

# The Role of Culture in Legal Risk Management

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The objective of Proactive Law is the management of legal risk through identifying, anticipating and planning for it in advance. Its economic premise is straightforward: legal disputes and legal liabilities generally cost less to avoid at the outset of a relationship or a transaction than they cost to cure once they have arisen. Even a successful lawsuit imposes financial costs and, worse, the losses that follow from the inevitable disruptions to normal business. Transactions that could have been beneficial can become sources of extended uncertainty as well as expense when legal claims are made either by the parties directly involved, or by others who feel that the transaction injures some interest of theirs. While it is not economical to worry through every remote contingency and every minor legal question that could possibly arise in the course of a business venture, it is decidedly uneconomical to ignore risk management entirely. In that sense, practicing Proactive Law is an indispensable part of transactional law practice. Even lawyers who have never heard the phrase “Proactive Law” employ its principles on a daily basis.

There are nonetheless advantages to identifying this part of law practice as a distinct field with its own name. It causes us to appreciate unifying principles in the practice, which can then be learned and applied in ways that make systematic – and more reliable – what might otherwise be applied only by “instinct” or experience. A good deal has been written about the principles and methods of Proactive Law;<sup>1</sup> and the essays in this volume will add even more to our understanding of the concrete lawyering techniques involved. I do not wish to repeat any of that ground here. The point of this essay is to be a reminder about a foundational premise of Proactive Law which too often becomes lost in the more technical analyses. That premise, given to us a generation ago by Louis Brown,

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<sup>1</sup> The same set of lawyering operations is known as “Preventive Law” in the United States. The U.S. literature can be accessed under that name. One useful source is the Preventive Law Reporter, which was published continuously from 1982 through 2004. The Reporter periodically included bibliographies. The National Center for Preventive Law website is another good source: [www.preventivelawyer.org](http://www.preventivelawyer.org), maintained by the NCPL at California Western School of Law in San Diego, California.

the “Father of Preventive Law” in the United States, is as straightforward as it is fundamental. It goes like this:

“In curative law, it is essential for the lawyer to predict what a *court* will do. In Preventive Law, it is essential to predict what *people* will do.”<sup>2</sup>

From his extensive experience in the practice Louis Brown became acutely aware of two important facts. The first was that legal claims and disputes most often do not arise because someone violates an agreement or a rule. They come about, rather, because someone feels a sense of injury and is moved by circumstances to see it redressed. The second fact, as many others are now coming to believe, is that legal-risk-creating behavior is most often just the everyday behavior of people doing anything and everything that people ordinarily do. People create legal risks, in addition to the fact that it is people, acting like people, who instigate legal disputes and claims.

The first of these Brownian lessons – that it is people who bring legal claims – has come hard to some. One of the areas in which I work is medical liability – the legal aftermath of adverse medical outcomes. Many lawyers on the defense side of those matters believe that the way to control excess liability is through law reform, by making it substantively more difficult for claims to be brought and limiting the remedies available when they are, and through rigorous defense – playing “hardball” some call it, to deflect less meritorious claims by showing how difficult and expensive they will be to bring.

Without disputing the effectiveness of some of these strategies, others who have studied the problem now advocate a wholly different view. In their estimation, the critical moment for managing liability claims comes when the injured patient is developing the motivation to respond in some way to the realization that they may have been injured by another’s fault. Relying on rigorous empirical studies – as well as ordinary common sense – some have suggested that the best way to manage claims is not to adopt a posture of unremitting staunch defense but, instead, to disclose the injury voluntarily, to recognize the hurt the patient has suffered, and to work with the patient to restore them as nearly as may be to the condition they reasonably hoped to achieve. Pilot programs implemented by insurance companies and hospitals in the United States and elsewhere have proven the wisdom of this latter view.<sup>3</sup>

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<sup>2</sup> Louis Brown’s writings in Preventive Law were prodigious. In 1978 he gathered up much of what he had theretofore developed into a law school teaching text, which I had the privilege of co-authoring with him. This point and others like it can be found in that text: L. Brown and E. Dauer, *Planning by Lawyers: Materials on a Nonadversarial Legal Process* (Foundation Press 1978).

<sup>3</sup> The leading liability insurer in this regard is the COPIC Insurance Company in Denver, Colorado. In 2002 COPIC inaugurated its “3Rs” program, with the three Rs being Recognize, Respond, and Resolve. Rather than wait for a patient concern to become a legal claim, COPIC restores communication between doctor and patient with disclosure, rapid restoration, and expressions of concern. The program is described on COPIC’s website, “[callcopic.com/publications/3rs/3rs\\_newsletter.htm](http://callcopic.com/publications/3rs/3rs_newsletter.htm)”. A pioneering effort among hospitals is the Veterans Administration hospital in Lexington, Kentucky, which found its program of full disclosure and ready compensation to have very favorable outcomes compared to the

Though not everyone has yet signed on, the turning point has been passed, and the defense of medical liability in the United States is irrevocably being altered.

