RX FOR TEACHING COMMUNICATION SKILLS: WHY AND HOW CLINICIANS SHOULD RECORD, TRANSCRIBE AND STUDY ACTUAL CLIENT CONSULTATIONS

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The legal academy has much to learn by recording, transcribing and systematically studying student-client and attorney-client consultations. Social scientists and medical providers have studied doctor-patient conversations using conversation analysis and other social science techniques for years. Through this systematic study, researchers have reached conclusions about effective doctor-patient consultations that form the basis for teaching these skills in medical school. This article will highlight findings from these studies and the evidence-based medical school texts. This article will also review the few similar studies that have been made of attorney-client consultations, and suggest topics that merit study in the law clinic. Finally, it will lay out how a law clinic could obtain informed consent, protect client confidentiality and privilege, and gain the necessary approval of the Institutional Review Board to carry out such valuable studies.

"Our law schools must learn from our medical schools." Jerome Frank, *Why Not A Clinical-Lawyer School?* 81 U. Pa. L. Rev 907, 916 (1933).

INTRODUCTION

Lawyers and other professionals have historically been expected to ply their "learned art[s] in the spirit of public service"[1] which includes putting "devotion to serving . . . the client's interests" above the

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[1] Roscoe Pound, *The Lawyer from Antiquity to Modern Times* 5 (1953) *quoted in* A.B.A. Commission on Professionalism, ". . .*In the Spirit of Public Service:" A Blueprint for Rekindling of Lawyer Professionalism* 10 (1986).

lawyer's self-interests.[2] Traditionally this involved substantial professional control, with the professional making recommendations and the client or patient accepting those recommendations.[3] Current medical school and law school texts describe these prior attitudes:

> There used to be a time when medical professionals were at the centre of care. The professionals, mostly doctors, undertook the history taking and investigation from their own point of view, in order to make a diagnosis. They told the patient what to do, how and when.[4]

> One traditional image of lawyers portrays them as professionals who control the choices that clients make by convincing clients as to what is in their best interests. . . . The traditional image generally regards clients as unsuited to the task of legal problem-solving, and usually satisfied to leave decision-making to lawyers.[5]

However, in the latter half of the last century, this assumption of professional control began to give way. In medicine, mental health professionals asserted that the model of the passive patient was fundamentally inconsistent with mental health treatment.[6] The doctrine of informed consent was recognized, requiring surgeons to disclose the risks and alternatives for treatment to their patients, and to allow the patients to decide.[7] Psychiatrist and professor George L. Engel demonstrated "the importance of psychological and social factors in disease and illness and how these factors affect care processes and outcomes" and posited the biopsychosocial model of interacting with patients.[8] Shortly thereafter other medical academics, influenced by

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[2] Eliot Freidson, *quoted in* A.B.A. Commission on Professionalism, *supra* note 1, at 10.

[3] *See* TALCOTT PARSONS, THE SOCIAL SYSTEM, 432-38 (1951) (regarding the roles of doctors and patients); Talcott Parsons, *The Professions and Social Structure* in ESSAYS IN SOCIOLOGICAL THEORY, 34, 38 (Talcott Parsons rev. ed. 1954) (regarding the way all professional practitioners assert authority).

[4] Myriam Deveugele, Forward, *in* JONATHAN SLIVERMAN, SUZANNE KURTZ & JULIET DRAPER, SKILLS FOR COMMUNICATING WITH PATIENTS, vi (3rd ed., 2013) [hereinafter SKILLS FOR COMMUNICATING WITH PATIENTS].

[5] DAVID BINDER, PAUL BERGMAN, SUSAN PRICE, & PAUL TREMBLAY, LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH 4 (2nd ed., 2004) [hereinafter LAWYERS AS COUNSELORS].

[6] Thomas Szasz & Mark Hollender, A *Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship*, 97 ARCHIVES OF INTERNAL MED. 587, 591 (1956).

[7] *Salgo v. Leland Stanford, Jr. University Board of Trustees*, 317 P.2d 170 (1957).

[8] AUGUSTE H. FORTIN IV, FRANCESCA C. DWAMENA, RICHARD M. FRANKEL, ROBERT C. SMITH, SMITH'S PATIENT-CENTERED INTERVIEWING: AN EVIDENCE-BASED METHOD, xvii (3rd ed., 2012) [hereinafter SMITH'S PATIENT-CENTERED INTERVIEWING] (citing George L. Engel, *The Need for a New Medical Model: A Challenge for Biomedicine,* 196 SCIENCE 129-36 (1977) and George L. Engel, *The Clinical Application of the Biopsychosocial Model*, 137 AM. J. PSYCHIATRY 535-44 (1980)).

Carl Rogers and others, proposed that doctors become "patient-centered" in their approach to interviewing and counseling patients.[9]

In the 1980s, when teaching about medical communications began to take shape, little was known about effective doctor-patient communication, so much of the teaching was developed by intuition.[10] "In the decades that have since passed, a wealth of research has been published providing a solid basis for teaching, testing and learning of communication skills."[11]

Similarly, the legal profession began to question the traditional relationship between attorney and client. In the 1970s, a pioneering study was published asserting that an attorney-client relationship that was "participatory," rather than traditionally authoritarian, produced better results.[12] Shortly thereafter, the "ground-breaking book" by law professor David Binder and psychologist Susan Price[13] coined the phrase "client-centered lawyering"[14] and urged lawyers to treat clients as collaborators rather than helpless persons who need to be rescued. They argued for the client-centered approach based on respect for client autonomy, and recognition that clients are usually best able to assess the non-legal consequences of particular solutions and to determine what risks are worth taking.[15]

The concept of client-centered lawyering has gained wide acceptance within the legal academy,[16] where clinics and simulation classes teach this approach.[17] This literature has relied heavily upon this theo-

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[9] *Id.* (citing J.H. Levenstein, et al., *Patient-centered, Clinical Interviewing,* in COMMUNICATING WITH MEDICAL PATIENTS, 107-120 (M. Stewart and D. Roter, eds., 1989) and I. McWhinney, *The Need for a Transformed Clinical Method,* in COMMUNICATING WITH MEDICAL PATIENTS, 25-42 (M. Stewart and D. Roter, eds., 1989)).

[10] SUZANNE KURTZ, JONATHAN SILVERMAN AND JULIET DRAPER, TEACHING AND LEARNING COMMUNICATION SKILLS IN MEDICINE vii (2nd ed., 2005).

[11] *Id.*

[12] DOUGLAS E. ROSENTHAL, LAWYER AND CLIENT: WHO'S IN CHARGE? (1974). Rosenthal drew on the social science literature to examine and critique the traditional professional-controlled relationship. He then examined personal injury cases, comparing outcomes of traditional and participatory lawyering to independent evaluations of the claim's value.

[13] DAVID A. BINDER & SUSAN M. PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH (1977).

[14] STEFAN H. KRIEGER & RICHARD K. NEUMANN, JR., ESSENTIAL LAWYERING SKILLS: INTERVIEWING, COUNSELING, NEGOTIATING AND PERSUASIVE FACT ANALYSIS, 22 (5th ed., 2015) [hereinafter ESSENTIAL LAWYERING SKILLS].

[15] LAWYERS AS COUNSELORS, *supra* note 5, at 4-8.

[16] *Id.* at 3.

[17] *Id. See also* STEPHEN ELLMAN, ROBERT D. DINERSTEIN, ISABELLE R. GUNNING, KATHERINE R. KRUSE & ANN C. SHALLECK, LAWYERS AND CLIENTS: CRITICAL ISSUES IN INTERVIEWING AND COUNSELING 6 (2009) [hereinafter LAWYERS AND CLIENTS]; G. NICHOLAS HERMAN & JEAN M. CARY, A PRACTICAL APPROACH TO CLIENT INTERVIEWING, COUNSELING AND DECISION-MAKING: FOR CLINICAL PROGRAMS AND PRACTICAL SKILLS COURSES 7 (2009); and ROBERT F. COCHRAN JR., JOHN M.A. DIPIPPA & MARTHA

retical conception of client-centeredness and upon psychological theories about human interaction.[18] Authors of textbooks teaching interviewing and counseling have also incorporated social science findings regarding memory and decision-making.[19] What we have not been able to do is to rely substantially on social science studies of actual client-attorney or client-student consultations in showing and teaching what is most effective. This is in sharp contrast to medical education.

The article will rely upon two leading medical school texts about communication and the research upon which these texts rely. In so doing, it will survey the wealth and diversity of social science studies regarding medical interviewing and counseling. It will then review the handful of studies that have been done of legal consultations and their current, albeit limited, value. This article makes the argument that the legal academy should pursue social science studies of client-lawyer communication as has been done in the medical arena, and suggests questions worthy of inquiry in light of our current theories and findings in the medical realm. Finally, this article discusses the possible reasons such studies of legal consultations are so rare. It argues that such studies are, indeed, possible and sets forth approaches that clinicians might take to engage in this research.

I. Medical Studies of Consultations with Patients

There have been thousands of social science studies of patient-provider consultations.[20] A leading text, published in 2013, references "over 400 papers per year listed on Medline on physician-patient relations and communication."[21] The "exponential growth in research addressing the nature, dynamics, context, and consequences of medical dialogue" has also been accompanied by regulatory changes in which "interpersonal communication" has been identified as one of the six

M. Peters, The Counselor-at-Law: A Collaborative Approach to Client Interviewing and Counseling 4 (1999).

[18] *See e.g*. Lawyers as Counselors, *supra* note 5, at 16-40 discussion of client motivation based on Abraham H. Maslow, Motivation and Personality (3rd ed., 1987) and at 41-63 of active listening based on psychological studies including Gerard Egan, The Skilled Helper (7th ed., 2002).

[19] *See e.g*. Essential Lawyering Skills, *supra* note 14, at 83 regarding observation and memory; Lawyers as Counselors, *supra* note 5, at 382-391 regarding cognitive illusions; Lawyers and Clients, *supra* note 13, at 365 regarding decision-making.

[20] "There is a huge cross-disciplinary literature on medical encounters" with over 7000 titles counted by 2003. Nancy Ainsworth-Vaughn, *The Discourse of Medical Encounters*, in The Handbook of Discourse Analysis 453 (Deborah Schiffrin, Deborah Tannen & Heidi Hamilton eds., 2003).

[21] Skills for Communicating with Patients, *supra* note 4, at x.

core competencies doctors must possess.[22] The "wide dissemination of patient-centered practices" has also been promoted by the Academy of Communication in Healthcare, the International Association for Communication in Healthcare, and the Institute for Healthcare Communication.[23]

As a result, medical texts on communication are firmly anchored in research findings. The "first entirely evidence-based textbook on medical interviewing"[24] is in its third edition, updated with the most recent research:

> We wish not only to demonstrate how to use communication skills in the medical interview, but also to provide the research evidence that validates the importance of communication skills and which documents the potential gains to both doctors and patients alike. There is now comprehensive theoretical and research evidence to guide the choice of communication skills to include in the communication curriculum — we know which skills can actually make a difference to clinical practice. These research findings should now inform the education process and drive the communication skills curriculum forward. . . .[25]

Another leading text, also in its third edition, relies heavily on a patient-centered method the author developed based on empirical evidence and subsequently tested for effectiveness in randomized controlled trials.[26] This text's Appendix B further "provides the research and humanistic rationale for being patient-centered."[27]

A. A Brief History of Studies Regarding Medical Consultations

There were initially two dominant approaches to this research – called "praxis literature" as contrasted with the "discourse literature" by one expert,[28] or termed the "process analysis / coding" approach

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[22] DEBORAH L. ROTER & JUDITH A. HALL, DOCTORS TALKING WITH PATIENTS / PATIENTS TALKING WITH DOCTORS: IMPROVING COMMUNICATION IN MEDICAL VISITS, xi (2nd ed., 2006) (citing requirements of the American Association of Medical Colleges and the American College of Graduate Medical Education).

[23] SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at xvii. *See* American Academy on Communication in Health Care homepage at http://www.aachonline.org/ (last visited November 24, 2017), European Association for Communication in Healthcare homepage at http://www.each.eu/ (last visited November 24, 2017) and Institute for Healthcare Communication homepage at http://healthcarecomm.org/ (last visited November 24, 2017).

[24] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at x.

[25] *Id.*

[26] SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at xviii.

[27] *Id*. at xx.

[28] Nancy Ainsworth-Vaughn, *The Discourse of Medical Encounters*, in THE HANDBOOK OF DISCOURSE ANALYSIS 453 (Deborah Schiffrin, Deborah Tannen & Heidi Hamilton eds., 2003).

versus the "microanalytic" approach by another expert.[29]

The praxis or coding approach "involves researchers assigning a single functional meaning (e.g. information-giving, affective display) to each utterance and then coding utterances into functional categories so that they can be quantified."[30] The talk itself is not further studied or reproduced, but the categories are compared to outcomes — such as to patient satisfaction surveys or to records showing whether patients followed physicians' recommendations.[31] The pros and cons of this approach have been much debated, with deficiencies being that coded categories are general, and the content and the context of the interaction are "largely washed out."[32]

The "discourse" or "microanalytic" literature consists of analysis of the talk itself, relying upon theories about "sequential situated discourse (e.g. conversation analysis, interactional sociolinguistics, the ethnography of communication)."[33] This approach involves audio- or video-recording the naturally occurring conversations, transcribing them using certain conventions, and then conducting a "fine-grained analysis" of the conversation, focusing on what is being accomplished and how.[34]

> A basic assumption, substantiated by empirical research, is that features of everyday conversation — including fundamental organizational features (such as turn-taking) and practices of achieving actions (such as describing troubles and delivering news) — are brought into medical encounters from the everyday worlds and adapted to accomplish particular tasks and address interactional dilemmas in those encounters.[35]

As in ordinary conversation, the actions in the medical consultation are seen as being jointly accomplished by all participants.[36]

Although quantitative data was originally confined to the praxis or coding approaches, and not utilized in the microanalytic conversation analysis (CA) research, today there are studies in which "quanti-

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[29] John Heritage & Douglas W. Maynard, *Introduction: Analyzing Interaction Between Doctors and Patients in Primary Care Encounter*s, in COMMUNICATION IN MEDICAL CARE: INTERACTION BETWEEN PRIMARY CARE PHYSICIANS AND PATIENTS, 2-4 (John Heritage & Douglas W. Maynard eds., 2006).

