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Get Real: Why and How Clinicians Should Record, Transcribe and Study Actual Client Consultations

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Get Real:
Why and How Clinicians Should Record, Transcribe and Study Actual Client Consultations
Linda F. Smith
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"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).

Abstract

This article will argue that the legal academy has much to learn by recording, transcribing and systematically studying student-client and attorney-client consultations. Clinical faculty can utilize conversation analysis and other social science techniques to do this. Social scientists and medical providers have studied doctor-patient conversations in this way over many 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 some of these studies and their findings. Some have contended that attorney-client conversations simply cannot be recorded and studied in the same way as doctor-patient consultations due to attorney-client privilege. This article will lay out how a law clinic could obtain client informed consent to this procedure, protect client confidentiality and privilege, and gain the necessary approval of the Institutional Review Board. Finally, this article will suggest topics about client consultations that could merit study in the law clinic.

I. INTRODUCTION

Lawyers and other professionals have historically been expected to ply their "learned arts[s] in the spirit of public service"[1] which includes putting "devotion to serving . . . the client's interests" above the lawyer's self-interests.[2] Traditionally this involved the professional making recommendations and the client or patient accepting those recommendations.[3] However, in the later half of the last century this assumption of professional control began to give way. Mental health professionals asserted that the model of the passive patient was fundamentally

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

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

[3] "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." Myriam Deveugele, Forward, in JONATHAN SLIVERMAN, SUZANNE KURTZ & JULIET DRAPER, SKILLS FOR COMMUNICATING WITH PATIENTS (3rd ed., 2013). *See also* DAVID BINDER, PAUL BERGMAN, SUSAN PRICE, & PAUL TREMBLAY: LAWYERS AS COUNSELORS: A CLIENT-CENTERED APPROACH 4 (2nd ed., 2004) describing the traditional approach as lawyers "convincing clients as to what is in their best interests . . . [as] clients [are] unsuited to the task of legal problem-solving."

inconsistent with mental health treatment.[4] 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.[5] Doctors began to become concerned with doctor-patient communication.[6] In the 1970's discourse literature analyzing medical consultations began to appear.[7]

Similarly, the legal profession began to question the traditional relationship between attorney and client. In the 1970's a pioneering study was published asserting that an attorney-client relationship that was "participatory" (rather than traditionally authoritarian) produced better results.[8] Shortly thereafter the "ground-breaking book" by law professor David Binder and psychologist Susan Price[9] coined the phrase "client-centered lawyering"[10] and urged lawyers to treat clients as collaborators rather than helpless persons who need 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.[11]

The concept of client-centered lawyering has gained wide acceptance within the legal academy,[12] and law students in clinics and in simulation classes are taught this approach.[13] This literature has relied heavily upon this theoretical conception of client-centeredness and upon

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[4] Thomas Szasz & Mark Hollender, A *Contribution to the Philosophy of Medicine: The Basic Models of the Doctor-Patient Relationship*, 97 ARCHIVES OF INTERNAL MEDICINE 587, 591 (1956).
[5] *Salgo v. Leland Stanford, Jr. University Board of Trustees* 317 P.2d 170 (1957).
[6] Deveugele, *supra* note 3.
[7] Nancy Ainsworth-Vaughn, *The Discourse of Medical Encounters* in THE HANDBOOK OF DISCOURSE ANALYSIS (Deborah Schiffrin, Deborah Tannen & Heidi E. Hamilton, eds., 2003) at 453. The discourse literature consisted of conversation analysis, interactional sociolinguistics and the ethnography of communication.
[8] DOUGLAS E. ROENTHAL, 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.
[9] DAVID A. BINDER & SUSAN M. PRICE, LEGAL INTERVIEWING AND COUNSELING: A CLIENT-CENTERED APPROACH (1977)
[10] STEGAN H. KRIEGER & RICHARD K. NEUMANN, JR., ESSENTIAL LAWYERING SKILLS: INTERVIEWING, COUNSELING, NEGOTIATING AND PERSUASIVE FACT ANALYSIS, 22 (5th ed., 2015).
[11] LAWYERS AS COUNSELORS *supra* note 3 at 4-8.
[12] *Id.* at 3.
[13] *Id., See also*: STEPHEN ELLMAN, et al., LAWYERS AND CLIENTS: CRITICAL ISSUES IN INTERVIEWING AND COUNSELING 6 (2009); 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. ET AL., THE COUNSELOR-AT-LAW: A COLLABORATIVE APPROACH TO CLIENT INTERVIEWING AND COUNSELING 4 (1999).