The core of this development lies in understanding what causes people to bring claims (it is the need for money in only a minority of instances), and what leads people to deal with problems in other ways. The key variables are far more the qualities of the underlying relationships than the state of the surrounding law.<sup>4</sup> Programs that build on an appreciation of those aspects of human behavior are successful. Those that ignore it will continue to waste money in rigorous and expensive defense. That is to say, that in proactive legal risk management it is essential to predict what *people* will do. And, of course, to appreciate what makes them do it. That understanding leads to the development, in advance, of programs and patterns of response that nip potential legal claims in the bud, allowing them to be managed in other, less costly and more satisfying ways.

The second half of Brown's lesson is, again, that legal risks are most often created by people behaving in perfectly ordinary and predictable ways. There are of course some miscreants who flout the rules of proper action knowingly and with malice aforethought, so to speak; but they are very likely the cause of a minority of legal disputes and claims. The larger part come from much more benign – though equally risky – mindsets and behaviors. Brown's lesson to us then is, that if we can predict what people are actually likely to do in whatever particular setting or situation we are concerned with, we may be able to limit the incidence of legal risk to a degree that might at best be more difficult to achieve otherwise.

That one point is the crux of this essay. We can often reduce legal risk by predicting and then shaping or accounting for the ordinary, well-meaning, everyday behaviors of the people who touch or are touched by the events.

To be even more specific, I want to address the role of *culture* in the application of Proactive Law. By culture I mean the unspoken vocabulary of behavior in a given place or time, and the aspects of a local environment that create expectations about what should and what should not be done. My argument, in short, will be that while attention to rules is necessary, it isn't enough. Effective legal risk management also requires attention to *culture*.

Lawyers, not surprisingly, are comfortable dealing with rules, whether the public rules of positive law or the very private rules created by a contract. Rules are the criteria by which legal disputes (though not necessarily *business* disputes) are often resolved. Rules are equally useful in Proactive planning. One of the truisms of legal risk management, for example, is that people are moved to bring claims when they experience a feeling of injury. Often, having a sense of injury arises from having suffered a disappointed expectation. Some of the expectations in a contractual transaction are in turn created by the "rules" that describe who gets to do, or has to do, what. Precision, clarity, and comprehensiveness in those kinds of rules promotes shared expectations, as well as creating norms for resolution if need be; and in that way they help create

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former defend-to-the-end. See L. Kraman and G. Hamm, *Risk Management: Extreme Honesty May be the Best Policy*, 131 *Ann. Int. Med.* 963 (1999).

<sup>4</sup> See, e.g., G. Hickson, *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 *JAMA* 1359 (1992).

expectations in the contracting parties which, due to their clarity and accuracy, reduce the possibility that one party's acts will be seen by the other as an injurious disappointment of a legitimate expectation. Thus much of Proactive Law involves predicting the possibilities of legal risk and then either restructuring the transaction to avoid it, or articulating more clearly the shared norms – the rules – by which any such future events will be assessed.

That much alone is a substantial contribution that Proactive lawyers can make to the affairs of their business and individual clients. I want to suggest, however, that the crafting of rules (contract terms, for example) is a necessary part of Proactive lawyering, but that it is not a sufficient part. There are two others. One of them is crafting the facts. The other, is attending to the transaction's culture. A couple of concrete examples will illustrate all three.

The first example is taken from an experience of my own from very early in life. As a youngster I had an after-school part-time job in a factory that manufactured costume jewelry – earrings, cufflinks, bracelets and other such trinkets and baubles. The various pieces of a cufflink, for example, are known in that industry as “findings.” Findings are most often made by stamping each one out of sheets or coils of a metal such as brass. The stamping is done by presses, powered by compressed air or by electrical motors, that deliver a hefty punch to the brass sheet, knocking out a finding of the proper size and shape. The presses generate hundreds if not thousands of pounds per square inch, and the dies come down on the brass sheet with great speed. Any finger in the way is a lost cause.

Any lost finger, of course, is a potential legal risk whether under the workers' compensation laws or as a claim, valid or otherwise, against the manufacturer of the press. The factory I worked in had *rules* about this. People operating the presses could not wear loose clothing nor have long untied hair that might be caught in the machinery; they were disallowed – on penalty of being fired – from using any press that did not have a working guard screen in place; they were instructed repeatedly NOT to insert the brass sheet with one hand while operating the press with the other, lest the right hand not know what the left was doing and, in the lack of coordination, cut it off. Those were the rules.

Not content with articulating rules – for who would be so sanguine in this kind of setting – the factory and maker of the presses tried to reduce the legal risk by changing the *facts*. The presses were designed with two large buttons, one on each side of the machine. The buttons were wired such that both of them had to be held down at the same time or the press would not stamp its die into the piece of brass. The point of that system was to force the operator to insert the brass sheet first, and then hold both buttons with both hands – thereby keeping both of them nicely out of the way – as a condition of having the tool come down and stamp out the finding. The finding would then be removed, a new piece of brass put in, both hands moved to the buttons, and so on. The two-button design was the fact.