[30] Ainsworth-Vaughn, *supra* note 28, at 453.

[31] *Id.* at 454.

[32] Heritage & Maynard, *supra* note 29, at 7.

[33] Ainsworth-Vaughn, *supra* note 28, at 453.

[34] *Id.* Conversation analysis (CA) does not attempt to determine why the participants behave as they do.

[35] Virginia Teas Gill & Felicia Roberts, *Conversation Analysis in Medicine* in THE HANDBOOK OF CONVERSATION ANALYSIS 575, 577 (Jack Sidnell & Tanya Stivers, eds., 2013) (citations omitted).

[36] *Id.*

tative analyses are built upon conversational analytic material."[37] Today leading researchers assert:

> [T]o extract robust outcome-based conclusions about how physicians (or patients) should conduct themselves in specific moments in the flow of the medical encounter, it is important to find a meeting point between the two methodologies of coding and microanalysis.[38]

B. Medical Instructional Literature Today

The medical school text *Skills for Communicating with Patients* provides extensive instruction in the skills of medical communication together with "the theoretical and research bases that validate the choice of these particular skills."[39] The other leading medical text, *Smith's Patient-Centered Interviewing*, "describes an 11-step, evidence-based interviewing method used to obtain a complete biopsychosocial story" while summarizing some of the most pertinent studies in Appendix B.[40] Two other important volumes about communication between doctors and patients, written by social scientists, will also be referenced as relevant, though neither volume aims to be a medical school text.[41]

1. Initiating the Consultation

The first topic addressed is "initiating the session" because research shows that "many problems in communication occur in this initial phase of the interview."[42] One problem has been identifying what issues the patient wishes to address. Studies, extending over 30 years, have shown that many of the patients' concerns are not elicited or addressed.[43] "Several studies have shown that patients often have more than one concern to discuss."[44] Yet patients often withhold psychosocial or other concerns until later in the visit.[45] An important study by Beckman and Frankel showed that doctors so frequently in-

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[37] Debra Roter, *Forward* in COMMUNICATION IN MEDICAL CARE: INTERACTION BETWEEN PRIMARY CARE PHYSICIANS AND PATIENTS (John Heritage & Douglas W. Maynard, eds., 2006).

[38] Heritage & Maynard, *supra* note 29, at 8 (citations omitted).

[39] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 34. This text is accompanied by a "teacher's manual" of sorts: KURTZ ET AL., *supra* note 10.

[40] SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 3 and 247.

[41] ROTER & HALL, *supra* note 22; COMMUNICATION IN MEDICAL CARE: INTERACTION BETWEEN PRIMARY CARE PHYSICIANS AND PATIENTS (John Heritage & Douglas W. Maynard, eds., 2006).

[42] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 35.

[43] *Id.*

[44] *Id.* at 43.

[45] *Id*. at 47.

terrupted patients — after 18 seconds on average — that the patients often failed to share all their concerns.[46] They found that the order with which patients present their concerns is not related to their clinical importance; doctors often erroneously assume the first complaint mentioned is the only one the patient has, and in follow-up visits doctors often erroneously assume that the only issue is the concern previously addressed.[47]

Researchers have used conversation analysis "to explore the effect of various opening questions" finding that general open questions (as opposed to confirmatory questions referencing information from screening or referral) resulted in "significantly longer problem presentations that included more discrete symptoms."[48]

Researchers have also pointed out the importance of listening skills.[49] Beckman and Frankel have analyzed "exactly how doctors' use of words and questions can so easily and inadvertently direct the patient away from disclosing their reasons for wishing to see the doctor."[50] Problems include interrupting the patients' opening statements, asking clarifying or closed questions that pursue the initial issue raised, and even reflecting the patient's words after the patient presents the first issue.[51] In these ways, doctors direct the conversation to the first issue and prevent the patient from raising other concerns. As a result, the patient either does not get to raise all the issues, or the patient raises a serious concern late in the consultation.

To address these observed problems, this medical text advises "attentive listening" which involves giving the patient more "wait time" to go on after a pause, and using only passive listening phrases (uh-huh, go on, yes) during the patient's initial statement of concerns.

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[46] *Id*. at 43, 47-48 (citing H.B. Beckman and R. M. Frankel, *The Effect of Physician Behaviour on the Collection of Data*, 101 (5) ANN. INTERN. MED. 692-6 (1984)). Fifteen years later this study was replicated with similar results — experienced family doctors interrupted after 23.1 seconds and only 28% of patients completed their opening statements. *Id.* at 48 *(*citing M.K. Marvel, R.M. Epstein, K. Flowers & H. B. Beckman, *Soliciting the Patient's Agenda: Have We Improved?* 281(3) JAMA. 283-7 (1999)).

[47] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 43.

[48] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 45 (citing J. Heritage and J. D. Robinson*, The Structure of Patients' Presenting Concerns: Physicians' Opening Questions,* 19 (2) HEALTH COMMUN. 89-102 (2006)).

[49] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 47 (*citing* H.B. Beckman and R. M. Frankel, *The Effect of Physician Behaviour on the Collection of Data*, 101 (5) ANN. INTERN. MED. 692-6 (1984) *and* H.B. Beckman, R.M. Frankel & J. Darnley, *Soliciting the Patients Complete Agenda: Relationship to the Distribution of Concerns*, 33 CLIN. RES. 714 A (1985)).

[50] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 47 *(*citing H.B. Beckman and R. M. Frankel, *The Effect of Physician Behaviour on the Collection of Data*, 101 (5) ANN. INTERN. MED. 692-6 (1984) and M.K. Marvel et al., *Soliciting the Patient's Agenda: Have We Improved?* 281(3) JAMA. 283-7 (1999)).

[51] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 48.

Interestingly, the Beckman Frankel study showed:

> [R]epetition (echoing), paraphrasing, and interpretation, which are all valuable facilitative skills later on in the interview, potentially act as interrupters at the beginning of the interview whereas other more neutral facilitative phrases such as "uh huh" . . . serve to encourage the patient to continue along his or her own path.[52]

Other recommended approaches include using non-verbal "attentive listening" during the opening moments such as "posture, movement, proximity, direction of gaze, eye contact, gestures, affect, vocal cues . . . facial expression, touch, physical appearance and environmental cues. . ." and picking up on the patient's verbal and non-verbal cues.[53] "Non-verbal cues and indirect comments . . . often feature very early in the patient's exposition of their problems and the doctor needs to look out specifically for them from the very beginning of the interview."[54]

Skills for Communicating with Patients advises deliberately attempting to discover all of the patient's concerns before actively exploring any one of them by asking open-ended enquiries about other topics and then confirming the agenda.[55] The text cites a recent conversation analysis study that demonstrated that asking if there is "something else" the patient wanted to discuss is superior to asking if there is "anything else" to discuss, because "anything" has a negative polarity (suggesting the answer should be no) and '"something" has a positive polarity (suggesting the answer should be yes).[56] Thus the four steps for the opening of the interview involve an open question, listening, screening for additional concerns, and confirming the agenda with the patient.[57]

The Smith text presents its five-step (21 sub-step) method for beginning the medical interview, citing eight different publications that have tested this approach and found it effective.[58] The first step includes 1. Setting the Stage (welcome, use patient's name, introduce yourself, ensure patient readiness and privacy, remove barriers to communication, ensure comfort). The next step, 2. Obtaining the

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[52] *Id*. at 51.

[53] *Id.*

[54] *Id*. at 51-52.

[55] *Id*. at 52.

[56] *Id.* at 53 (citing J. Heritage, J.D. Robinson, M.N. Beckett & M. Wilkes, *Reducing Patients' Unmet Concerns in Primary Care: The Difference One Word Can Make*, 22(10) J. GEN. INTERN. MED. 1429-33 (2007)); *see also* John Heritage & Jeffrey D. Robinson, *'Some' versus 'Any' Medical Issues: Encouraging Patients to Reveal Their Unmet Concerns* in APPLIED CONVERSATION ANALYSIS: INTERVENTION AND CHANGE IN INSTITUTIONAL TALK 15 (Charles Antaki, ed., 2011).

[57] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 53.

[58] SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 29.

Agenda, is consistent with the *Skills for Communicating with Patients* text. This Smith text cites five studies that point out the problems with doctors not obtaining a complete agenda at the outset. Appendix B of this text also cites the Beckman & Frankel study showing how frequently and early doctors interrupt patients' opening statements.

2. Gathering Information

Medical students had long been taught to obtain a traditional medical history, concentrating on the underlying disease mechanism in order to arrive at a diagnosis.[59] Today's texts argue against such a limited doctor-centered practice, in favor of "patient-centered clinical interviewing" or "relationship-centered care" in which the patient's experience of the illness and the patient's ideas, feelings, and expectations about the illness and about treatment are equally important to consider.[60] While doctors have always been aware of both perspectives, they have tended to discard the patient's illness framework in favor of their focus on the diagnosis.[61] A social scientist observed that the doctors selectively listen to and pursue a patient's comments from the technological perspective, but do not pursue comments that provide insight into the patient's lived experience.[62]

The *Skills for Communicating with Patients* text recommends eliciting the patient's narrative in chronological order, then moving from open to closed questions on each topic in order to learn the patient's perspective as well as diagnostic facts.[63] This medical text provides evidence in support of the open-to-closed questioning including that open questions prompted revelation of more information, that patients preferred being able to first express themselves, and that concluding with closed questioning resulted in more information.[64]

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[59] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 62-64.

[60] *Id*. at 64-71.

[61] *Id*. at 66.

[62] *Id.* (citing E.G. MISCHLER, THE DISCOURSE OF MEDICINE: DIALECTICS OF MEDICAL INTERVIEWS (1984)).

[63] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 74. The "open-to-closed" cone is similar to the "T-funnel" recommended in the Binder legal texts. See BINDER & PRICE, *supra* note 13, at 92 and LAWYERS AS COUNSELORS, *supra* note 5, at 167-75.

[64] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 78-79 (citing D.L. Roter & J.A. Hall, *Physicians' Interviewing Styles and Medical Information Obtained from Patients,* 2(5) J. GEN. INTERN. MED. 325-9 (1987) (medical students elicited on average only 50% of important information from simulated patients); W.B. Stiles, S.M. Putnam, S.A. James & H.J. Wolf, *Dimensions of Patient and Physician Roles in Medical Screening Interviews*, 13A SOC. SCI. MED. 335 (1979) (patients were more satisfied if allowed to express themselves rather than answer narrow questions); A. Cox, K. Hopkinson & M. Rutter, *Psychiatric Interviewing Techniques II: Naturalistic Study* 138 BR. J. PSYCHIATRY 283 (1981); A. Cox, K. Hopkinson & M. Rutter, *Psychiatric Interviewing Techniques V: Exper-*

During the information gathering stage of the consultation, it is still important to use silence to encourage the patient to continue.[65] In this stage, repeating or echoing what the patient had said encouraged the patient to continue.[66] Other facilitative utterances, including paraphrasing, summarizing, and checking understanding, were also recommended at this phase. Evidence for these techniques included gaining more information and facing fewer malpractice suits.[67]

At all stages, patients are giving verbal and non-verbal clues about their concerns, which doctors frequently miss.[68] The text recommends attentive listening, asking for clarification when statements are vague or ambiguous, and periodically summarizing the information learned to check for accuracy.[69]

Skills for Communicating with Patients sets forth evidence in support of exploring the patient's perspective about the illness. Anthropological studies have shown how social, cultural and spiritual beliefs about health and illness shape perceptions of symptoms and expectations for treatment.[70] The medical providers need to elicit the patients' frameworks in order to then openly compare and discuss any conflicting ideas and come up with a treatment plan the patient can

imental Study 139 BR. J. PSYCHIATRY 29 (1981) (interviewing parents bringing children to a psychiatric clinic supported lengthy patient-controlled narrative followed by closed questions)).

65 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 81 (citing M.B. Rowe, *Wait Time: Slowing Down May be a Way of Speeding Up,* 37(1) J. TEACH EDUC. 43-50 (1986)).

66 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 82.

67 *Id*. at 83 (citing W. Levinson, D.L. Roter, J.P. Mullooly, V.T. Dull & R. M. Frankel, *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277(7) JAMA, 553-59 (1997) (primary care doctors who used more facilitation statements—soliciting patients' opinions, checking understanding, encouraging patients to talk, and paraphrasing—were less likely to have suffered malpractice claims); Y. Takemura, R. Atsumi & T. Tsuda, *Identifying Medical Interview Behaviors that Best Elicit Information from Patients in Clinical Practice* 213(2) TOHOKU J. EXP. MED. 121-27 (2007) (facilitation, open-to-closed cone questioning, and summarization were positively related to the amount of information obtained by family doctors)).