psychological theories about human interaction.[14] Authors have also incorporated social science findings regarding memory and decision-making[15] in textbooks teaching legal interviewing and counseling skills. 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 review the handful of studies that have been done of legal consultations, their current albeit limited value, and the possible reasons such studies are in such short supply. It will then survey the wealth and diversity of studies regarding medical consultations and report on some of the interesting and possibly applicable findings. This article makes the argument that such studies would be valuable for legal education and that they are, indeed, possible. Finally, this article sets forth an approach that clinicians might take to engage in such studies and suggests questions worthy of inquiry.

II. Social Science Studies of Client Consultations

A. Early Studies of Professional Control

As clinical faculty were advocating participatory or client-centered lawyering, some researchers were taking tentative steps to study actual consultations with clients. Not surprisingly, the early studies 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.[16] 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.[17] He followed the cases to their conclusion, comparing the amount and kind of service the client received to the interview characteristics he analyzed.[18] The author also surveyed the lawyers about these clients and their cases. 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.[19] An independent review of the

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[14] *See e.g*. LAWYERS AS COUNSELORS *supra* note 3 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).
[15] *See e.g*. ESSENTIAL LAWYERING SKILLS, *supra* note 10, at 83 regarding observation and memory; LAWYERS AS COUNSELORS *supra* note 3 at382 - 391 regarding cognitive illusions; LAWYERS AND CLIENTS *supra* note 13 at 365 regarding decision-making.
[16] 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).
[17] *Id.* at 600.
[18] *Id*. at 601.
[19] *Id*. at 609.

files uncovered many possible legal courses of action that were overlooked by the lawyers handling the cases.[20] 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."[21]

The next study was of a single interview in an Israeli legal aid office. These researchers also studied question form, interruptions, and topic control.[22] They 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."[23]

In the 1980's a law professor researcher observed six consumer bankruptcy attorneys, taking copious notes of each consultation and further interviewing the lawyers about their practices.[24] 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."[25] 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.[26]

Austin Sarat and William Felstiner conducted an extensive ethnographic study of attorney-client consultations in divorce cases, audio-taping over one hundred conversations in forty different cases, attending court hearings and mediations, and interviewing both clients and attorneys.[27] In their first article they focus upon one attorney-client conference that presented the most common pattern -- lawyers explaining the process, then proposing the best way for the case to

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[20] *Id.*
[21] *Id.* at 610.
[22] Bryna Bogoch & Brenda Danet, *Challenge and Control in Lawyer-Client Interaction: A Case Study in an Israeli Legal Aid Office,* 4 TEXT 249 (1984).
[23] *Id.* at 270.
[24] 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).
[25] *Id.* at 229.
[26] *Id*. at 233.
[27] Austin Sarat & William L. F. Felstiner, *Law and Strategy in the Divorce Lawyer's Office*, 20 LAW & SOCIETY REV. 93, 95 (1986). *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) and AUSTIN SARAT & WILLIAM L. F. FELSTINER, DIVORCE LAWYERS AND THEIR CLIENTS: POWER AND MEANING IN THE LEGAL PROCESS (1997).

be resolved, then describing how the client must behave if settlement is to be reached.[28] They characterize 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.[29] 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."[30] In their next 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 an insider.[31] "Lawyer cynicism and pessimism about legal actors and processes is a means through which they seek to control clients and maintain professional authority."[32] In their book that followed some years later, these authors continued 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.[33]

B. More Recent Clinical Faculty Study Interviews

More recently clinical faculty have made a few attempts to study clients interacting with law students or with attorneys. These studies have not been focused on professional control as such, but have taken various tacks to better understand client interviewing.