Changing the facts is a very good way to bolster the desired effect. In general aviation, for example, there are two kinds of fuel for two different kinds of aircraft engines. Turbine engines can burn almost anything. But reciprocating engines cannot run on turbine fuel. Not every line-boy knows what kind of engine every airplane has, and so mistakes are legally costly as well as deadly

when Jet A fuel is pumped into a reciprocating-engine airplane. There are lots of rules – doublecheck the type, ask the operator, require the aircraft operator to observe the refueling, require the pilot to drain the fuel sumps after every top-up to be sure the fuel color is right, and so on. But the accident rate – and with it the liability risk – did not decline until the system was made physically impossible to defeat without deliberate effort. Turbine fuel nozzles were made wider than avgas nozzles, and the aircraft manufacturers' association distributed kits that made the filler ports of reciprocating engine aircraft too small for the turbine nozzles to fit into. Misfueling an aircraft from a fuel truck when both were outfitted with these changed facts became physically much harder to do (except for truly determined idiots and assassins.) Problem solved, and not by rules.<sup>5</sup>

The same sort of thing happened in healthcare. The connectors for anesthesia gases and for oxygen are now made in such a way that the oxygen line cannot physically be connected to the outlets for other gases. Rules about the use of concentrated KCL (a very dangerous chemical in concentrated form but a very common infusion when properly mixed) could not have been clearer, nor less effective, until the facts were changed – concentrated KCL was physically banned from nurses' stations. Computerized order entry systems block orders for drugs that have the dosage off by enough to be harmful, thereby avoiding the error of the misplaced or misread decimal point. Likewise, for the two-buttons-at-once scheme at the jewelry shop. Changing the *facts* can be even more important than changing the *rules*.

In the jewelry factory, however, even that was not enough. There continued to be close calls and accidents. Setting the rules and changing the facts were necessary, but they weren't sufficient. The enemy was the shop's *culture*.

Although the owners of the plant cared about safety, the environment they created was all about productivity. Jewelry manufacturing margins are slim, and labor is a major cost. A worker who produced more findings per hour was valued more than one who produced fewer. Bonuses and other perquisites conveyed that message. It did not take long for the workers to learn how to flout the rules and bypass the facts. With duct tape they permanently fastened one of the two buttons down, so they could use one hand to feed the brass sheets into the press while they operated the stamping with the other. They thought it would be faster. It was; but it was also riskier, and the risk of liability predictably followed.

This same kind of trumping, of rules and facts by culture, can be seen almost everywhere. A workplace can have exquisitely crafted rules about worker-to-worker harassment, but a culture of rough-and-tumble boys-will-be-boys results in female workers being harassed. The accounting office can have all the guidelines one could ask for, yet a culture that disrespects financial integrity will foster a lack of financial integrity. A firm that values sales and market share

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<sup>5</sup> This overstates the separateness between facts and rules just a bit, since the change of facts in these examples came about as the result of a change of rules, in some cases by public law and in some cases by the rules created in insurance contracts. I discuss this point further below, where I suggest that the focus of risk management rule-making include not just the direct shaping of behavior, but as well the creation of new facts and the support of more functional cultures.

above all else will see its salespeople violate the antitrust laws more than a firm that has a different kind of culture. Culture means nothing more than the norms and expectations about behavior that color and in turn take shape from the environment. It is culture that make some things seem OK even when they really aren't. So far as I know this has never been precisely measured, but I think it's a fair bet that when law and culture clash, culture always wins.<sup>6</sup>

Healthcare is again a case in point. We learned just a decade ago, in the United States, that the incidence of injurious medical error is unacceptably high – so high, as a proportion of all hospitalizations, that the same error rate would simply not be tolerated in any other industry, much less in one whose mistakes create enormous personal risks. At the same time the costs of the ensuing legal liability have become a dominating theme in discussions of medical policy, and the curtailment of those costs has been a point of attention even by the American presidency.

Much work in the last decade has been devoted to improving “patient safety” – the reduction of avoidable iatrogenic injuries – and a good deal has been learned about how to do that.<sup>7</sup> Two of the central features of healthcare that affect patient safety are, in the short term, communication among care providers; and in the longer term, the reporting of data about today's errors and near misses as a way of learning how to avoid the same risks tomorrow.

The latter of those two may be obvious. Given the new understanding, that errors in healthcare come more frequently and profoundly from failures of systems than from failures by individual humans, “root cause analysis” of the origins of error is key to changing the systems that allow them to occur. The patient died from the wrong dose of a drug. How was the wrong dosage infused? The prescription order was filled by a pharmacist who misread the handwriting on the scrip. How could the reading error have happened? The scrip was handwritten. Why was the scrip handwritten? Because this hospital does not have a CPOE (computerized pharmaceutical order entry) system. Why not? Why did the nurse infusing the drug not spot the error? Because the dosage was not

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<sup>6</sup> I must share an anecdote about this. The occasion for this essay was a talk I gave at an international meeting of the Nordic School of Preventive Law in Stockholm during the summer of 2005. Before leaving Denver for Stockholm I gave a summary of my talk to one of my colleagues at the University of Denver, a native Swede who had lived and practiced law for some years in Stockholm. He told me that this assertion – that when rules and culture clash, culture always wins – would not be well accepted by a Swedish audience. “Swedes,” he said, “stand in line even when there is no line.” Not true. Part of the city of Stockholm is an island called Skeppsholmen, a delightful place with museums and gardens and pedestrian walkways – and green grass lawns. On a sunny summer afternoon I personally saw, on Skeppsholmen, two kinds of walking paths – the official ones, in well-maintained concrete, laid out in architecturally subtle ways along the lawns and quays; and the real paths, described by dead grass and well-trod earth, made by real people who had good reason to walk where they thought it would be good to walk., and where – as I observed from the location of the people themselves – there was no disincentive in the environment against doing so. Culture always wins, even in Sweden.