68 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 84. Numerous studies demonstrate doctors often miss patients' own thoughts and feelings. *Id.* (citing W. Levinson, R. Gorawara-Bhat & J. Lamb, *A Study of Patient Clues and Physician Responses in Primary Care and Surgical Settings*, 284(8) JAMA, 1021 (2000) (patients gave clues throughout the interview, but doctors responded to them only 38% of the time for surgery and 21% of the time in primary care. Nevertheless, when doctors did pick up and respond to the clue, the visit time was shortened)).

69 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 84-87.

70 *Id.* at 88 (citing A. Kleinman, I. Eisenberg, & B. Good, *Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research* 88(2) ANN. INTERN. MED. 251 (1978) (Anthropology professor Arthur Kleinman and colleagues' seminal work relied upon qualitative anthropological research and explained how the findings of that research can be applied to medical interviews.)).

accept.[71] Various studies have shown that patients' outcomes are improved if the patients have had the opportunity to discuss their own perspectives about their illness with the doctors.[72] Studies have also "documented a relationship between the patient-centered approach and patient satisfaction and compliance."[73] Even where the doctors do not provide the treatment desired by the patients, there is no decline in satisfaction or compliance where the doctors elicited the patients' expectations and discussed the situation with the patients.[74]

Further, this text points out studies that show patient-centered consultations are not generally more time-consuming than traditional consultations.[75]

There are two ways to discover the patient's illness perspective — asking directly about it or picking up on verbal and nonverbal cues the patient provides, the text recognizes.[76] A systematic review of 58 original quantitative and qualitative studies based on analysis of audio- or video-recorded consultations revealed that most of the time, doctors missed most cues and adopted behaviors that discouraged direct disclosure.[77] Accordingly, the authors conclude that while "picking up on patient cues might be easier, asking specifically about the illness perspective is still a very necessary task."[78]

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[71] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 89.

[72] *Id*. at 90 - 92. Examples included studies of treatment of chronic headaches, hypertension, upper respiratory infections, psychosocial problems, diabetes and general practice.

[73] *Id.* at 92.

[74] *Id*. at 93. Four related, seminal studies by Lazare and Eisenthal demonstrated that patients were more satisfied and cooperative with treatment plans if their ideas had been elicited and addressed, even if their initial expectations were not met. *Id.* (citing A. Lazare, S. Eisenthal, & L. Wasserman, *The Customer Approach to Patienthood: Attending to Patient Requests in a Walk-in Clinic,* 32(5) ARCH. GEN. PSYCHIATRY 553-8 (1975); S. Eisenthal & A. Lazare, *Evaluation of the Initial Interview in a Walk-in Clinic: The Patient's Perspective on a 'Customer Approach'*, 162(3) J. NERV. MENTAL DIS. 169-76 (1976); S. Eisenthal, R. Emery, A. Lazare & H. Udin*, 'Adherence' and the Negotiated Approach to Parenthood,* 36(4) ARCH. GEN. PSYCH. 393 (1979); S. Eisenthal, C. Koopman & J.D. Stoeckle, *The Nature of Patients' Requests for Physicians,* 65(6) HELP ACAD. MED. 401-5 (1990)).

[75] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 95 (citing D.L. Roter, J.A. Hall, D.E. Kern, R. Barker, K.A. Cole & R.P. Roca, *Improving Physicians' Interviewing Skills and Reducing Patients' Emotional Distress*, 155(17) ARCH. INTERN. MED. 1877-84 (1995); W. Levinson & D. Roter, *Physicians Psychosocial Beliefs Correlate with Their Patient Communication Skills,* 10(7) J. GEN. INTER. MED. 375-9 (1995)).

[76] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 96.

[77] *Id.* at 97 (citing C. Zimmermann, L. Del Piccolo & A. Finset, *Cues and Concerns By Patients in Medical Consultations: A Literature Review*, 133(3) PSYCHOL. BULL. 438-63 (2007)).

[78] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 99 (citing F.W. Platt, D.L. Gaspar, J.L. Coulehan, L. Fox, A.J. Adler, W.W. Weston, R.C. Smith & M. Stewart, '*Tell Me About Yourself': The Patient-Centered Interview,* 134(11) ANN. INTERN. MED. 1079-85 (2001)). In response to sequenced questioning about the patient's perspective, 44% of family practice patients revealed specific, significant concerns that had not other-

This text presents one "practical approach" to combining the skills necessary to understanding both perspectives, recognizing that it is one of many ways, and "the key is to be flexible and dynamic, responding to the patient's cues and responses."[79]

In contrast, the Smith text provides a clear step-by-step process to elicit the patient's perspective about the illness. After listening to the patient-directed narrative about the reason for the visit, the doctor is supposed to use focusing skills to elicit the "symptom story," the "personal context" and the "emotional context."[80] The doctor should ask the patient to describe the symptoms in her own words, using open questions, echoing, and summarizing.[81] Then, rather than following up with narrow questions about the symptoms, the doctor should "learn about the patient and . . . illness in its broader psychosocial/personal context" by either exploring a personal aspect the patient mentioned or by asking how the condition is affecting the patient's life.[82] After the patient has completed that narrative, the doctor should turn to explore the emotional context by asking something like "How does that make you feel?"[83]

While *Smith's Patient-Centered Interviewing* does not review the social science literature as extensively as does the *Skills for Communicating with Patients* text, it does explain that the personal and emotional contexts should be explored because studies have shown that patients often have worries that are unspoken.[84]

After exploring the patient's three stories, the doctor will transition to the more doctor-controlled stage of the interview by first summarizing what the patient has shared, checking for accuracy of the summary, and then indicating a move to further questioning when the patient is ready.[85]

3. Rapport

Both texts address relationship building skills. *Smith's Patient-*

wise been disclosed. *Id.* (citing F. Lang, M.R. Floyd, K.L. Beine & P. Buck, *Sequenced Questioning to Elicit the Patient's Perspective on Illness: Effects on Information Disclosure, Patient Satisfaction and Time Expenditure*, 34(5) FAM. MED. 325-30 (2002)).

79 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 102.

80 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 30.

81 *Id*. at 43.

82 *Id.* at 43-48.

83 *Id*. at 48.

84 *Id.* at 46-47 (citing R.L. Marpel et. al, *Concerns and Expectations in Patients Presenting with Physical Complaints — Frequency, Physician Perceptions and Actions, and 2-week Outcome*, 157 ARCH. INTERN. MED. 1482-1488 (1997) (67% were worried about a serious illness, 67% wanted testing, 53% expected a referral, 62% indicated interference with routine activities, and 47% described stress)).

85 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 56.

Centered Interviewing covers these skills at the outset, explaining that "addressing feelings and emotions leads to the strongest clinician-patient relations and produces the most effective communication"[86] and that emotions and the thoughts and feelings they evoke can be central to decision-making.[87] Accordingly, this text includes instructions on when and how to directly draw out feelings and emotions, as well as instructions on employing empathy skills. Inquiries about emotion should be direct and open ("How did that make you feel?") rather than the doctor guessing at an emotion.[88] If patients do not respond to direct inquiries, the doctor should make indirect inquiries, including 1) asking how the situation is affecting the patient's life, 2) asking what the patient thinks caused the problem, 3) demonstrating understanding through self-disclosure, and 4) seeking to understand the "trigger" such as why the patient is seeking treatment now.[89]

Smith's Patient-Centered Interviewing also addresses empathy skills: "When the patient expresses an emotion you should respond verbally" or the patient may feel disapproval or disinterest.[90] "Empathy skills communicate that you have heard the patient and result in the patient feeling understood and cared for."[91] Students are instructed to use four separate verbal skills: 1) Naming the feeling or emotion the client is expressing, 2) Understanding or legitimating the feeling ("I can see why you'd feel that way"), 3) Respecting the feeling ("Thanks for being so open") or praising or appreciating the patient's plight ("You've been through a lot"), and 4) Supporting the patient ("I'm here to help.")[92]

The *Smith's* text does not relate any one piece of advice regarding empathy to a particular social science study. Instead, this text asserts that its step-by-step method for beginning the medical interview has been shown to be effective through many studies over 20 years.[93] In

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[86] *Id.* at 18 (citing E.M. STERNBERG, THE BALANCE WITHIN—THE SCIENCE CONNECTING HEALTH AND EMOTIONS (2000)).

[87] *Id*. (citing E. KANDEL, PSYCHIATRY, PSYCHOANALYSIS AND THE NEW BIOLOGY OF MIND (2005) and A. Bechara et al., *Deciding Advantageously Before Knowing the Advantageous Strategy*, 275 SCIENCE 1293 (1997)).

[88] *Id*. at 19.

[89] *Id.* at 20-21.

[90] *Id.* at 21.

[91] *Id.*

[92] *Id.* at 21-22.

[93] *Id.* at 29 (citing seven articles authored by Smith and others: R. Smith et al., *Behaviorally-Defined Patient-Centered Communications — A Narrative Review of The Literature*, 26 J. GEN. INT. MED. 185-91 (2010); R. C. Smith, *An Evidence-Based Infrastructure for Patient-Centered Interviewing* in THE BIOPSYCHOSOCIAL APPROACH: PAST, PRESENT, FUTURE (R.M. Frankel, T.E. Quill & S.H. McDaniel eds., 2003); R.C. Smith & R.B. Hoppe, *The Patient's Story: Integrating the Patient- and Physician-Centered Approaches to Interviewing*, 115 ANN. INTERN. MED. 470-77 (1991); R.C. Smith et al., *The Effectiveness of*

Appendix B the text cites 87 articles that provide the "research and humanistic rationale for patient-centered interviewing."[94] One author frequently cited by *Smith's Patient-Centered Interviewing* reports that, in a randomized study, teaching doctors to better recognize and respond to patients' psychosocial problems resulted in trained doctors being better able to recognize mental distress in their patients and that their patients showed significantly greater improvement in their mental health up to six months after the visit.[95]

Skills for Communicating with Patients notes that nearly all the communication skills it advocates also "contribute to building a solid relationship with the patient."[96] However, they also address relationship-building skills including non-verbal behaviors, acceptance, and empathy. Research shows that doctors' non-verbal communication — such as eye contact, physical distance, tone of voice, smiling, nodding — make a difference to patients.[97] Accordingly, doctors are advised to maintain eye contact throughout the beginning of the consultation, and explain to the patient when they must give attention to the file or to taking notes.[98] Computers, too, can come between doctor and patient, so doctors should endeavor to use the computer collaboratively with the patient and after the patient narrative.[99]

The first step of developing rapport is understanding and accepting the patient's perspective. Once the patient has shared thoughts or feelings, the doctor should acknowledge them rather than

Intensive Training for Residents in Interviewing. A Randomized, Controlled Study, 128 ANN. INTERN. MED. 118-26 (1998); R.C. Smith et al., *A Strategy for Improving Patient Satisfaction by the Intensive Training of Residents in Psychosocial Medicine: A Controlled, Randomized Study,* 70 ACAD. MED. 729-32 (1995); R.C. Smith et al., *Evidence-Based Guidelines for Teaching Patient-Centered Interviewing,* 39 PATIENT EDUC. COUN. 27-36 (2000); R.C. Smith, *Improving Residents' Confidence in Using Psychosocial Skills*, 10 J. GEN. INTERN. MED. 315-20 (1995)).

94 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 247, 249-54.

95 Debra Roter, Judith A. Hall, David E. Kern, L. Randol Barker, Karen A. Cole & Robert P. Roca, *Improving Physician's Interviewing Skills and Reducing Patients' Emotional Distress: A Randomized Clinical Trial,* 155 ARCHIVES OF INTERN. MED. 1877 (1995) (*reported in* ROTER & HALL, *supra* note 22, at 179-81 (2nd ed., 2006)).

96 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 119.

97 *Id*. at 128-30 (citing over a dozen studies that focus on non-verbal communication).

98 *Id.* at 131-33.

99 *Id.* at 132-33 (citing R.S. Margalit, D. Roter, M.A. Dunevant, S. Larson & S. Reis, *Electronic Medical Record Use and Physician-patient Communication: An Observational Study of Israeli Primary Care Encounters*, 61(1) PATIENT EDUC. CONS. 134 (2006) (finding that screen gaze was disruptive to psychosocial inquiry and emotional responsiveness); P. Duke, S. Reis & R.M.A. Frankel, *How to Integrate the Electronic Health Record and Patient-Centered Communication into the Medical Visit: A Skills-Based Approach*, 25(4) TEACH. LEARN. MED. 358-365 (2013) (giving a review of literature on computer use during consultation, suggesting clearly demarking patient-centered and computer-centered phases)).

giving immediate reassurance, rebuttal or agreement.[100] The "supportive response" or "acknowledging response" may restate or summarize what the doctor heard, and can acknowledge the patient's right to feel or think in that way.[101] The doctor should then come to a "full stop" and employ attentive silence to permit the patient to say more.[102] The doctor may need to employ these techniques in responding to the patient's overt feelings and indirectly expressed emotions.[103] Only after such acknowledgment and attentive listening should the doctor explain his or her understanding of the issue in relation to the patient's understanding in order to reach a mutual understanding.[104]

A key building block in developing rapport is empathy, which begins with cognitive empathy (the capacity to understand how another feels) and then includes emotional empathy (the capacity to feel with the other), and then concern (the desire to want to help).[105] Once the doctor has developed the ability to empathize, the next task is communicating the understanding back to the patient in a supportive manner.[106] Studies have shown that medical students' ability to empathize did not improve over the course of their studies without specific training.[107] This text also identifies additional supportive responses, explaining that unless the empathy is overtly verbalized, the patient may not be aware of the support.[108]

Various studies have shown that patients are more satisfied and have improved health outcomes with doctors who use rapport-building skills.[109] In contrast, simple reassurance — the most common re-

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100 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 133.

