dep't*, No. 2:10-cv-02122-KJD-GWF, 2013 WL 592893, at *6 (D. Nev. Feb. 14, 2013) (holding that internal investigation files were discoverable in plaintiff's section 1983 suit against the police department, and citing several cases that found internal affairs reports are not entitled to high levels of protection from discovery); *Groark v. Timek*, 989 F. Supp. 2d 378, 400 (D.N.J. 2013) (ordering the production of all internal affairs investigations involving defendant officers in a section 1983 suit); *Estate of Bui v. City of Westminster Police Dep't*, 244 F.R.D. 591, 597 (C.D. Cal. 2007) (ordering production of the internal affairs investigation of the incident that was the basis for the section 1983 suit).

ing police officers in lawsuits have refused to share information about pending litigation with police officers in apparent fear that disclosures may be discoverable.²⁴² For this reason, perhaps, even the litigation-attentive police departments in my study did not analyze discovery and expert reports while litigation was pending; instead, police auditors reviewed case files after the cases were concluded.

D. *Encouraging Introspection*

I have shown that lawsuits can reveal useful, previously unknown information that has fallen through the cracks of organizations' other information systems. I have also shown that some organizations—including police departments—infrequently review information from lawsuits in an effort to improve their performance. Based on a comparison of police department and hospital practices, it seems that organizations are more likely to engage in introspection through litigation if they have incentives to do so, a positive view of the value of lawsuit information to performance improvement efforts, and the personnel in place to analyze lawsuits for lessons.

Given the benefits of lawsuit data to organizational improvement efforts, outsiders—agencies, government officials, insurers, and others—might conclude that they want to encourage organizations to pay closer attention to lawsuit data.²⁴³ After closely examining practices in only two settings, it is impossible to reach definitive conclusions about the types of interventions that would increase attention to lawsuit data in all organizational settings.²⁴⁴ Nevertheless, this Section offers several possible interventions inspired by the comparison of police departments and hospitals that might cause police to increase the attention they pay to lawsuits and might be of use to those interested in encouraging introspection in other organizational settings.

First, law enforcement agencies need stronger incentives to engage in introspection through litigation. Researchers, policymakers, and advocates should continue to call for law enforcement to engage in systemic reviews of errors when they occur. The Department of Justice should continue to require the departments it investigates and prosecutes to gather and analyze

242 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1065–66 (observing that “[s]ome city attorneys discretely ‘pocket[]’ information developed during the lawsuit that might reflect poorly on their client” and other attorneys “more explicitly refuse to assist internal investigations” for fear that transparency would harm their client’s case).

243 For some discussion of how outsiders might think about the relative value of lawsuit data to an organization’s performance improvement efforts, see generally *supra* Section I.D. For discussion about how introspection through litigation might coexist with other priorities, see *infra* notes 250–52 and accompanying text.

244 Despite the differences between police departments and hospitals, they share several characteristics in common. Both, for example, are engaged in public or quasi-public services; both also rely heavily on their employees to make split-second, high-stakes decisions that will invariably lead to error. Indeed, hospitals and police departments may share more in common with each other than they do with other types of organizations. Accordingly, the practices in police departments and hospitals, and the comparison of the two, may offer limited guidance for other types of organizations.

lawsuits for performance lessons. Steps could also be taken to increase the financial incentives for police departments to review lawsuit data. Local, state, or federal governments could require police departments to gather and analyze lawsuit data as a condition of funding.²⁴⁵ Police departments could be required to bear more financial responsibility for litigation costs.²⁴⁶ Police departments could also take a more active role in approving litigation decisions: defense counsel might be more likely to share information about pending suits with police officials if those officials had settlement authority.

Evidence of the value of lawsuit data could also be used to encourage police officials and those overseeing police departments to gather and analyze information from lawsuits. This is already happening to some extent; the effective uses of lawsuit data in Seattle, Portland, and the Los Angeles Sheriff's Department inspired New York City to adopt the ClaimStat program.²⁴⁷ If ClaimStat helps reduce litigation costs in New York City, this model may well be adopted by other jurisdictions. Malpractice insurers' closed claims studies have identified trends in errors across multiple hospitals; perhaps, encouraged by the success of these studies, municipal insurers could begin examining police litigation trends across jurisdictions for similar lessons.