<sup>7</sup> A seminal work is D.M. Berwick et al., *Curing Health Care: New Strategies for Quality Improvement* (Jossey-Bass 1990). See also L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994).

marked on the vial for comparison. Why ...? And so the system failures are identified, and the system repaired where it can and needs to be.

Such root cause analysis requires lots of data, about near misses as well as actual accidents. As some put it, “every error is a treasure.” Certainly large collections of information about errors allows for better systems analysis. Improvements in safety – and reductions in liability – cannot make much headway without the reporting of data.

Such data, however, aren’t reported nearly well enough. The problem lies very largely in the culture of healthcare. Physicians are taught that individuals are responsible for mistakes; that perfection is expected and mistakes are failures; and, almost paradoxically, that their actions are not to be questioned by others. They bring that mindset into the hospital, and so the culture becomes one that inhibits confessing errors, and that resists seeing errors as both inevitable and as occasions for learning. Other aspects of the culture counter the idea of reporting *other* providers’ errors – the “conspiracy of silence,” in its most pernicious form. The culture also includes a deep distaste and a not entirely irrational fear of the legal liability that may follow voluntary disclosure of mistakes or avoidable outcomes. Against that outcome, no rule mandating disclosure will cause full disclosure to happen. The culture simply won’t let it.

Lucian Leape, a leader in the patient safety movement in the United States, recently took the measure of progress in this area over the past few years. He concluded that while there had been some areas of very significant gains, the overall record was disappointing. Chief among the reasons, Leape believes, is these and similar aspects of “the culture of medicine.” Increasing regulation – rules, in the argot of this essay – and even rules that threaten institutional decertification, “produce evanescent compliant behaviors, but [seem] insufficient to do the job of transforming cultures, where the deeper solutions lie.”<sup>8</sup>

The Veterans’ Administration is the largest single hospital system in the United States. Recently it adopted a patient-safety-focused policy requiring disclosure of unexpected adverse outcomes, mishaps and errors. More recently the GAO (Government Accounting Office) did an ethnographic study of a sample of VA hospitals to see how well the new policy was working, and what the factors were that aided or inhibited its implementation. The GAO report was titled, interestingly enough, “VA Patient Safety Program: A Cultural Perspective ...” The major conclusion was stark: where the new policy was being implemented well, it was aided by a “supportive culture.” Where it was not working, there was still in place the old medical culture of “blame and shame,” of the fear and distaste of reporting, and of the inability to see error as anything other than blameworthy failure.

A second factor of importance to advances in healthcare risk reduction is communication among providers. Particularly in tertiary care settings, attention to the patient is fractionated among specialists and various levels of providers. The quality of care is sensitively dependent on how well those numerous participants communicate with each other. Nurses, for example, who see a

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<sup>8</sup> L. Leape, *Five Years After ‘To Err is Human’ What Have We Learned?*, 293 JAMA 2384 (May 2005).

problem happening or about to happen need to speak, in real time. Too often the culture keeps them from doing so.

By contrast, one of the most dangerous working environments there is anywhere is the deck of an aircraft carrier. The tolerances are almost unbelievably tight and the systems have to work just right every time, lest aircraft or arresting cables or parts of either go whipping across the flight deck killing anyone in their path. During landing operations on a carrier anyone – down to the lowest ranked hand – can wave off a landing if they think there is something going wrong. Most important, there is neither penalty nor obloquy for doing so. Those are the rules; but the reality is also the culture.

That is not, unfortunately, always the case in healthcare. In 2004 the Institute for Safe Medical Practices published the results of its 2003 study on communication among nurses and physicians in hospitals in the United States. Communication of just this sort, the ISMP concluded, was essential to improvements in the quality of patient care. Communication, however, was often inhibited by a culture of status and hierarchy and the expectations driven by that culture about who should say what to whom. At the worst institutions the culture tolerates inter-professional intimidation. Risk to the patient is the obvious result.

Just like the economic culture of the jewelry shop, the culture of medicine stands as a major barrier to reductions in risk, and with it reductions in legal liability. When rules and culture clash, culture always wins.

To examine how these insights may be applied proactively and to diverse problems in legal risk management, we turn from health care to IT, or information technology. Proactive law in IT trade and commerce was the topic of a Symposium held in Stockholm in the summer of 2005, under the auspices of the Nordic School of Proactive Law. The settings and the legal risks addressed by the Symposium were of several kinds – legal risks facing firms in the IT business itself; legal risks facing any firm that uses IT in conducting their business affairs; and legal risks facing IT as the vehicle for commerce most broadly. Concretely, examples of the problems facing many of the users of IT include the risks of information *corruption*, the need for safe information *validation*, and a plethora of problems grouped under information *misuse*. One of the most common of the last of these is the misuse of internal e-mail systems by employees.