101 *Id.* at 133-34 (citing S. Steihaug, P. Gulbrandsen, & A. Werner, *Recognition Can Leave Room for Disagreement in the Doctor-Patient Consultation,* 86(3) PATIENT EDUC. COUNS. 316 (2012) (accepting response may help reduce potential conflict and make it easier to tolerate disagreement when patient's and doctor's values conflict)).

102 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 134-36.

103 *Id*. at 135 (citing J.L. Donovan & D.R. Blake, *Qualitative Study of Interpretation of Reassurance Among Patients Attending Rheumatology Clinics: 'Just a Touch of Arthritis, Doctor?'* 320(7234) BMJ 541 (2000) (the key to reassurance was doctors acknowledging the patients' perspectives or concerns)).

104 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 137.

105 *Id.* at 137-38 (citing seven separate studies that show that doctors can learn to incorporate the building blocks of empathy into their personal styles).

106 *Id.* at 139-42.

107 *Id.* at 140.

108 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 143 (citing R.P. Williamson, *Appendix I: A 4-step Model of Relationship-Centered Communication* in, LEADING CHANGE IN HEALTHCARE: TRANSFORMING ORGANIZATIONS USING COMPLEXITY POSITIVE PSYCHOLOGY AND RELATIONSHIP-CENTERED CARE (A. Suchman, D.M. Sluyter & P.R. Williamson eds., 2011) (using the acronym PEARLS to identify the variety of rapport building responses: partnership, empathy, acknowledgment, respect, legitimization, support)).

109 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 143-45 (citing M.K. Buller & D.B. Buller, *Physicians' Communication Style and Patient Satisfaction,* 28(4) J.

sponse by doctors — led to no improvements.[110]

The final skill in rapport building involves the doctor explaining the rationale for questions or for aspects of the physical examination.[111] This meta-discussion of where the interview is going reduces uncertainty for the patient and results in a more collaborative consultation.[112]

4. Explanation and Planning

Research has identified significant difficulties in the explanation and planning stage of the consultation.[113] A common problem is giving advice, information or reassurance prematurely — the doctor must complete the information-gathering phase before beginning to advise.[114] Doctors generally give little information to their patients,[115] and use medical jargon.[116] Patients often do not recall or understand

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HEALTH SOC. BEHAV. 375-88 (1987) (patients were more satisfied with doctors who adopted an "affiliative style"); J.A. Hall, D. Roter & N.R. Katz, *Meta-analysis of Correlates of Provider Behavior in Medical Encounters,* 26(7) MED. CARE. 657-75 (1988) (a meta-analysis of 41 studies showing patient satisfaction related to doctors who engaged in "partnership building" and "positive talk"); S.S. Kim, S. Kaplowitz & M.V. Johnston, *The Effects of Physician Empathy on Patient Satisfaction and Compliance*, 27(3) EVAL. HEALTH PROF. 237-51 (2004) (reporting that patient perception of doctor empathy led to greater satisfaction and compliance)).

110 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 144 (citing R.C. Wasserman, T.S. Inui, R.D. Barriatua, W.B. Carter & P. Lippincott, *Pediatric Clinicians' Support for Parents Makes a Difference: An Outcome Based Analysis of Clinician-Parent Interaction,* 74(6) PEDIATRICS 1047-53 (1984) (empathic statements made to mothers during pediatric visits lead to increased satisfaction and reduction of concerns but simple reassurance led to no improvements in outcome)).

111 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 146-48.

112 *Id.* (citing L. Robins, S. Witteborn, L. Miner, L. Mauksch, K. Edwards & D. Brock, *Identifying Transparency in Physician Communication* 83(1) PATIENT EDUC. COUNS. 73-79 (2011) (stating that doctors spent little time using such process-related transparency)).

113 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 149.

114 *Id.* at 170.

115 *Id*. at 149-51 (citing H. Waitzkin, *Doctor-Patient Communication: Clinical Implications of Social Scientific Research*, 252(17) JAMA. 2441-6 (1984) (reporting that internists devoted one minute on average to giving information in consultations that lasted 20 minutes); G. Makoul, P. Arnston & T. Scofield, *Health Promotion in Primary Care: Physician-Patient Communication and Decision About Prescription Medications*, 41(9) SOC. SCI. MED. 1241-54 (1995) (doctors overestimated how well they gave information, discussed patients' abilities to follow treatment plan, and elicited patient's opinion about it); D.M. Tarn, J. Heritage, D.A. Paterniti, R.D. Hays, R.L. Kravits & .S. Wenger, *Physician Communication When Prescribing New Medications*, 166(17) ARCH. INTERN. MED. 1855-62 (2006) (doctors often failed to communicate critical elements about new medications prescribed)).

116 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 151 (citing J.*B.* McKinlay, *Who Is Really Ignorant: Physician or Patient?* 16(1) J. HEALTH SOC. BEHAV. 3-11 (1975) (doctors used medical jargon even after having identified the terms as ones their patients might not understand); S. Koch-Weser, W. DeJong & R.E. Rudd, *Medical Word Use in Clinical Encounters*, 12(4) HEALTH EXPECT. 371-82 (2009) (rheumatologists did not explain 79% of their terms and patients seldom responded so one could tell whether they

what they have been told, and do not comply with the treatment regime.[117] Doctors frequently underestimate the amount of information their patients want, or rely on studies of poor patient recall to justify providing less information.[118]

Today the pendulum has swung away from the doctor withholding information so the patient does not worry, to patients wanting more information and even researching their conditions themselves over the internet.[119]

A meta-analysis of various "provider behaviours" concluded that the amount of information conveyed by the doctor was "the most dramatic predictor of patient satisfaction, compliance, recall and understanding."[120] Other studies link the "provision of information to

understood); C.H. Bagley, A.R. Hunter & I.A. Bacarese-Hamilton, *Patients' Misunderstanding of Common Orthopaedic Terminology: The Need for Clarity*, 93(5) ANN. R. COLL. SURG. ENGL. 401-4 (2011) (patients exhibited low levels of understanding of common orthopaedic terms)).

117 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 152-53. Early studies showed only 50-60% of information given is recalled. *Id.* (citing S.M. Dunn, P.N. Butow, M.H. Tattersall, Q.J. Jones, J.S. Sheldon, J.J. Taylor & M.D. Sumich, *General Information Tapes Inhibit Recall of the Cancer Consultation* 11(11) J. CLIN. ONCOL. 2279-85 (1993) (cancer patients in their first interview with an oncologist remember only 45% of key points); R.B. Haynes, K.A. McKibbon & R. Kanani, *Systematic Review of Randomised Trials of Interventions to Assist Patients to Follow Prescriptions for Medications* 348(9024) LANCET 383-6 (1996) (stating that 10 - 90% - with an average of 50% - of patients do not take their prescribed drugs or take them incorrectly); K.B.H. Zolnierek & M.R. Dimatteo, *Physician Communication and Patient Adherence to Treatment: A Meta-Analysis* 47(8) MED. CARE 826-34 (2009) (meta-analysis shows communication is highly correlated with better patient adherence and that training doctors to communicate better enhances patients' adherence)). *See also* SMITH'S PATIENT CENTERED INTERVIEWING, *supra* note 8, at 135.

118 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 161-64 (citing H. Waitzkin, *Information Giving in Medical Care*, 26(2) J. HEALTH SOC. BEHAV. 81-101 (1984) (in 65% of cases doctors underestimated the amount of information their patients wanted); R. PINDER, THE MANAGEMENT OF CHRONIC DISEASE: PATIENT AND DOCTOR PERSPECTIVE ON PARKINSON'S DISEASE (1990) (doctors frequently under-disclosed to protect Parkinson's patients from worry, although most patients wanted more information and did not want protected); P. LEY, COMMUNICATION WITH PATIENTS: IMPROVING SATISFACTION AND COMPLIANCE (1988) (hospital patients — though not general practice patients — forgot a larger percentage as they were told more information, leading doctors to conclude that it is not worth telling patients very much)).

119 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 165-67 (citing M.C. Hay, R.J. Cadigan, D. Khanna, C. Strathmann, E. Lieber, R. Altman, M. McMahon, M. Kokhab & D.E. Furst, *Prepared Patients: Internet Information Seeking by New Rheumatology Patients* 59(4) ARTHRITIS RHEUM. 575-82 (2008) (over 87% of rheumatology patients had researched symptoms and suspected condition prior to their first appointment); P. Bowes, F. Stevenson, S. Ahluwalia & F.E. Murray*, I Need her to be a Doctor: Patients' Experiences of Presenting Health Information from the Internet in GP Consultations*, 62(604) BR. J. GEN. PRACT. e732-8 (2012) (patients used the internet to be informed and expected their general practitioner to acknowledge, discuss and contextualize what they had found)).

120 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 167 (citing J.A. Hall,

substantial benefits in health outcomes."[121] However, studies also show differences in preference, with 80% of the population wanting to be fully informed and 20% wanting less information.[122]

Accordingly, doctors are advised to give "information in small pieces, pausing and checking for understanding before proceedings and being guided by the patient's reactions to see what information is required next."[123] The doctor is wise to begin by inquiring into the patient's prior knowledge of the condition and asking what other information would be helpful as the consultation progresses.[124]

Research into patient recall suggests various techniques, including presenting information category by category (e.g. diagnosis, cause, treatment plan), labeling important information, giving information in small chunks and checking for understanding.[125] Repetition by the doctor has been shown to improve recall, as does patient restatement.[126] A collaborative request that the patient recount what she has understood was more effective than a yes/no question or a directive requirement to repeat the information.[127]

D.L. Roter & N.R. Katz, *Task Versus Socioemotional Behaviour in Physicians*, 25(5) MED. CARE 399-412 (1988) (conducting literature search from 1966 - 1985 that found 41 independent studies where communication variables were related to improvements in satisfaction, recall or compliance)).

121 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4 (citing S.H. Kaplan, S. Greenfield & J.E. Ware*, Assessing the Effects of Physician-Patient Interactions on the Outcomes of Chronic Disease*, 27(3 Suppl.) MED. CARE S110-27 (1989); M.A. Stewart, *Effective Physician-Patient Communication and Health Outcomes: A Review*, 152(9) CAN. MED. ASSOC. J. 1423-33 (1995); L.D. Egbert, G.E. Battit, C.E. Welch & M.K. Bartlett*, Reduction of Postoperative Pain by Encouragement and Instruction of Patients* 270 N. ENGL. J. MED. 825-27 (1964) (preoperative education from anesthetist about postoperative pain control led to less use of analgesia and to shorter hospital stays)).

122 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 167-68 (citing S.M. Miller & C.E. Mangan, *Interacting Effects of Information and Coping Style in Adapting to Gynecologic Stress: Should the Doctor Tell All?* 45(1) J. PERS. SOC. PSYCHOL. 223-36 (1983) and R. Deber, *The Patient-Physician Partnership: Changing Roles and the Desire for Information and Autonomy in Decision Making* 6(8) ACAD. EMERG. MED. 171-6 (1994)).

123 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 169.

124 *Id.* at 169-70.

125 *Id.* at 173-74 (citing P. LEY *supra* note 118 (recommending giving the most important information, especially about treatment, first due to primacy effect)).

126 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 174-75 (citing M. Kupst, K. Dresser, J.L. Schulman & M.H. Paul, *Evaluation of Methods to Improve Communication in the Physician-Patient Relationship*, 45(3) AMER. J. ORTHOPSYCHIAT. 420-9 (1975)).

127 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 175 (citing E.C. Kemp, M.R. Floyd, E. McCord-Duncan & F. Lang*, Patients Prefer the Method of 'Tell Back-Collaborative Inquiry' to Assess Understanding of Medical Information*, 21(1) J. AM. BOARD FAM. MED. 24-30 (2008); B.N. Bravo, J.M.L. Postigo, R.L Segura, J.P.S. Selva, J.J.R. Trives, M.J.A. Corcoles, M.N. Lopez & J.L.T. Hidalgo, *Effect of the Evaluation of Recall on the Rate of Information Recalled by Patients in Primary Care,* 81(2) PATIENT EDUC. COUNS. 272-4 (2010) and A.S. Fink, A.V. Prochazka, W.G. Henderson, D. Bartenfeld, C. Nyirenda, A. Webb, D.H. Berger, K. Itani, T. Whitehill, J. Edwards, M.

Studies have identified the use of medical jargon as a major problem and note that patients rarely ask for clarification.[128] Recall can be improved with clarity and simplicity, specificity, and using visual methods, including audio- or video-recordings of the consultation.[129]

While the doctor must convey the information that she thinks the patient needs, the patient's own perspective must be taken into account.[130] Studies have shown this is rarely done.[131] However, patients often covertly seek clarification, express doubt, ask for reasons or indicate their own theories.[132] When patients did these things overtly, they often got answers; but they generally did not feel it was their place to ask.[133] A key study found that patients remembered about 90% of important information their doctors had conveyed and correctly understood the key point 73% of the time.[134] Patients had difficulty with recall and understanding when there was a mismatch with their own (unexpressed) explanatory framework.[135] When patients had remembered and understood, a large majority (75%) were committed to the doctor's view. The authors of this study conclude that doctors must take two concerted approaches to achieve patient recall, understanding and commitment: clarification and exploration of the patient's own beliefs and ideas, and negotiation of a shared explanatory model.[136] Other studies have shown that eliciting patients' understanding or expectations is positively correlated with better outcomes. Accordingly, doctors should negotiate "interactional alignment" with the patient before providing diagnosis and a treatment plan in order

Wilson, C. Karsonovich & P. Parmelee, *Enhancement of Surgical Informed Consent by Addition of Repeat Back: A Multicenter, Randomized Controlled Clinical Trial*, 252(1) ANN. SURG. 27-36 (2010)).