Professor Peggy C. Davis studied transcripts of two simulated "lawyer-client" interviews taken from NYU's first-year Lawyering program.[34] 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."[35] 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."[36]

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

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[28] *Law and Strategy, supra* note 27 at 96.
[29] *Id*. at 128, 126.
[30] *Id*. at 132.
[31] *Lawyers and Legal Consciousness, supra* note 27, at 1665, 1685.
[32] *Id.* at 1665.
[33] DIVORCE LAWYERS AND THEIR CLIENTS supra note 27.
[34] Peggy C. Davis, *Contextual Legal Criticism: A Demonstration Exploring Hierarchy and "Feminine" Style*, 66 N. Y. U. L. REV. 1635 (1991).
[35] *Id*. at 1676.
[36] *Id*.

their marriages.[37] 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."[38]

Professor Smith similarly attempted to study interviews conducted by students who had studied client-centered lawyering and were interacting with extemporaneous actors playing clients.[39] Three interviews 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.

This same author employed very similar analysis of two experienced attorneys interviewing extemporaneous actor-clients.[40] 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. This attorney's questioning appeared to be driven by legal theories the attorney had in mind, but the client conveyed information she thought relevant even when it was only tangentially related to the question asked. Because these attorneys were interviewing in an area of law outside their expertise, a comparison of these two interviews should serve to demonstrate the benefit of client-centered interviewing by novice attorneys.

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[37] 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).
[38] *Id*. at 184.
[39] Linda F. Smith, *Interviewing Clients: A Linguistic Comparison of the 'Traditional' Interview and the 'Client-Centered' Interview*, 1 CLIN. L. REV. 541 (1995).
[40] Linda F. Smith, *Was It Good for You Too? Conversation Analysis of Two Interviews*, 96 KENTUCKY L. J. 579 (2007-2008).

Professors Gellhorn, Robins and Roth teamed law students and anthropology students to study interviews of clients seeking federal disability benefits.[41] They recorded ten and transcribed eight interviews using "applied linguistic anthropology"[42] 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 student initially focusing on fact gathering and anthropology students honoring the clients' stories.[43] 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 imagined), leading the professors to recommend the use of video recordings rather than personal observation in teaching future law students.[44]

Professor Gellhorn relied upon twenty-nine videotaped and transcribed initial interviews to demonstrate that "clients reveal critical self-information in their opening words" regardless of the "interviewer's role in eliciting them:"[45]

> 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.[46]

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.[47] 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.[48]

While some texts today cite to Gellhorn's conclusion that clients "will reveal critical material as soon as they have the opportunity to speak"[49] they do not integrate this recognition with the discussion of "chit chat"[50] and do not warn against active-listening in the opening moments.

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[41] Gay Gellhorn, Lynne Robins & Pat Roth, *Law and Language: An Interdisciplinary Study of Client Interviews*, 1 CLIN. L. REV. 245 (1994).
[42] *Id.* at 254. This approach is closely related to applied conversation analysis.
[43] *Id*. at 280-82.
[44] *Id.* at 292-95.
[45] Gay Gellhorn, *Law and Language: An Empirically-Based Model for the Opening Moments of Client Interviews*, 4 CLIN. L. REV. 321 (1998).
[46] *Id.* at 325-26.
[47] *Id.* at 336-344.
[48] *Id*. at 325.
[49] Kreiger & Neumann *supra* note 13 at 100.
[50] *Id*. at 102. See also COCHRAN, DIPIPPA & PETERS, THE COUNSELOR-AT-LAW: A COLLABORATIVE APPROACH TO CLIENT INTERVIEWING AND COUNSELING (2006) that excerpts Gellhorn's article encouraging

Other legal texts have not incorporated Gellhorn's insights and continue to recommend chit-chat without discussion of how a student's focus on ice breaking may obscure the student's recognition of important matters revealed in the opening moments.[51]

Professor Smith 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.[52] 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 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 competitive 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.

Professor Smith recently used conversation analysis to analyze four experienced attorneys interviewing and counseling family law clients at a brief advice clinic.[53] These clients typically had more than one matter or question 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 aspects of their stories that they felt were important at various points throughout the consultation. One attorney questioned sufficiently before turning to provide advice so that the advice was complete and relevant and there was time to discuss choices. Three attorneys began providing advice before they understood the full picture, and this was inefficient and

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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.

[51] "As do many social interactions, effective client meetings typically begin with a few moments of 'chit-chat.'" Binder et al. *supra* note 3 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 13 at 19.

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

[53] 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 work in progress focuses on law students interviewing and advising clients in the same brief advice clinic.

sometime resulted in inaccurate or irrelevant advice being conveyed. The article concludes with recommended best practices for brief advice clinics.