The problem is truly epidemic, and the legal risks to businesses are severe. Newspapers in recent years, for example, have been full of stories about high-profile prosecutions being aided if not instigated by careless internal e-mails. Even innocuous messages, taken out of context, can be damaging to the company's position in litigation; while other messages reminding everyone of the document retention policies – actually, document deletion policies -- look even worse. Consider what the internal e-mail messages would look like in a major firm that has just learned of a government investigation, if those messages were unchecked, or even in a self-imposed internal audit or review.<sup>9</sup>

These most sensational examples, however, may not be the most frequent. Ordinary chatting on the system probably is. Employee-to-employee e-mail messages are sent by workers every day by the hundreds of millions. They are

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<sup>9</sup> See, e.g., *Stanton v. Boeing*, 3131 F.3d 447 (9<sup>th</sup> Cir. 2002).



ubiquitous, but hardly harmless. Depending on their content they can be the source of defamation claims; they can inadvertently (or intentionally) disclose trade secrets or violate confidentiality requirements in contracts or regulations; circulated privately they can be a source of securities law violations; and, as some firms have learned very much to their chagrin and cost, e-mail messages and internal communications carrying offensive material downloaded from the Internet can be the predicates for a “hostile workplace environment” action or similar employment discrimination allegations brought by employees who find the messages offensive or threatening.<sup>10</sup>

One way to deal proactively with this problem is through the promulgation of rules: articulated policies made a part of every employment contract, explicitly providing for discharge if the policy is violated. In support of new rules, the proactive effort can also include changes in the facts – e.g. software installed by management to monitor or in some cases block communications or computer uses that are inconsistent with the rules. Those techniques are, of course, necessary if the legal risks are to be managed. History, and wide experience from other settings, however, suggest that rules and facts are not sufficient. When the culture clashes with the rules, the culture will eventually win – even when severed fingers or patients’ well-being are at stake.

A comprehensive scheme of proactive legal risk management will therefore include initiatives from all three domains: rules, changed facts, and attention to the operative culture. How, then, is the last of these three done?

The lawyer, even a lawyer fully committed to the notion of proactive risk management, will most often find the legal literature unhelpful. Our usual sources abound with analyses of cases in which some risk has made itself known, with articles assessing how well or poorly the existing legal regime deals with the consequences of these misadventures; practicing lawyers and academicians alike propose new laws which, in their view, ought to be; and there is no lack of guidance about promulgating rules – about drafting corporate policies, about their inclusion within existing employment contracts and procedures, and about the techniques (and risks) of their enforcement. At the same time the management literature and some of the legal literature will carry the latest in factual suggestions – monitoring and blocking software and the like, and of course a special attention to the legal risks of the new facts themselves (invasions of privacy and inhibitions of speech, for example.) Very little if any of the usual literature addresses the management of culture in concrete settings such as this. We are not, however, wholly without experience to draw upon.

Necessity, it is said, is the mother of invention. In the United States business firms and their proactive legal counsel have recently been treated to two rounds of necessity. One of them was the promulgation in 1991 of the US “Federal

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<sup>10</sup> See, e.g., *Vicarelli v. Business International, Inc.*, 1997 US Dist Lexis 12944 (D Mass 1997); *Wheaton v. North Oakland Medical Center*, 2005 US APP Lexis 8159 (6<sup>th</sup> Cir. 2005) (racially offensive e-mail message); *Dick v. Phone Directories Co.*, 397 F.3d 1256 (10<sup>th</sup> Cir. 2005) (threatening internal e-mail message directed at one employee by another, supporting hostile work environment claim); *Curtis v. Citibank N.A.*, 97 Civ. 1065 (S.D.N.Y. 1997), (black employees alleging that white managers exchanged “vulgar and racially vile” E-Mail messages.); *Owens v. Morgan Stanley & Co.*, 96 Civ. 9747 (S.D.N.Y. 1996), (jokes in e-mails evidence in action alleging racially-motivated discrimination in promotion).

Sentencing Guidelines for Organizations.” The other was the enactment, in the wake of the Enron and similar accounting scandals, of the Sarbanes-Oxley Act of 2002. Both statutes caused a flurry of activity as managers and lawyers began to realize that attention to corporate culture was no longer entirely optional. The histories and provisions of these two sets of laws are well-known.<sup>11</sup> I rehearse them only briefly here, by way of offering the linkage between developments intended to meet them and the principal question before us, *viz.* the management of legally risky culture.

The Sentencing Guidelines apply to a wide variety of federal crimes in which US corporations might engage, both felonies and misdemeanors. They set the standards and parameters for sentencing, and in that they have some real teeth: following conviction, a court may set a term of organizational “probation” for the corporation, where that may be necessary to enforce a remedial order or otherwise to effect an order of restitution or an order to prevent repeated violations. The probation order and the court’s authority to supervise it are scarifying propositions for any company. Management can lose its ability to manage as it likes, while the court looks over its shoulder. One of the factors that goes to the imposition of probation is whether, “at the time of sentencing an organization having 50 or more employees does not have an effective program to prevent and detect violations of law.” That same phrase appears in another section of the Guidelines, dealing with mitigation of financial penalties. In assessing the corporation’s “culpability score,” courts are instructed that, “If the offense occurred despite an effective program to prevent and detect violations of law, subtract 3 points.” Three points can mean a halving of the otherwise applicable fine. The Guidelines then define what an “effective program to prevent and detect violations of law” requires: it must have been a system “*reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct,*” including the promulgation of “*compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal conduct;*” the taking of “*steps to communicate effectively its standards and procedures to all employees and other agents;*” and “*utilizing monitoring and auditing systems reasonably designed to detect criminal conduct by its employees and other agents and . . . having in place and publicizing a reporting system whereby employees and other agents could report criminal conduct by others within the organization without fear of retribution;*” and, finally, a system of enforcement through “*appropriate disciplinary mechanisms*” including “*discipline of individuals responsible for the failure to detect an offense.*”