128 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 175 (citing J.M. Mazzullo, I. Lasagna & P.F. Griner, *Variations in Interpretation of Prescription Instructions,* 227(8) JAMA 929-31 (1974)). *See also* SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 135.

129 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 176-77 (citing P. LEY, COMMUNICATION WITH PATIENTS: IMPROVING SATISFACTION AND COMPLIANCE (1988) (summarizing studies on design of printed material to improve use, understanding and recall); R. Minhas, *Does Copying Clinical or Sharing Correspondence to Patients Result in Better Care?* 61(8) INT. J. CLIN. PRACT. 1390-5 (2007) (providing recordings of consultation or writing to patients increases satisfaction, recall and understanding)).

130 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 177.

131 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 178-79 (citing D. TUCKETT, M. BOULTON, C. OLSON & A. WILLIAMS, MEETINGS BETWEEN EXPERTS: AN APPROACH TO SHARING IDEAS IN MEDICAL CONSULTATIONS (1985)).

132 *Id*. at 180.

133 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 180-81.

134 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 183 (citing TUCKETT ET AL., MEETINGS BETWEEN EXPERTS: AN APPROACH TO SHARING IDEAS IN MEDICAL CONSULTATIONS (1985)).

135 *Id.*

136 *Id.* at 183-84.

to enhance patient acceptance.[137]

Skills for Communicating with Patients recommends a collaborative approach to decision-making in order to improve patient outcomes, with respect to both patient satisfaction and adherence to the treatment regime, citing numerous studies that support this conclusion.[138] Recent studies have shown that patients increasingly prefer a shared decision-making approach.[139] The text advocates that medical providers "openly ask about patients' preferences" as this will inform patients that they have choices and they may change over time.[140]

Doctors are advised to share their own thinking and questions, offer choices, and encourage the patient to contribute ideas.[141] A challenge is explaining risks in a way the patient can understand and use in decision-making.[142] The provider should be aware of the effect of framing a risk as a positive or negative outcome, as individuals have cognitive biases against negative outcomes. Doctors should present risks by using natural frequencies rather than percentages.[143]

Another challenge is getting the patient to agree to the recommended course, as it may conflict with the patient's "views about perceived benefits, barriers and motivations."[144] The doctor may need to conduct "motivational interviewing" where the doctor fosters the patient's desire to make behavioral changes to improve his health.[145]

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[137] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 184-85 (citing Douglas W. Maynard, *Bearing Bad News* 7 MED. ENCOUNTER 2-3 (1990)).

[138] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 194-98 (citing S. Eisenthal, R. Emery, A. Lazare & H. Udin, *'Adherence' and the Negotiated Approach to Parenthood*, 36(4) ARCH. GEN. PSYCHIATRY 393-8 (1979) (higher levels of patient participation in sharing requests about treatment are associated with increased adherence and greater satisfaction); S.H. Kaplan, *supra* note 121; S.H. Kaplan, S. Greenfield, B. Gandek, W.H. Rogers & J.E. Ware, *Characteristics of Physicians with Participatory Decision-Making Styles*, 124 ANN. INTERN. MED. 497-504 (1996) (patients coached to be active participants received more information and achieved better outcomes)). *See also* SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8 at 136.

[139] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 199 (citing B. Chewning, C.L. Bylund, B. Shah, N.K. Arora, J.A. Gueguen & G. Makoul, *Patient Preferences for Shared Decisions: A Systematic Review*, 86(1) PATIENT EDUC. COUNS. 9-18 (2012)).

[140] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 199-200. Not all patients want active involvement in decision-making but prefer to leave decisions to their physicians. *Id.* at 198.

[141] *Id.* at 202.

[142] *Id*. at 203-05.

[143] *Id*. at 203. The text provides this example: If 100 patients like you took this medicine, at the end of 10 years only 4 would have had a heart attack; if they took no medication, 6 would have had heart attacks. *Id.*

[144] *Id*. at 209.

[145] *Id*. at 210. Motivational interviewing fosters the individuals' desire to make behavior changes and is based on a model described in J.O. Prochaska & C.C. DiClemente, *Toward a Comprehensive Transtheoretical Model of Change* in TREATING ADDICTIVE BEHAVIOURS, 3-24 (R. Miller & N. Heather, eds., 1986). *Id.*

Smith's Patient-Centered Interviewing has substantial advice about giving patients "bad news."[146] Patients may perceive as "bad news" diagnostic information that a doctor may consider routine.[147] The first step is for the doctor to be self-aware, as unrecognized emotions like guilt or identification with the patient can cause the doctor to avoid the bad news or give false reassurance.[148] Next, the doctor should be fully prepared regarding the diagnosis, prognosis and treatment options, as patients will ask questions.[149] Since many patients remember little after getting bad news, it is wise to prepare written information that summarizes the main points which the patient can take away.[150] The doctor should begin the conversation by ascertaining what the patient already knows or suspects then determine how much the patient wants to know about the condition.[151] The doctor should deliver the bad news by first indicating that a problem exists (a warning shot) and then share the news directly and candidly.[152] The doctor will need to use relationship-building skills to express empathy and reassure patients they will not be abandoned.[153] The doctor's "own genuine emotions are appropriate and often consoling" for patients.[154] The doctor will need to respond to the patient's questions and emotions, and move on to negotiate next steps only when the patient is ready.[155]

The *Skills for Communicating with Patients* text similarly provides a comprehensive set of consistent instructions for the bad new conversation, including that it be done in person, the doctor ascertain what the patient already knows, give a warning shot that difficult information is to follow, give basic information simply and honestly and

146 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 135, 140-46.

147 *Id.* at 135 (citing S. Eggly, et al., *Discussing Bad News in the Outpatient Oncology Clinic: Rethinking Current Communication Guidelines*, 24(4) J. CLIN. ONCOL. 716-19 (2006); and L. Fallowfield & V. Jenkins, *Communicating Sad, Bad, and Difficult News in Medicine*, 363(9405) LANCET 312-19 (2004)).

148 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 135 (citing R.C. Smith, F.C. Dwamena, & A.H. Fortin, *Teaching Personal Awareness*, 20 J. GEN. INTERN. MED. 201-07 (2005); and W.F. Baile & E.A. Beale, *Giving Bad News to Cancer Patients: Matching Process and Content*, 19(9) J. CLIN. ONCOL. 2575-7 (2001)).

149 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 142 (citing A. Girgis, R.W. Sanson-Fisher, & M.J. Schofield, *Is there Consensus Between Breast Cancer Patients and Providers on Guidelines for Breaking Bad News?,* 25(2) BEHAV. MED. 69-77 (1999)).

150 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 142.

151 *Id.* at 143.

152 *Id.* at 144.

153 *Id.*

154 *Id.* at 145 (citing A.W. Frank, *Just Listening: Narrative and Deep Illness*, 16(3) FAMILIES, SYSTEMS & HEALTH 197-212 (1998)).

155 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 145-46 (citing S. Eggly et al., *Discussing Bad News in the Outpatient Oncology Clinic: Rethinking Current Communication Guidelines*, 24(4) J. CLIN. ONCOL. 716-19 (2006)).

in small chunks, respond sensitively to the patient's reactions, offer help and support, and ally themselves with the patient.[156] This text cites many additional studies and provides a detailed framework taken from a study designed to discover whether there was a consensus of patients and providers on this important topic.[157]

5. Closing the Consultation

Finally, the social science studies of doctor/patient consultations have helped develop protocols for ending the session. *Skills for Communicating with Patients* suggests that problems in closing the session — the patient raising a new concern or confusion about the treatment plan — often arise from communication issues that occurred earlier in the consultation.[158] However, they also identify communication skills needed at the end of the session.

One study showed that patients raised new concerns at closing even after open-ended beginnings and early probing for all the issues. The authors of that study made the following observations: 1) only when both patient and doctor are ready to close the visit will they be able to do so successfully, 2) doctors should avoid asking for "anything else" or "other concerns" near the end of the session, and 3) doctors should clearly "signpost" the stages of the consultation at each point, so the patient is prepared for closing.[159]

This text identifies the following elements of successful closing: contracting with the patient about the next steps for both patient and doctor to take, establishing contingency plans if problems arise (e.g. what to do if there is a bad reaction), providing a brief summary of the session, and checking with the patient to ensure the patient agrees and is comfortable with the plan.[160]

6. Particular Issues

As lawyers encounter in legal interviewing a range of clients and need insight into the best way to help all of their clients, doctors do as well. Both *Skills for Communicating with Patients* and *Smith's Patient-Centered Interviewing* conclude by raising various special communica-

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156 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 226-233.

157 *Id.* at 233 (citing Girgis et al., *Is there Consensus Between Breast Cancer Patients and Providers on Guidelines for Breaking Bad News?,* 25(2) BEHAV. MED. 69-77 (1999)).

158 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 215.

159 *Id.* at 219-20 (citing J. White, W. Levinson & D. Roter, *'Oh by the Way': The Closing Moments of the Medical Interview,* 9 J. GEN. INT. MED. 24-8 (1994)).

160 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 220-21 (citing M. Tai-Seale, R. Bramson & X. Bao, *Decision or No Decision: How Do Patient-Physician Interactions End and What Matters?* 22(3) J. GEN. INTERN. MED. 297-302 (2007) (stating that it is important to invest in ending to ensure patient understanding.))

tion challenges, including for example, cultural and social diversity, communicating with the elderly, communicating with minor children and their parents, interviewing by telephone, and patients with mental illness or cognitive impairments.[161]

The need to discover the patient's perspective and belief holds special importance when there is cultural or social diversity. Doctors must also be sensitive to the possibility of unintentional discrimination in dealing with minority populations. The use of interpreters is also a topic for consideration, with best practices being to use professional interpreters and pay particular attention to nonverbal relationship-building skills. Knowledge of the patient's culture is very useful but should not prevent the doctor from learning about the patient as an individual.[162]

Communicating with older patients may present challenges related to special psychological and physical problems of aging. However, a study has shown the older patients accompanied by family members have shorter consultations with less psycho-social information shared. Accordingly, it remains important to deal with and to treat patients as individuals rather than as members of "the elderly."[163]

When treating children, the doctor must engage in a triadic consultation, involving both the parents and the child. There has been comparatively little research on this interactional dynamic. Parents often interrupt their children during the consultation and may disagree with them. Often the doctor may need to meet separately with the parents and an older child patient.[164]

The telephone consultation "is now becoming a common mode of doctor-patient communication."[165] Studies show patients value the improved access this offers, but there have been few studies of what it takes to make a telephone consultation successful.[166] It appears that patients may be more focused in a telephone consultation as these consultations are shorter and more often involve only a single topic. However, the doctor is advised to use more verbal cues; active listening, frequent checking for understanding, and passive listening cues are more important over the telephone.

Interviewing patients with mental illness demonstrates the core

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161 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 223-60; SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 155-88.

162 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 233-40.

163 *Id.* at 240-41.

164 *Id*. at 244-47.

165 *Id.* at 248.

166 *Id.*

skills of gathering information and building the relationship.[167] Depression is often missed in diagnosing the patient's problems. Depressed people may not be forthcoming and thus receive inadequate care. The interviewer must not only hear the patient's story, but make an informed assessment of the patient's mental state and risk of harm to himself.[168] Patients with delusions and hallucinations present even more communication challenges.[169] It is important to empathize with the patient's situation without necessarily agreeing or colluding with his or her interpretation of reality.[170] Finally, gathering information from others who know the patient can be helpful.

7. Summary of Doctor-Patient Communication Studies and Texts

The earliest studies of doctor-patient communication recorded and analyzed the actual conversations, and pointed out problems that were observed (e.g. doctors interrupting patients' narratives). As a result, doctors and medical school professors developed models of interviewing intended to correct these communication problems. There were also studies of various characteristics of the medical consultation and how well they correlated with patient satisfaction or patient compliance with treatment recommendations. The instructional models continued to be improved. Ultimately the medical community has produced evidence-based recommended protocols for doctor-patient communication: Patient-Centered Interviewing described in Smith's text[171] and the Calgary-Cambridge Guides included in the *Skills for Communicating with Patients* text.[172] Smith's method itself was subjected to random controlled studies demonstrating, first, that it was easy to learn, efficient and replicable, and, second, that its use rendered clinically significant improvement in multiple measures of patients' health and high levels of patient satisfaction.[173] Both methods

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167 *Id.* at 251.

168 *Id*. at 252.

169 *Id*. at 254.

170 *Id*. at 257.

171 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at 29-62. "The Michigan State University group, under the direction of . . . Smith developed a behaviorally defined, replicable patient-centered method based on empirical evidence, literature review, consultation with others, and their own experiences." *Id*. at xviii.

172 SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 22-26. "We present our overview of what to teach and learn in the form of the Calgary-Cambridge Guides, the centrepiece of our whole approach to communication skills teaching and a major feature of . . . this book. . . ." SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at 14.