C. Current Status of Studies About Attorney-Client Consultations

The studies described above constitute the majority of studies published regarding client legal consultations.[54] As should be obvious, these studies are few in number and focus almost exclusively on client interviewing. They have not been coordinated one with another, so that findings from one site could be further tested or developed at another site. Nor have the few findings that are presented been fully incorporated into the law texts used to instruct students in legal interviewing and counseling.

III. Medical Studies of Consultations with Patients

In sharp contrast to legal studies, there have been thousands of social scientific studies of patient-provider consultations,[55] and these studies have determined what is taught to medical students about doctor-patient interaction. A leading text, published in 2013, references "over 400 papers per years listed on Medline on physician-patient relations and communication"[56] and promises to present "an evidence-based approach to communication skills in medicine":[57]

> 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

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[54] There are a handful of other studies, some conducted outside the USA, 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).

[55] "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).

[56] SILVERMAN, KURTZ & DRAPER, *supra* note 3, at Preface to the third edition. The "exponential growth in research addressing the nature, dynamics, contexts, and consequences of the medical dialogue" has perhaps been driven by the adoption of core competencies (including interpersonal communication) by accrediting bodies beginning in 2002. DEBORAH L. ROTER & JUDITH A. HALL, DOCTORS TALKING WITH PATIENTS / PATIENTS TALKING WITH DOCTORS: IMPROVING COMMUNICATION IN MEDICAL VISITS at Preface (2nd ed., 2006).

[57] SILVERMAN, KURTZ & DRAPER, *supra* note 3, at 1.

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. . . . [58]

A. A Brief History of Studies regarding Medical Consultations

The medical studies have involved different approaches, deemed the "praxis literature" and the "discourse literature" by one expert.[59] Both literatures have concerned power within the patient-provider relationship, given each party may have an agenda regarding the consultation and regarding treatment. The praxis literature has focused on control over future action and the discourse literature has focused on control over the emerging discourse.[60]

The praxis literature "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."[61] 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 follow physicians' recommendations.[62] The pros and cons of this approach have been much debated, with deficiencies being that coded categories are general, and the content of the interaction and the context of the interaction are "largely washed out."[63]

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)."[64]

> 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

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[58] *Id.*
[59] Nancy Ainsworth-Vaughn*, The Discourse of Medical Encounters*, in THE HANDBOOK OF DISCOURSE ANALYSIS 453 (Deborah Schiffrin, Deborah Tannen & Heidi Hamilton eds., 2003). Others have referenced "process analysis" and "coding" in contrast with "microanalytic approaches." *See* John Heritage & Douglas W. Maynard, *Introduction: Analyzing Interaction Between Doctors and Patients in Primary Care Encounters*, in COMMUNICATION IN MEDICAL CARE: INTERACTION BETWEEN PRIMARY CARE PHYSICIANS AND PATIENTS, 2-4 (eds. John Heritage & Douglas W. Maynard, 2006).
[60] Ainsworth-Vaughn, *supra* note 60 at 454.
[61] *Id*. at 453.
[62] *Id.* at 454.
[63] Heritage & Maynard *supra* note 60 at 7.
[64]Ainsworth-Vaughn, *supra* note 60 at 453.

> brought into medical encounters from the everyday worlds and adapted to accomplish particular tasks and address interactional dilemmas in those encounters.[65]

As in ordinary conversation, the actions in the medical consultation are seen as being jointly accomplished by all participants.[66] This approach to studying the consultation is to audio- or video-record the naturally occurring conversations, transcribe them using certain conventions, and then conduct a "fine-grained analysis" of the consultation focusing on what is being accomplished and how.[67]

Although quantitative data was originally confined to the praxis or process analysis approaches, and not utilized in CA research, today there are studies in which "quantitative analyses are built upon conversational analytic material."[68] 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.[69]

B. Medical Instructional Literature Today

The 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."[70]

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."[71] One problem has been identifying what issues the patient wishes to address. Various studies have shown that many of the patients' concerns are not elicited or addressed.[72] "Several studies have shown that patients often have more than one concern to discuss."[73] Yet patients often withhold