The gravamen of the requirement is a prevention system that would be far more than the mere promulgation of rules and enforcement. It had to be a system that actually *worked*. Its minimal requisites – articulation, communication, leadership, monitoring, feedback and reporting – were in themselves among the fundamental steps necessary to change the workplace culture. But even beyond

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<sup>11</sup> An excellent source for the Sentencing Guidelines is the US Sentencing Commission’s own Guidelines Manual of 1997 (hereafter Guidelines Manual). For the Codes of Ethics sections of Sarbanes-Oxley, see 17 CFR parts 228, 229 and 249, esp. Section 406.

that, the program had to be reasonably designed and implemented so as actually *to be effective* in changing employee behavior. This called for more than just an internal code of rules.

If the point was not made well enough by the Sentencing Guidelines, it came even more pointedly to management's attention with the passage of Sarbanes-Oxley. That Act focused legal attention on the responsibilities of individual executives and directors, and among other things required the promulgation of Codes of Ethics to be published and publicly reported by listed corporations.

One of the responses to the interest generated by both of these sets of events was a growth in attention to "business ethics." While exploring much of that fairly well-developed field would be a digression here, what is interesting is the menu of strategies its proponents offer as a way of achieving its culture-shifting goals. The core is the corporate expression of values as well as rules; the education of employees into the meaning and importance of those values; the explicit observance of the same values on the part of every level of the firm including the very top; and a system of enforcement that reinforces the firm's sincerity in values as its operating culture.<sup>12</sup>

In response to the Sentencing Guidelines and to Sarbanes-Oxley, the National Center for Preventive Law and the National Association of Corporate Directors, respectively, published manuals for corporations and their lawyers and managers, addressing the practical question of how to do it.<sup>13</sup> The components of an effort to manage cultural change, as derived from those bodies of work, seem to be nine in number. I list them briefly here, along with some comments about each derived from the NCPL and NACD guides on the subject:

1. *Promulgate codes of proper behavior.* There are codes of rules, and there are codes of principles. Some blend of both may be right. There are some clear Dos and Don'ts, and they should be spelled out clearly. Believe it or not, not everyone has the same notion of what constitutes invasions of privacy, for example, or what a trade secret is. At the same time, building a culture rather than a police state means recruiting people to the objectives of the code, through clear explanation of its reasons, its aspirations, its importance. To the extent the policies are directive, they should be both proportionate to the business and the problem, not inconsistent with the other needs of the workplace, and consistent with the best of the rest of the culture. One way to assure this, as some companies have found with their internal compliance programs, is to have at least some part of the code, whatever it may be, drafted by each functional business unit itself.
2. *Include employees in the development of those codes.* The phrase "buy-in" may seem trite, but it is essential. If culture is the unspoken vocabulary that guides expectations about behavior, it should be inclusive rather than being

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<sup>12</sup> See, e.g., John Copeland, *Business Ethics: Three Critical Truths*. (May be downloaded at "www.soderquist.org".)

<sup>13</sup> National Center for Preventive Law, *Corporate Compliance Principles* (NCPL 1996); National Association of Corporate Directors, *Corporate Director's Ethics and Compliance Handbook* (2003). (The present author confesses to having had a hand in each of them.)

imposed from without. One company I know of tasked its own employees to make a video that was shown to other employees.

3. *Communicate (train and educate) the principles effectively.* I have been employed at the University where I now work for twenty years. Before that I was with another university for eleven years. At both places there were employee manuals that governed the teaching as well as the administrative staff. In thirty-one years as a law professor I have never seen one. I know they exist, however, because I was Dean once and came to know of it. But I daresay no-one else ever has, at least not until they are charged with having violated something in it and seen the dust blown off the cover. Those things, in my view, however important they are after the fact, are essentially useless as preventive devices – unless they are made live. Flyers on hiring, during orientation, at annual review; segments during those already-ghastly department retreats; “pop-ups” on computer screens. Or even better, one hospital reported success with what it called “storytelling.” To overcome the reluctance of providers to report errors and near misses, senior physicians who had themselves spotted and reported and dealt with them found opportunities to relate the events, lending both credibility and salience to the process.
4. *Illustrate the principles with consistent leadership from the top.* This needs no more comment than to ask whether an auditor at Enron, seeing the highly questionable structures created by the executives, could be expected to believe that the corporation’s ethos was integrity in accounting. And assuming the allegations are true of Dennis Kozlowski’s lavish use of Tyco’s funds for his own pleasure, it is not hard to imagine anyone else at Tyco feeling that self-dealing at the company’s expense is probably not so bad.
5. *Establish visible accountability.* In the compliance setting, one of the more important structural aspects of a system that “prevents and detects” violations, is where accountability for compliance lies. To say that it lies with everyone doesn’t work – that which is everybody’s business often turns out to be nobody’s business. On the other hand, centralizing responsibility for compliance (not for system design) in one office or person risks making it an outside job for everyone else. Some companies have successfully addressed the balance by making compliance the responsibility of middle-level managers, who on their own review must report to those above how they have implemented that concern, and who may in turn decide how best to make sure their responsibility is achieved among those who report to them.
6. *Enforce the codes fully and fairly.* Enforcement underscores for everyone who sees it the message that this really is important, and it really is the shared value here. To parody Marshall McLuhan, the message is the message. Fair enforcement is at least as important. Lawyers need no lecture on the requisites of fair process, and the idea that it matters in a practical sense is intuitive. In what is destined to become a minor classic in the literature of organization psychology, Bies and Tyler examined the variables that bring employees to