173 SMITH'S PATIENT-CENTERED INTERVIEWING, *supra* note 8, at xviii (citing R.C. Smith et al., *Evidence-based Guidelines for Teaching Patient-Centered Interviewing*, 39 PATIENT EDUC. COUNS. 27 (2000); R.C. Smith et al., *The Effectiveness of Intensive Training for Residents in Interviewing: A Randomized, Controlled Study*, 128 ANN. INTERN. MED. 118 (1998); R.C. Smith et al., *Primary Care Clinicians Treat Patients with Medically Unex-*

are very similar and the texts that teach them cite and rely upon a wide variety of social science studies that provide the evidence to support the methods.

II. Studies of Client-Attorney Consultations — The Current Literature

The review of medical studies and the protocols developed based on these studies suggests this question: Have similar studies established how lawyers should interview and counsel their clients? The short answer is that very few social science studies have been conducted regarding client-attorney or client-student interaction. This article will briefly describe the few studies that have been mounted and summarize what we have learned from this limited research.

The article then explores, given what the many medical studies suggest about effective professional-client communication, what legal researchers could be asking about the client consultations. This article will propose various questions that could and should be addressed by the legal academy in the context of law school clinics.

A. Early Descriptive Studies: Focused on Questions Related to Professional Control

As clinical faculty were advocating participatory or client-centered lawyering, some researchers were taking tentative steps to study actual consultations with clients. As with the early medical studies, these were primarily descriptive, seeking to know exactly what goes on in the client-attorney consultations. These early studies were similarly focused on the theme of professional control, usually finding too much attorney control and not enough client-centered interaction.

The first published study considered legal service consultations by relatively inexperienced attorneys and poor clients.[174] The author personally observed over fifty initial interviews and took written notes, coding paralinguistic aspects of the conversation such as topic and floor control, interruptions, and question form.[175] He followed the cases to their conclusion, comparing the amount and kind of service the client received to the interview characteristics he analyzed.[176] The author also surveyed the lawyers about these clients and their cases.

plained Symptoms—A Randomized Controlled Trial, 21 J. Gen. Intern. Med. 671 (2006); R. Smith et al., *Primary Care Physicians Treat Somatization,* 24 J. Gen. Int. Med. 829 (2009)).

[174] Carl J. Hosticka, *We Don't Care About What Happened, We Only Care About What is Going to Happen: Lawyer-Client Negotiations of Reality*, 26 Soc. Probs. 598 (1979). The researcher was a professor of public policy and management.

[175] *Id.* at 600.

[176] *Id*. at 601.

He concluded that the attorneys controlled the problem definition and formulation of the solution in light of predetermined categories and standard solutions, but clients had some control over the "when" and "how much" assistance would be provided.[177] An independent review of the files uncovered many possible legal courses of action that were overlooked by the lawyers handling the cases.[178] The author concluded that while attorney control might be justified by limited availability of legal services and the goal of expeditiously addressing as many problems as possible, the "high degree of control exercised by lawyers in confining communication to prescribed subjects can communicate to clients the feeling that 'the system does not care' about the unique individuality of persons."[179]

The next study was of a single interview in an Israeli legal aid office and considered question form, interruptions, and topic control.[180] The authors concluded that the attorney defined the client's problem in a way that was most convenient for the bureaucracy of the legal aid office and "applie[d] her professional skills to discredit the client and deny him opportunities for self-enhancement."[181]

In the 1980s a law professor researcher observed six consumer bankruptcy attorneys, taking copious notes of each consultation and further interviewing the lawyers about their practices.[182] He characterized the interactions as being either "client-centered" or employing the "product" model, where the attorneys acted as if they were selling a product (either a Chapter 7 or Chapter 13 bankruptcy as advertised). Four of the six attorneys pursued the "product" model and exercised "virtually exclusive control over the structure, sequence, content, and length of the dialogue with the clients."[183] Only two attorneys were client centered, inviting clients to put their financial difficulties in a broader context and explaining the law and options available to the clients.[184]

Professors Austin Sarat and William Felstiner, combining legal and political science expertise, conducted an extensive study of attorney-client consultations in divorce cases, audio-taping over one hundred conversations in forty different cases, attending court hearings

177 *Id*. at 609.

178 *Id.*

179 *Id.* at 610.

180 Bryna Bogoch & Brenda Danet, *Challenge and Control in Lawyer-Client Interaction: A Case Study in an Israeli Legal Aid Office,* 4 TEXT 249 (1984).

181 *Id.* at 270.

182 Gary Neustadter, *When Lawyer and Client Meet: Observations of Interviewing and Counseling Behavior in the Consumer Bankruptcy Law Office,* 35 BUFF. L. REV. 177, 283-84 (1986).

183 *Id.* at 229.

184 *Id*. at 233.

and mediations, and interviewing both clients and attorneys.[185] Their analysis focused on ethnographic insights about the ways the lawyers and clients communicated with one another; they did not attempt to address the skills needed for the best consultation.

In their first article based on their study, they focused upon one attorney-client conference that presented the most common pattern — lawyers explaining the process, then proposing the best way for the case to be resolved, then describing how the client must behave if settlement is to be reached.[186] They characterized attorney-client conferences as "involving complicated processes of negotiation" as lawyers try to move clients' expectations and images of law and legal justice closer to reality.[187] The lawyer emphasizes the need to separate emotion from the instrumental issues of settling the case, expressing "the indifference of the law to those parts of the self that might be most salient [to the client] at the time of divorce."[188] In another article, Sarat and Felstiner focused upon the legal order that attorneys present to their divorce clients — a chaotic system in which clients cannot rely upon good faith or proficiency of opposing attorneys or of judges and for which clients must therefore rely upon their own attorney who is a knowledgeable insider.[189] "Lawyer cynicism and pessimism about legal actors and processes is a means through which they seek to control clients and maintain professional authority."[190] In their book that followed some years later, these authors continue to explore how attorneys and clients "negotiate" their relationship, showing how both lawyers and clients are able to draw on resources of power to set the agenda of their interaction in which neither one is fully in charge.[191]

B. More Recent Studies: An Increased Focus on Interviewing Skills

More recently, clinical faculty have made attempts to study attorney-client interactions with an eye to looking beyond questions of professional control as such; especially seeking to better understand client interviewing skills. Some of these studies involved actors play-

185 Austin Sarat & William L. F. Felstiner, *Law and Strategy in the Divorce Lawyer's Office*, 20 LAW & SOCIETY REV. 93, 95 (1986) [hereinafter *Law and Strategy*]. *See also* Austin Sarat & William L. F. Felstiner, *Lawyers and Legal Consciousness: Law Talk in the Divorce Lawyer's Office*, 98 YALE L. J. 1663 (1989) [hereinafter *Lawyers and Legal Consciousness*] and AUSTIN SARAT & WILLIAM L. F. FELSTINER, DIVORCE LAWYERS AND THEIR CLIENTS: POWER AND MEANING IN THE LEGAL PROCESS (1997) [hereinafter DIVORCE LAWYERS AND THEIR CLIENTS].

186 *Law and Strategy*, *supra* note 185, at 96.

187 *Id*. at 128, 126.

188 *Id*. at 132.

189 *Lawyers and Legal Consciousness*, *supra* note 185, at 1665, 1685.

190 *Id.* at 1665.

191 DIVORCE LAWYERS AND THEIR CLIENTS, *supra* note 185.

ing clients rather than real clients.

Professor Peggy C. Davis studied transcripts of students engaged in simulated "lawyer-client" interviews taken from NYU's first-year Lawyering program.[192] Analyzing topic control, interruptions, loquaciousness, and patterns of requesting/challenging, she noted a "strong pattern of dominance based upon role, with the attorney taking the interactive lead in each interview."[193] She noted two approaches, with the male duo focusing on inquiry into facts that could have legal relevance and the female duo engaged in "conversation or collaboration in which problem context and client perspective" were probed with the goal of "broader problem-solving."[194]

Professors Don and Martha Peters studied students who had been taught client-centered lawyering attempting to employ those skills while interviewing indigent clients wishing to end their marriages.[195] They observed that students had difficulty following the client-centered model in that "few open questions were asked and few active listening responses were used."[196]

I also attempted to study interviews conducted by students who had studied client-centered lawyering and were interacting with extemporaneous actors playing clients.[197] Three interviews I identified as successful were analyzed with respect to interruptions, control of the floor, time spent questioning and question form. In each case the client gave a narrative at the beginning of the meeting, and clients controlled the floor approximately half the time. Interruptions (or simultaneous talk) exceeded those in ordinary conversation but were primarily cooperative rather than competitive interruptions seeking to control or change the topic. Contrary to descriptions in the text, most of the students' utterances were not questions. They asked far more leading, yes/no and narrow questions than open questions, however the vast majority of leading questions confirmed or clarified statements that clients had already made. They did not ask questions in the recommended funnel structure (beginning with an open question and following with narrow questions). Nor did they utilize emotional reflection, but did engage in reflection for goal clarification. The arti-

192 Peggy C. Davis, *Contextual Legal Criticism: A Demonstration Exploring Hierarchy and "Feminine" Style*, 66 N.Y.U. L. REV. 1635 (1991).

193 *Id*. at 1676.

194 *Id*.

195 Don Peters & Martha M. Peters, *Maybe That's Why I Do That: Psychological Type Theory, The Myers-Biggs Type Indicator, and Learning Legal Interviewing*, 35 N.Y.L. SCH. L. REV. 169 (1985).

196 *Id*. at 184.

197 Linda F. Smith, *Interviewing Clients: A Linguistic Comparison of the 'Traditional' Interview and the 'Client-Centered' Interview*, 1 CLIN. L. REV. 541 (1995).

cle concluded that instruction in client-centered interviewing can avoid excessive professional control and that listening to a client narrative was crucial, however question form and T-funnel questioning were of lesser importance.

I employed very similar analysis of two experienced attorneys who interviewed extemporaneous actor-clients.[198] One (client-centered) attorney ceded substantial control to the client (59% client talk), and engaged in simultaneous talk no more than occurs in ordinary conversation (fewer than 5% of turns) or every 7:15. This attorney invited a narrative and was able to learn the client's problems and goals in under three minutes. He followed the narrative with questions in chronological order about the relevant events. Open questions were used to raise new and important topics, narrow and yes/no questions also produced client mini-narratives on the topics raised by the questions. The other (not client-centered) attorney conducted a longer, choppier interview, with interruptions every 42 seconds, and the attorney controlling the floor (55%). This attorney interrupted the client's narrative and did not learn the contours of the situation until nine minutes (one-third of the interview) had passed. The article concluded that the client-centered interview with the substantial narrative was the more successful approach.

Professors Gellhorn, Robins and Roth brought legal and anthropological expertise to their study. They teamed law students and anthropology students to study interviews of clients seeking federal disability benefits.[199] They recorded ten and transcribed eight interviews using "applied linguistic anthropology"[200] to analyze the conversations. Much of the learning was the two groups of students coming to understand the perspectives of the other group, with law students initially focusing on fact gathering and anthropology students honoring the clients' stories.[201] The transcripts together with video recordings allowed the law students to more accurately observe and critique their interactions (controlling the clients to a larger degree than they had imagined), leading the professors to recommend the use of video recordings rather than personal observation in teaching future law students.[202]

Professor Gellhorn relied upon twenty-nine videotaped and transcribed initial interviews to demonstrate that "clients reveal critical

198 Linda F. Smith, *Was It Good for You Too? Conversation Analysis of Two Interviews*, 96 KENTUCKY L.J. 579 (2007-2008).

199 Gay Gellhorn, Lynne Robins & Pat Roth, *Law and Language: An Interdisciplinary Study of Client Interviews*, 1 CLIN. L. REV. 245 (1994).

200 *Id.* at 254. This approach is closely related to applied conversation analysis.

201 *Id*. at 280-82.

202 *Id.* at 292-95.

self-information in their opening words" regardless of the "interviewer's role in eliciting them:"[203]

> These revelations sometimes occurred in the phase of an interview generally regarded as solely serving the purpose of putting the client as ease ("icebreakers" or "chit chat". . .) Often interviewers are focused on themselves or make the assumption that nothing substantive is happening in this phase.[204]

Gellhorn then reviewed medical literature that similarly identified opening moments as particularly important and reported difficulties when doctors interrupt the patient narrative or respond with closed questions or active listening responses based on the patient's first utterance.[205] Gellhorn proposed a model for conducting opening moments of legal interviews that involves adjustments to the techniques then taught in texts regarding legal interviewing — expect revelation of key data in the opening moments of the encounter and do not use active-listening techniques in the opening moments, as they cut off the client's story.[206]

More recently, I was able to record, transcribe and analyze an experienced attorney interviewing an adult client with Down syndrome about his exclusion from a children's museum because he did not have minor children with him.[207] This client, like Gellhorn's clients, opened with significant statements about himself — that he had a girlfriend and this problem occurred on a date. The attorney attended to this presentation of self, and returned to it in questioning the client about the situation and empathizing with the client's feelings. This allowed the client to expand upon his feelings and life circumstances, resulting in excellent rapport and understanding of the client and his goals. The attorney permitted the client to begin with a narrative, and the client spoke most of the time (54%). The attorney followed the narrative with a time line, confirming and developing facts. While many of the questions were yes/no or leading (64%, the lowest percentage in my similar studies), the attorney asked open questions at important points and for new topics. Nor did the attorney dominate with questioning — she spent as much time making statements about the interview or of empathy as she did asking questions. Although interruptions slightly exceeded normal conversation (10% rather than 5% of turns), only once did the attorney engage in a com-

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203 Gay Gellhorn, *Law and Language: An Empirically-Based Model for the Opening Moments of Client Interviews*, 4 CLIN. L. REV. 321 (1998).