Personnel could also be hired to gather and analyze lawsuit data and other relevant information about organizational performance. The Department of Justice could recommend appointing these types of personnel to the departments it investigates and advises. Federal grants could be offered to departments that make these hires.²⁴⁸ Or cities and counties could hire more police auditors and risk managers on their own initiative, inspired by the productive role these personnel have played in performance improvement efforts in other jurisdictions.²⁴⁹

When considering the sensibility of various approaches to encourage introspection through litigation, policymakers should recognize that some approaches might have undesirable secondary effects. For example, evidentiary protections appear to reduce the fears associated with discussing pending lawsuits for quality improvement purposes in hospitals.²⁵⁰ Perhaps

245 See, e.g., Harmon, *supra* note 171, at 1132–44 (describing the federal government's authority to collect data, and reasons why that authority is not being used to collect data about police behavior); Schwartz, *Myths and Mechanics*, *supra* note 10, at 1082 (suggesting that municipalities require police departments to gather and analyze suits as a condition of funding or indemnification).

246 See Schwartz, *supra* note 149, at 958 (suggesting that departments be required to take more financial responsibility for litigation costs).

247 See *supra* note 204 and accompanying text.

248 See Harmon, *supra* note 153, at 54–55 (recommending that the Department of Justice offer grants to police departments to improve infrastructure and personnel in ways that promote civil rights).

249 See Schwartz, *Myths and Mechanics*, *supra* note 10, at 1084 (describing the role of outside monitors and auditors in efforts to increase police departments' collection and analysis of information).

250 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1264–66 (describing the effects of evidentiary protections on hospitals' internal discussions of error).

similar evidentiary protections would encourage more discussion about lawsuits within police departments. Yet orders protecting discovery of internal information could limit the public disclosure of litigation information and thereby inhibit lawsuits' role as a source of information for the public.²⁵¹ Such orders could also impair the ability of plaintiffs to gather the information they need to prove their claims.²⁵² Moreover, there is no guarantee that giving police this type of evidentiary protection would actually lead to increased introspection without other shifts in incentives, views of lawsuits' informational value, and personnel. More study would be necessary to assess the costs and benefits of evidentiary protections for police before making a recommendation in this regard.

Other strategies to encourage introspection through litigation will not require such stark tradeoffs between different regulatory strategies. For example, hiring a risk manager will not compromise plaintiffs' ability to prevail on their claims or limit public access to lawsuit data. Moreover, some interventions would likely lead a police department to engage in multiple efforts to improve performance beyond simply reviewing lawsuits for lessons. A police risk manager might—in addition to reviewing lawsuit data—also institute a mediation program, work to improve internal affairs investigations, and assist with training and supervision issues.

Any intervention will, however, require some type of tradeoff. Hiring a risk manager will cost money that could be used for other types of performance-improvement efforts, such as hiring more internal affairs investigators or better training investigators already on the job, creating tip lines for people to more easily report misconduct, establishing a civilian complaint review board, or hiring a police auditor to oversee the department. Alternatively, the money spent to hire a risk manager could be used for other types of police accountability efforts—dashboard cameras or body-mounted cameras, for example. A comparison of the relative costs and benefits of different methods that could be used to increase constitutional policing and the effects of those interventions on crime control efforts is far beyond the scope of this Article. I leave it to policymakers to make these judgments, but encourage them to do so only after considering the particularities of the organization, existing information systems, available resources, and the benefits of introspection through litigation illustrated here.

CONCLUSION

Organizations can learn valuable information from lawsuits brought against them. Complaints describe claims of wrongdoing, discovery unearths

251 See generally Miller & Wright, *supra* note 150, at 780 (criticizing sealed settlement agreements in police misconduct suits and advocating for more transparency); Rapoport & Teich, *supra* note 54, at 233–34 (criticizing protective orders in aviation litigation because litigation discovery generates useful, previously unknown information).

252 See Schwartz, *A Dose of Reality*, *supra* note 10, at 1298 (raising the same concern in the medical malpractice context).

details about those claims, and, throughout the litigation process, the parties marshal available evidence in ways that can reveal previously unseen patterns in the data and frame defendants' behavior in relation to applicable legal standards. Despite the value of litigation information, some organizations do not integrate the data into their performance improvement efforts. I have offered several tentative explanations for why that might be the case. Organizations need the incentives to improve behavior, an understanding of the value of lawsuit data to their performance improvement efforts, and the personnel and infrastructure to collect and analyze the data.

Although this Article focuses primarily on the behavior of law enforcement agencies and hospitals, introspection through litigation is relevant in contexts far removed from policing and medical care. Contemporary society is populated by bureaucracies—schools, food producers, and retailers—that function through the discretionary acts of their lowest-level employees. The larger and more complex the organization, the more levels of delegation and discretion separate front-line employees from boardroom executives. In such settings, information about possible wrongdoing must reach higher-level decisionmakers. Even with robust internal information systems, important information about errors may be overlooked, disregarded, or hidden. In these complex organizations, lawsuits are one means of bringing this diffuse information to the surface. Putting litigation information into the hands of organizational leaders is one promising, but long overlooked, means of improving organizational performance.