sue their employers over, for example, promotions and discharges.<sup>14</sup> While disputes over discharge look different from the misuse of e-mail, the substrate may be the same. Employees who intentionally subvert organizational policy are acting from a lack of solidarity that is at least analogous to the willingness to sue one's own boss. The conclusion of their studies was this: "In particular, we found that employee consideration of litigation is influenced heavily by their perceptions of the procedural justice of [the] managerial decision."

So there; we now have robust data to support what everyone already knew.

7. *Allow for enforcement and reporting by other employees.* Recurring again to corporate compliance policies, perhaps because of the express requirements of the Sentencing Guidelines – or as a way to bridge the distance between directors and employees – many companies have installed systems by which employees who spot violations by other employees (or even their own bosses) can bring those facts to someone's attention. To a great degree this is meant to be instrumental – it aids enforcement by deputizing everyone to be an enforcer. The key characteristics are confidentiality, the guarantee of no reprisals, and – of equal importance – feedback to the reporter. Confidential hot-lines are used in some places; others have internal ombudsmen; still others simply allow the crossing of reporting lines or direct access, for serious matters, to management levels above those to which the employee normally reports. I would suggest that the existence and operation of these systems has, however, another, less mechanistic, effect. Like the endorsement of a policy from the very top, these reporting system signal clearly that the subjects to be brought to them are important, and that the organization really does both and expect its employees to care. Contributions to the culture, that is.

8. *Measure the results.* And celebrate successes. Why? See the next point.

9. *Reward successes.* I was amused at first when I read of the program at one hospital, which has been more successful than most at implementing its error-reduction systems. With some pride of accomplishment the reporter told of nurses receiving certificates good for \$4 in the cafeteria when they spotted an incipient risk and did something to bring it to others' attention. In one case, the department with the best record as measured by the program goals was treated to an afternoon break with – trust me, this is true – a plate of cookies. It is difficult to imagine such trivial rewards changing deep-seated behaviors, if we think of rewards in the Pavlovian sense of reward and punishment. Certainly no-one would ever calculate that "I will get a cookie if I confront Doctor Welby." But that's not the mechanism that's going on. Culture is, again, expectations about what is right and what is wrong, and expectations that others will see things in the same way. Culture shapes behavior not by conditioning it, but by reducing the sense of cost altogether. A plate of cookies merely says that this behavior is the *right* behavior, and that doing this was important, and that by this token the institution is saying that to

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<sup>14</sup> R. Bies & T. Tyler, *The Litigation Mentality in Organizations: A Test of Alternative Psychological Explanations*, 4 *Org. Sci.* 352-366 (Aug. 1993).

everyone all at once. But I take back the word “merely.” This is not a mere anything. It is a powerful thing, and a thing that helps make rules make sense.

I admit that some of that may be heavy-handed for the problem of misused e-mail. It was derived, after all, from the more truculent problem of corporate crime. It may nonetheless be suggestive, for each of these points is meant more to install changes to corporate culture than to be mechanistically self-effecting. There is no one-size-fits-all in the culture business; but this might be a pattern to begin with.

Stepping back now from these few details of implementation, the central message is this again: effective legal risk management requires a trio of strategies – the creation of rules, the application of facts that limit violations of the rules, and the inculcation of a culture that makes compliance with the rules both easy and likely. The final question is, how much of this trio ought to be the work of *lawyers*. My own answer is straightforward: All of it.

I do not mean to say that lawyers should be involved in, for example, designing the educational efforts under point three above, nor in operating the feedback and hot-lines in point seven. While some lawyers to my knowledge have done all of those things, and more, we must recognize that there are other experts, in human resources, for example, who know vastly more about employee communications and enforcement / incentive programs than we do. I for one can't recall having taken any law school course in any of those subjects. I nonetheless believe the proper answer is “all of it” on three other grounds.