204 *Id.* at 325-26.

205 *Id.* at 336-344.

206 *Id*. at 325.

207 Linda F. Smith, *Always Judged — Case Study of An Interview Using Conversation Analysis*, 16 CLIN. L. REV. 423 (2010).

petitive interruption — to stop the client's narrative to ask if she could take notes. This stands as an excellent example of client-centered interviewing in which the client's identity and attitudes are respected.

Most recently, I have used conversation analysis to analyze four experienced attorneys interviewing and counseling family law clients at a brief advice limited scope "clinic."[208] The clients typically had more than one issue they wanted addressed and their cases were far from simple. Some clients provided a written narrative on their intake papers, but none of the attorneys asked for an oral narrative. This created difficulties in most cases, as the clients inserted their stories at various points throughout the consultation. Although one attorney questioned sufficiently before turning to provide advice, three attorneys began providing advice before they understood the full picture. The first attorney was able to provide complete and relevant advice, but the other three attorneys sometimes conveyed inaccurate or irrelevant advice. The article concludes with recommended best practices for operating and interviewing in a brief advice limited scope setting.

C. Summary

The studies described above constitute the majority of those published regarding client legal consultations.[209] These studies are few in number and focus almost exclusively on the interviewing phase of the consultation. They have not been coordinated one with another, so that findings from one study could be further tested or developed in another study. Nevertheless, they parallel the medical studies in some regards. The initial studies focused on unmediated attorney-client interactions and criticized the excessive lawyer control observed. The later studies were able to reference the "client-centered" model, to compare the performances with that model, and occasionally to test the efficacy of having taught the client-centered model to students. To some small degree, these studies have confirmed aspects of the client-centered model, particularly with regard to the importance of listening to the client.

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208 Linda F. Smith, *Drinking from a Firehose: Conversation Analysis of Consultations in a Brief Advice Clinic*, 43 OHIO N.U. L. REV. 63 (2017) (A second work in progress focuses on law students interviewing and advising clients in the same brief advice limited scope "clinic").

209 There are a handful of other studies, some conducted outside the United States, and some testing how well legal interviewers conform to a given approach to interviewing. *See e.g*. Karen Barton, Clark C. Cunningham, Gregory Todd Jones & Paul Maharg, *Valuing What Clients Think: Standardized Clients and the Assessment of Communicative Competence*, 13 CLIN. L. REV. 1 (2006); Avrom Sherr, *The Value of Experience in Legal Competence*, 7 INTERNATIONAL J. LEGAL PROF. 95 (2000); John Griffiths, *What Do Dutch Lawyers Actually Do in Divorce Cases?* 20 LAW & SOC. REV. 135 (1986).

The few findings that are presented have not been fully incorporated into the law texts used to instruct students in legal interviewing and counseling. While some texts today cite to Gellhorn's conclusion that clients "will reveal critical material as soon as they have the opportunity to speak,"[210] they do not integrate this recognition with the discussion of "chit chat"[211] and do not warn against active-listening in the opening moments. Other legal texts have not incorporated Gellhorn's insights and continue to recommend chit-chat without discussing how a student's focus on ice breaking may obscure the student's recognition of important matters revealed in the opening moments.[212]

The article will explore, below, why the legal consultation has not enjoyed the same focused study as has the medical consultation, and present ideas of how to overcome some of the impediments to such study. However, it first turns to discuss various inquiries that the medical literature suggests.

III. A Proposal for Studies of Client Consultations in the Law Clinic

Given the depth and breadth of studies about medical consultations, and the impact these studies have had upon the way medical interviewing and counseling is taught, the clinical community should endeavor to mount similar studies using conversation analysis and related techniques.

Conversation analysis does not require the researcher have a hypothesis to test; rather, it is by the careful study of transcripts that the researcher discovers truths about the conversation. The clinical community can and should begin recording, transcribing and carefully analyzing client consultations to better understand the legal consultation and to observe what is more and what is less effective. This is consistent with many early medical studies.

Today medical studies combine conversation analysis with satisfaction surveys and analysis of patient compliance. The legal academy, too, should incorporate these approaches. We should correlate particular communication practices with greater client satisfaction and/or with retaining the client throughout the matter and/or success

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210 Essential Lawyering Skills, *supra* note 14, at 100.

211 *Id*. at 102. *See also* Cochran, et al., *supra* note 17, which excerpts Gellhorn's article encouraging interviewers to restrict themselves to continuers (mm-hm), at 84, but also lists "reflective statements" as "ways to encourage the client to continue," at 83.

212 "As do many social interactions, effective client meetings typically begin with a few moments of 'chit-chat.'" Lawyers as Counselors, *supra* note 5, at 83. "*Introductions and Greetings* will include introductions and whatever 'small talk' that can help make a client comfortable. This will typically involve asking directly, How can I help?" Ellmann et al., *supra* note 17, at 19.

in having the client take up the advice that is proffered.

Medical studies have sought to test the efficacy of their models, comparing the effectiveness of students and doctors who have been trained with those who have not received the same training. While all clinical students should be instructed in client-centered lawyering, it may be possible to compare our students' first interviews with their end-of-year interviews to assess the extent to which the instruction has changed the interaction. Clinic students might be recorded interviewing a mock actor before receiving instruction in interviewing, for a richer comparison. It might also be possible to compare trained clinic students with uninstructed law students where both participate in law school sponsored pro bono work that involves interviewing and counseling clients.

Both the extensive medical literature and the few legal studies that have been published suggest many topics for inquiry. Accordingly, the following ideas for study are proposed.

A. Openings

Studies of medical consultations first illuminated that patients often revealed crucial things about themselves in the opening seconds or minutes of a consultation. By recording and transcribing initial interviews, Professor Gellhorn discovered that clients often revealed significant things about themselves in the very opening exchanges but that these revelations were often missed by the students who thought they were just engaged in welcoming "chit chat."[213] This phenomenon of early self-revelation was also present (but understood and deftly incorporated) in the interview of a young man with Down syndrome.[214] Because of these studies, both the medical text and Professor Gellhorn recommend against responding with anything other than passive listening responses (uh huh, go on) during the client's initial narrative. If clinics regularly recorded and studied the initial interviews of clients, we could explore how typical this phenomenon is, whether reflection interrupts the client's narrative, and how recognizing or ignoring the self-revelation affects the rest of the interview.

Both medical and legal consultations face the possibility that the client has come with more than one concern, and the challenge when the client raises an important concern late in the consultation. In our clinics, we could explore whether the techniques developed by the medical research are successful in getting all the concerns on the table early in the consultation.

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213 Gellhorn, *Opening Moments, supra* note 203, at 325-26.

214 Smith, *Always Judged, supra* note 207, at 441-45.

Medical texts recommend maintaining eye contact throughout the initial narrative, and only turning to take notes once the narrative is complete. Our texts differ with respect to when and how the interviewer should take notes.[215] It would be interesting to experiment with the medical approach and to compare the outcomes of that approach to interviews where notes are taken from the outset.

B. Information Gathering

Medical texts, like law texts, recommend moving from open to closed questions on each topic, noting that this creates more satisfied patients and the collection of more information. Clinics could study the extent to which T-funnel questioning is used and whether clients are similarly more satisfied and more revealing when it is used. (My studies of students and attorneys interviewing actor clients did not result in many T-funnel sequences, yet, after a narrative had been given, the actor clients were forthcoming on any topic the interviewer raised irrespective of question form.)[216]

The medical texts address the problem that patients sometimes make ambiguous statements. They recommend asking clarifying questions and summarizing what has been learned at various points throughout the consultation. Clinics could study the efficacy of these techniques.

C. Rapport

Medical texts, like legal texts, emphasize the benefit of learning about the patient's perspective, noting this leads to more satisfied patients and better compliance with treatment plans. Clinics could assess the degree to which the client's perspective is listened to and explored and how this correlates with client satisfaction and client cooperation. Clients, like patients, are often asked to cooperate in developing the case (from bringing in documents to conducting themselves in certain ways) and to remain in contact. Legal clinics could attempt to correlate rapport-building techniques with greater levels of cooperation.

Medical studies have shown that patients appreciate it when doctors express empathy and that empathy correlates with better out-

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[215] LAWYERS AS COUNSELORS opines that rapport may be harmed "if your head is buried in a computer or legal pad. On the other hand, taking notes is necessary lest important data be lost and your theory development questioning be curtailed. Hence, you usually take notes as you listen to a time line narrative, and may want to explain. . ." *supra*, note 5, at 121-22; ESSENTIAL LAWYERING SKILLS suggest taking notes while listening to the client's narrative; *supra* note 14, at 104.

[216] See Smith, *Interviewing Clients*, *supra* note 197, at 586-87; Smith, *Good for You Too*, *supra* note 198, at 620-26.

comes. Legal studies too could identify empathic utterances and explore whether more expressed empathy is related to higher levels of cooperation.

Medical texts recommend the interviewer expressly ask for the patient's perspective — his thoughts and feelings about his condition — and express acceptance and understanding about those feelings. This is necessary even when the doctor will present a different perspective about the condition or the treatment. While legal texts encourage reflection and respect for the client's values, especially in the counseling phase, they do not advise that attorneys directly ask for the client's thoughts and feelings about his predicament. Maybe they should. It could be valuable to experiment with this innovation — randomly assign some students to ask about the client's thoughts and feelings, and other students to simply reflect when thoughts and feelings are volunteered. Then we could test whether this approach that is well established in medical consultations should be incorporated into legal interviewing as well.

D. Counseling

Medical studies recognize that patients have their own world view about health and illness, and advise doctors to learn and acknowledge patients' feelings about these topics. Sometimes patients covertly express doubt about the doctor's diagnosis or treatment, or reference their own theories. Doctors are advised to follow up on any such ambiguous expressions. The patients' feelings (even if the result of mental illness) must be acknowledged before the doctor attempts to inform the patients and ultimately to align the medical science and the patients' world views. Legal texts explicitly recommend that lawyers ask clients for their ideas about solutions and about extra-legal consequences. Our texts, however, do not grapple with how to respond to clients' mistaken notions about how the law or legal process works. Recording client consultations might shed light on the efficacy of exploring the clients' world view before attempting to advise, and the effectiveness of the consultation when the attorney's legal advice conflicts with some aspect of the client's beliefs or attitudes.

Medical studies have focused on how much the patient understands and is able to recall from the medical consultation. It might be useful to survey our clients for understanding and remembering, and to consider what counseling approaches lead to the best understanding and recall.

Our respect for client autonomy has lead us to teach students to counsel clients by setting forth the different choices for handling the matter, and to structure the conversation in this way. However, medi-

cal counseling proposes a different conversational structure, with the doctor providing information by category (diagnosis, cause, treatment plan) while taking the patient's perspective into account. "Bad news" medical counseling is quite clearly conveyed outside of this client-choice conversational structure. I have theorized that bad news legal counseling should be structured in a similar way.[217] In my most recent study, four attorneys providing limited scope legal advice did not structure their counseling conversation as presenting a menu of choices to clients. Rather, they "taught" the law or procedure to the clients, explaining what to do and sometimes why to do it, and only in the context of that discussion did they sometimes give the client choices.[218] It would be fascinating to have a data set of initial counseling sessions to explore the range of conversational structures that might succeed and when one structure is more appropriate than another.

IV. How Clinics Can Conduct Conversation Analysis and Related Social Science Studies Without Risks to Clients or Students

Given the depth and breadth of studies about medical consultation, one must ask "Why have similar studies not been conducted on legal consultations?" This section will briefly discuss why similar studies of legal consultations may be few and far between. Then it will explain how road blocks can be overcome and successful social science studies mounted in law clinics.

A. The Alleged Impossibility of Studying Attorney-Client Conferences

An early investigator, Brenda Danet, wrote movingly of her research team's failure to observe, record and study client-attorney interactions.[219] This 1980 article begins by making this point:

> Research on lawyer-client relationships is long overdue. It cannot be mere accident or oversight that while there have been hundreds of studies of doctor-patient communication, . . . there are hardly any parallel studies of lawyer-client communication.[220]

Danet, a sociologist and sociolinguist, added a lawyer collabora-

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[217] *See* Linda F. Smith, *Medical Paradigms for Counseling: Giving Clients Bad News*, 4 Clin. L. Rev. 391 (1998); Essential Lawyering Skills, *supra* note 14, at 295-96 (presenting the "bad news" counseling structure).

[218] Smith, *Drinking from a Firehose*, *supra* note 208, at 136-37, 149.

[219] Brenda Danet, Kenneth B. Hoffmann, & Nicole C. Kermish, *Obstacles to the Study of Lawyer-Client Interaction: The Biography of Failure,* 14 Law & Soc'y Rev. 905 (1980).