The least important of the three grounds is that our judgment about our involvement in these “business affairs,” as opposed to strictly legal affairs, is skewed away from what our own clients often prefer. A few years ago I had the privilege of speaking at the annual management meeting of a large multi-national corporation. The participants were thirty or so executives of the company, and a somewhat lesser number of lawyers from the General Counsel's office. These were all people who interacted with one another continuously, so that one might expect they would have some idea about what each side – management and law – expected of the other. To test that possibility I presented them with a survey, done on the spot, that portrayed a dozen kinds of circumstances in which the degree of the nominally legal concern varied, from none to extensive. The lawyers were asked what they believed their clients expected them to do. The clients were asked what they preferred their lawyers do. Each of the questions focused on the degree of the lawyers' participation in decision-making and business planning. The results, which have since been more fully published elsewhere, surprised the lawyers in the audience. The lawyers' understanding of what their clients expected of them was not consistent with what the clients actually preferred; and in every case the bias was in a single direction – the clients wanted their lawyers more involved in matters that were not nominally legal, than the lawyers thought the clients would want. Our reluctance to go beyond traditional rule-focused lawyering seems, from this small experiment, to be self-imposed.

The more important of my three grounds, for urging lawyer involvement in all three facets of the risk management enterprise, is that none of it should be done in isolation from any other part of it. A beginning point for the drafting of

the code of behavior, for example, is the knowledge of what kinds of misbehaviors create legal risks. On that, we are the experts. Likewise, while we may not be the best architects of enforcement and reporting systems, we are certainly among the engineers. Incentives and discipline policies have long been settings in which lawyers work in teams with the experts in HR. Monitoring performance is often done with “Legal Audits,” which has been within our ken for nearly a generation.<sup>15</sup>

The third argument requires something of a refinement of what I have already said I have suggested that Louis Brown’s lesson about “predicting what people will do” calls for risk management strategies to include three areas of attention: rules, facts, and culture. I did not mean to suggest, however, that the three are otherwise independent, for they are not. For example, we can think of rules as admonitions directly addressing human behavior, in which case rules are one part of the trio of necessary ingredients. However, we can also think of rules as creating the conditions under which the other ingredients can come about. I might illustrate that with one counter-example, again from health care.

In the United States, every payment made on behalf of a medical practitioner to a patient who has made a written complaint about medical injury is reportable to the National Practitioner Data Bank. Likewise, for every significant corrective action taken against a practitioner by a hospital, by way of reductions or limitations of their professional privileges. Physicians loathe the Data Bank. Although the reports are not “public” they are available to every health plan or hospital to which that practitioner makes application for privileges in the future. Doctors fear that, to limit their own legal risk, institutions will discriminate against those whose name are in the Data Bank. These rules, well-meaning as they may have been, create a culture of punishment that many authorities believe drive useful information about system flaws underground, much to the disadvantage of future patient safety. Thus one way in which rules and facts and culture interact. If we wanted to change the culture of healthcare, to encourage reporting of errors and to facilitate the communication across professional statuses and lines, we can think of rules that would help create those cultures. Rules of confidentiality for exception reports, for example; rules of non-retaliation for “whistle-blowers”; rules that create opportunities for remediation and correction rather than reportable punishment; and many others of the same kind. In a like way, it was rules – both public rules and the rules of private contracts such as insurance – that changed the facts about avgas and Jet A fuel nozzles. If we needed another argument for the inclusion of lawyers in every phase of the risk management enterprise, this might be it – rules play an independent role (“Don’t use a machine without an effective guard or you’ll be fired), and they play a role supporting the roles of facts and culture as well. That is without doubt the stuff of which even the most traditional lawyering is made.

Having thus convinced the reader on these several points, I will sum up with a brief discussion of Swiss cheese.

This is actually a metaphor that comes originally from the world of aviation risk management and more recently from that of healthcare. It may be just an

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<sup>15</sup> A standard reference is L. Brown, R. Gruner & A. Kandel, *The Legal Audit: Corporate Internal Investigation*, (1994, updated annually through 2004).

elaboration of what we used to call in the old days a “belt and suspenders” approach, but it offers additional meaning as well. In aviation, most serious accidents do not come from a single failure or error. They come, usually, from an error whose consequences were permitted to be amplified either by additional faults or errors, or by the absence (or failure) of a secondary wall. With respect to medication errors, there are multiple such steps: the physician either prescribes the wrong dose (error number one) or writes it in a way that results in its being misread. There is no CPOE or other system that challenges the apparent mistake and bring the challenge to the physician’s attention (error number two). The pharmacy fills it without realizing that the dose departs from the usual by an order of magnitude (error number three). The dose is administered by a nurse who does not read the dose or does not know that it is a deviation from the norm (error number four), or who senses something wrong but who fails to interrupt or question the physician’s decisions (error number five). There may be more, but even in this stripped-down version of a fatal dosing error there were five mistakes, all of which had to happen for the consequence to take its toll. Looking at them positively, each was an opportunity to prevent harm from flowing from any of the others. If any one of them had stopped the flow, the patient would be alive today. An error, that is to say, needs to make its way through the Swiss cheese, and it won’t come out the other side unless all the holes line up. Block any hole, and the cheese cannot be penetrated.

The same may be suggested for almost any area of legal risk management, even the common problem of e-mail and internet misuse in the workplace. The five slices of cheese at the minimum might be these:

1. Teach people what to do, and what not to do, and state it with clarity.
2. Provide physical barriers to doing the wrong things.
3. Have detection systems that discover problems early.
4. Create incentives for people to want to do things right.
5. Create systems that encourage reporting and foster follow-up.

May I say it one last time? Only point one is rules. Points two and three are changes to the facts. Points four and five, are changes to the culture. In doing proactive legal risk management, don’t forget the culture.