[220] *Id.* at 906.

tor, Hoffman, to her research team, and they reached out to over 300 attorneys seeking to involve them and their clients in this research. Nevertheless, they ran into difficulties, the chief among them being that attorneys were concerned about privilege being lost if their client conferences were recorded and/or observed by a researcher.[221] Another concern was complying with Clinical Research Review Committee requirements for informed consent.[222] These researchers also had the ambitious research plan of following a legal case from initial interview to final disposition, rather than simply studying attorney-client conferences. Their conclusion was that the law regarding attorney-client privilege should be changed in order "to open up the inner sanctum of the legal profession" for study.[223] Douglas Rosenthal, author of *Lawyer and Client: Who's in Charge?*, commented upon Danet's article, and suggested that researchers obtain an order from the highest court to honor the privilege for such research to take place.[224]

More recently, a team of experts in law and anthropology recorded and studied initial student-client conferences regarding disability cases.[225] They sought informed consent, addressing the psychological impact of having a third party present for the interview, but did not address the litigation risk of compelled disclosure of the confidential communications, considering the risks of such compelled disclosure to be minimal.[226] This study also sought informed consent from the participating students.[227]

Felstiner and Sarat do not address the process they used for obtaining consent from the clients and lawyers of their iconic and comprehensive study of attorney-client consultations. With respect to the issue of privilege, they obtained a "waiver of the waiver of the privi-

221 *Id.* at 917-18. Danet references Rosenthal's similar failure to obtain permission to observe attorney-client consultations and thereafter interview both attorney and client, and the reasons he identified for that failure as concerning privilege, the lawyers' reluctance to impose on their private clients, the lack of incentive for lawyers to cooperative in a venture "which could only cause them troubles" and the lawyers' reluctance to be observed.

222 *Id*. at 910-11.

223 *Id*. at 921.

224 Douglas E. Rosenthal, *Comment on "Obstacles to the Study of Lawyer-Client Interaction: The Biography of a Failure"*, 14 LAW & SOC'Y REV. 923, 928 (1980).

225 Gellhorn et al., *supra* note 199.

226 *Id.* at 272-73. The authors lay out the arguments they would make against any forced disclosure, including that privilege should not be lost as the researchers were helping to prepare the case, that researchers' sources should receive protection similar to journalists' sources, and that as a matter of public policy this sort of social science research should be protected from discovery. They also explain that risks of waiver of the privilege were muted given the context of the legal issue — a hearing before the Social Security Administration where the client has already waived confidentiality of medical, employment and similar records. *Id*. at n. 83.

227 *Id*. at n. 76.

lege" from the opposing parties in their study,[228] permitting them to record and conduct their study without creating any risk to the clients in litigation.

B. Obtaining Informed Consent and Protecting Privilege and Confidentiality

Law clinics are in a uniquely advantageous position to conduct research into client-student and client-lawyer/professor conferences while protecting confidentiality and privilege and minimizing risks to subjects.

Many clinics may already record student-client conferences for educational purposes. These recordings allow the supervising faculty member to oversee the legal work, a benefit for the client, and to provide feedback and instruction for the student, a benefit for the student. If so, the additional step of seeking permission to use the recordings for research will not involve an additional intrusion into the consultation. If student-client consultations are not already being recorded, any recording for research purposes should also be utilized to benefit the client through enhanced supervision and the student through improved feedback.

Ethics and federal legal requirements regarding research on human subjects require that risks to subjects be minimized and that informed consent be sought from all prospective subjects.[229] When some of the subjects are "likely to be vulnerable to coercion or undue influence such as children, prisoners, . . . economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects."[230] The researcher must obtain "legally effective informed consent of the subject or the subject's legally authorized representative . . .under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence."[231] The elements of informed consent must include a statement that the study involves research, an explanation of the purposes of the research and the procedures to be followed, "any reasonably foreseeable risks or discomforts to the subject," any benefits to the subject or others that

[228] Email correspondence to author from Austin Sarat, September 21, 2017, on file with author.

[229] 45 C.F.R. § 46.111(a)(1) and (4). These regulations apply to any research on human subjects carried out at an institution that receives federal funds. *See also* THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, THE BELMONT REPORT (1979).

[230] 45 C.F.R. § 46.111(b).

[231] 45 C.F.R. § 46.116.

may reasonably be expected, alternative procedures, a statement describing "the extent to which confidentiality of records identifying the subject will be maintained," an explanation of whom to contact with questions about the research and the subject's rights, and a statement that participation "is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time . . . ."[232] If the research involves more than minimal risk,[233] the informed consent must also address whether compensation is available in the event of injury.[234] Once the clinical program has determined to conduct such research, the clinic will need to present its plans for the research and its draft consent forms to the Institutional Review Board of the college or university for the IRB's approval.[235]

In light of these ethical and legal requirements, a law clinic might well decide against recording and researching conferences with certain clients because of their vulnerability and the added burden of obtaining fully informed consent from them without the possibility of coercion or undue influence. For example, a clinic representing juveniles charged with delinquency might well not wish to complicate the important rapport building process with recording the consultation and completing paperwork with both the minor client and the minor's legal guardian to permit research about the consultation.

However, most clinic clients likely will be able to consider whether to consent to the research without undue influence or coercion. If the clinic is already recording the student-client consultations and asking the client to sign documents agreeing to that recording, then adding an agreement for subsequent research should be minimally intrusive.

Once a clinic has determined that its clients and students could be recorded and their conversations analyzed, the clinic must design the research in ways that minimize risk[236] to the subjects. The protocol should include — and the informed consent document should explain — how any risk will be minimized.

With respect to the client subjects, the most significant risk is that attorney-client privilege will be lost if a social science researcher lis-

232 *Id.*

233 "Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life. . . ." 45 C.F.R. § 46.102(i).

234 45 C.F.R. § 46.116(a)(6).

235 45 C.F.R. § 46.109.

236 In any event, recording, transcribing and then analyzing student-client consultations should not involve more than minimal risk — the risk encountered in daily life. *See* 45 C.F.R. § 46.102(i).

tens to the recordings. There are various ways to deal with this concern. First, the law faculty researcher may wish to remain the sole researcher with access to the recordings, eliminating any waiver of the privilege. If guidance from a social scientist is desired, it could be obtained after the recordings have been transcribed and after names and various identifying details have been changed. In that case, the social scientist would not have been party to the confidential conversation and no privilege would have been lost; the transcripts shared with the researcher could be fully anonymized. Alternatively, the law faculty researcher may wish to delay sharing the recordings with the social scientist until after the case is concluded. Then, although the conversation might no longer be protected by attorney-client privilege, there would be no risk to the client because the case would be over.[237] Third, the law professor might reach out to opposing counsel to explore a "waiver of the waiver of privilege" as Felstiner and Sarat arranged. This should work well when there is one opposing party (e.g. for Low Income Taxpayer Clinics dealing with the IRS, with criminal defense clinics dealing with one prosecutor's office) and may also be effective with a handful of frequent opposing attorneys.

Gellhorn, who conducted her study with the social scientist listening to the recordings as the cases were still pending, has argued that privilege should not be lost or that such social science research should be protected from discovery as a matter of public policy.[238] As Gellhorn reports, while a few courts have protected academic researchers from compelled discovery, no court has held that such research is privileged or that the attorney-client privilege is maintained under these circumstances.[239] She cites a few cases that could support an argument against loss of the privilege — attorney-client privilege is not lost if the attorney involves an expert in the interview, like an accountant in order for the attorney to understand the client's finances;[240] or where an attorney asked that the client's friend participate in their conferences in order to provide a "cool head."[241] However, without a waiver from the opposing party, a change to the rule or a ruling from an authoritative court, there is a risk that the privilege could be deemed to have been waived. Accordingly, in my view, the risk of loss

[237] Gellhorn gives the example of a disability case client who was also a defendant in a criminal and civil case such that the recording might be subpoenaed for those cases. *See* Gellhorn et al., *supra* note 199. It would be my recommendation to exclude from the study any client with other pending cases for which the recording could have relevance or who makes admissions that could lead to other cases.

[238] This argument is developed in Gellhorn et al., *supra* note 199, at 273, n. 85-89.

[239] *Id.*

[240] *United States v. Kovel*, 296 F.2d 918 (2d Cir. 1961).

[241] *Newman v. State*, 863 A.2d 321, 334 (Md. 2004).

of privilege should be fully explained to the client in the Informed Consent document if a researcher is to have access to identifiable recordings during the pendency of the case.[242] A better plan is to wait until the case in concluded and the recordings can be shared with a social scientist without any risk to the client.

A final way to minimize risk of loss of privilege depends upon the issue being studied and the design of the study. For example, if the study were to compare initial interviews where the student asks the client if there are "some other issues" (rather than "any other issue") with the number of topics surfaced through this question, there might be no need for the researcher to have access to the entire recording. The student and faculty member could keep account of the number of issues raised, when they were raised, and whether using the "some other" formulation correlated with more issues being raised at the outset.

A second risk to the client and student subjects is psychological rather than legal. They may feel some loss of privacy if their conversations are recorded and analyzed. If their consultation is criticized in an article, they may feel some embarrassment. These risks should be explained in the protocol and the informed consent documents. However, these risks should be minimized by the researcher altering names and identifying information in any publication (e.g. dates, location, court, number of children, possibly gender or ages of persons mentioned in the consultation). In this way, even the subjects may not be able to recognize any excerpts that are published.

Depending upon the goals of the research and the protocol adopted, there may be additional ways to minimize risk. While early researchers often aspired to record all attorney-client conferences and also attend court hearings, there may be no need for such breadth of inquiry. If the focus is on initial interviews, it may be sufficient to record and study only those initial interactions. Similarly, if the focus is on some issue regarding client counseling, the client could be invited to participate in the study after rapport is well established, and record only counseling sessions.

If the clinic routinely records student-client interactions, there is yet another possibility for obtaining fully informed consent for research under circumstances that "minimize the possibility of coercion or undue influence."[243] That is to seek permission to conduct the research at the conclusion of the case. At that point, the client would be aware of how the student-client interaction has felt and how the case

[242] Professor Gellhorn chose not to explain this risk to her clients, and I disagree with this decision.

[243] 45 C.F.R. § 46.116.

has concluded, and would be in a much better situation to fully consider whether he or she would like the clinic to be able to use the recordings to study how to do better interviewing and counseling. The student subject, too, might be given the opportunity to consent to such study at the conclusion of the clinic semester after grades have been submitted and there is no longer the possibility of feeling coercion to consent to the study.

For purposes of studying client-attorney consultations, it would be ideal if clinical faculty also interviewed and counseled clients, and recorded and transcribed these consultations. Clients would likely agree to be recorded if it meant they got to deal directly with a faculty member, and they would likely agree to have the recording used for research and educational purposes provided privilege is not lost. As with student recordings, waiting until the case is concluded to share the recordings with outside researchers and then eliminating the maximum amount of identifying information from the transcripts should adequately protect the client.

Another approach that would further protect client confidentiality and avoid loss of privilege would be for consortia of clinical faculty to share their recordings and transcripts with one another for study. The clinic producing the recording could guarantee confidentiality and no loss of privilege if the recording were sent to a professor at another law school who would retain the raw data but not retain any identifying information including the source of the recording.

Where law schools sponsor pro bono programs, clinical faculty might also seek permission to study attorney-client or student-client consultations carried out through those programs. The clinical faculty member could become part of the pro bono program, so that there would be no loss of privilege when then clinical faculty member listens to and transcribes the consultations. As with the law clinic, the faculty member should alter identifying information in the transcripts to protect client (and attorney or student) confidentiality, and not share the recordings or transcripts with others until the case is concluded to eliminate any risk of losing attorney-client privilege. I obtained recordings of student-client and attorney-client consultations through a law school pro bono program with which I volunteer, and described the approach to this research (together with protocol and consent documents approved by the Institutional Review Board) in a recent law review article.[244]

[244] Linda F. Smith, *Community Based Research: Introducing Students to the Lawyer's Public Citizen Role*, 9 ELON L. REV. 67 (2017).

Conclusion — We Should Record, Transcribe and Study Consultations

Undertaking these studies will benefit legal education and the practice of law. Professor Gellhorn shares the significant benefit that she and her students derived from recording and transcribing their interviews:

> Students need to have a defining moment—an "aha" experience—before they will accept that 1) the clinical interview is more than just an exercise in fact gathering; process and content are a piece, 2) language is not just a medium for information exchanges; the linguistic choices one makes in an interview have interactive consequences, and 3) (perhaps most fundamentally that) their interpersonal skills need enhancement. The review of videotapes with transcripts provides the best possibility for such an experience and breaks down student resistance to having to learn skills they are convinced they already possess.[245]

The recordings and transcripts allow the students to see their successes and failures, and to become convinced of best practices. A study based on such recordings and transcripts will amplify the value to all learners.

Today our texts are predominantly based upon theories about professional-client interaction. Recording, transcribing and studying consultations will permit our texts to be, like the medical school texts, evidence based. Just as the student is convinced when he hears himself on the recording, the class should be more convinced of our lessons once we can cite evidence in support. We should endeavor to explore and test what we think we know about interviewing, counseling, rapport-building and client-centered decision-making as well as many ideas suggested by the medical studies.

For various reasons, legal education has not had the advantage of the robust social science studies into attorney-client interviewing, counseling, rapport building and decision-making that medical education has enjoyed. Fortunately, legal clinics are the ideal setting to conduct such studies while respecting client confidentiality and attorney-client privilege. We can use conversation analysis to better understand what goes on between our students, ourselves, and our clients; and can supplement that study with certain other data such as satisfaction surveys. The medical literature offers a wealth of ideas about what to study and what we might want to test. As Jerome Frank looked to medical education as a model that suggested clinics be established at law schools, we should similarly look to medical education

[245] Gellhorn et al., *supra* note 199, at 283.

as a model for using conversation analysis to study—and improve through scholarship—the ways we interact with our clients in our clinics.[246] Then we legal educators, like our medical colleagues, will be able to say "these research findings should now inform the education process and drive the communication skills curriculum forward. . . ."[247]

[246] *See* Jerome Frank, *Why Not a Clinical-Lawyer School?* 81 U. PA. L. REV. 907, 916 (1933).

[247] SKILLS FOR COMMUNICATING WITH PATIENTS, *supra* note 4, at x.