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65 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).
66 *Id.*
67 *Id.* Conversation analysis (CA) does not attempt to determine why the participants behave as they do.
68 Debra Roter, *Forward* in COMMUNICATION IN MEDICAL CARE: INTERACTION BETWEEN PRIMARY CARE PHYSICIANS AND PATIENTS (eds. John Heritage & Douglas W. Maynard, 2006).
69 Heritage & Maynard, *supra* note 64 at 8 (citations omitted).
70 SILVERMAN, KURTZ & DRAPER, *supra* note 3 at 34.
71 *Id.* at 35.
72 *Id.*
73 *Id.* at 43.

psychosocial or other concerns until later in the visit.[74] An important study by Beckman and Frankel has shown that the order with which patients present their concerns in 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.[75] 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."[76]

Researchers have also pointed out the importance of listening skills.[77] 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."[78] Problems include interrupting the patients' opening statements, asking clarifying or closed questions to pursue the initial issue raised, and even reflecting the patient's words after the patient presents the first issue.[79] In these ways doctors direct the conversation to the first issue and prevent the patient from raising other concerns. One serious problem with this is that 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. 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.[80]

Other recommended "attentive listening" approaches during the opening moments include non-verbal skills including "posture, movement, proximity, direction of gaze, eye contact, gestures, affect, vocal cues . . . facial expression, touch, physical appearance and environmental

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[74] *Id*. at 47.

[75] *Id*. at 43. *See* 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).

[76] *Id*. 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).

[77] *Id.* at 47, citing Beckman and Frankel, supra note 76 and Beckman et al., *Soliciting the Patients Complete Agenda: Relationship to the Distribution of Concerns*. 33 CLIN. RES. 714 A (1985).

[78] Id. at 47.

[79] *Id*. at 48.

[80] *Id*. at 51.

cues. . ." and picking up on the patient's verbal and non-verbal cues.[81] "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."[82]

The medical text 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.[83] 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).[84]

2. Gathering Information

Medical students have long been taught to obtain a traditional medical history, concentrating on the underlying disease mechanism in order to arrive at a diagnosis.[85] Today's texts argue against a doctor-centered practice, in favor of "patient-centered clinical interviewing" or "relationship-centered care" in which the patient's experience of the illness and ideas, feelings, and expectations about the illness and treatment are equally important to consider.[86] They recommend moving from open to closed questions on each topic in order to learn the patient's perspective as well as diagnostic facts.[87] The 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 express themselves, and that concluding with closed questioning resulted in more information.[88]

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[81] *Id.*

[82] *Id*. at 51-52. This observation is consistent with Gay Gellhorn's observation that clients often say very meaningful things about themselves in the opening seconds of the interview, which students may miss if they think they are just engaged in ice breaking or chit chat. See *supra* note 46.

[83] *Id*. at 52.

[84] *Id.* at 53 citing Heritage et al. *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 and 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).

[85] *Id*. at 62-64.

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

[87] *Id*. at 74. The "open-to-closed" cone is similar to the "T-funnel" recommended in the Binder legal texts. See BINDER et al. *supra* note 9 at 171.

[88] *Id*. at 78-79.

During the information gathering stage of the consultation, repeating or echoing what the patient had said encouraged the patient to continue.[89] 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.

At all stages patients are giving verbal and non-verbal cues about their concerns, which doctors frequently miss.[90] The text recommends attentive listening, asking for clarification when statements are vague or ambiguous, and periodically summarizing the information learned to check for accuracy.[91]

The text 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.[92] 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 accept.[93] 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.[94] Many studies have documented a relationship between the patient-centered approach and patient satisfaction and compliance.[95] Even where the doctors did not provide the treatment desired by the patients, there was no decline in satisfaction where the doctors fully discussed the situation with the patients.[96]

Finally, the text points out studies that show patient-centered consultations are not more time-consuming than traditional consultations.[97]

3. Rapport

The SKILLS FOR COMMUNICATING WITH PATIENTS text notes that nearly all the communication skills it advocates also "contribute to building a solid relationship with the patient."[98] 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,

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[89] *Id.* at 82.
[90] *Id*. at 84.
[91] *Id*. at 84-87.
[92] *Id.* at 88.
[93] I*d*. at 89.
[94] *Id*. at 90 - 92. Examples included studies of treatment of chronic headaches, hypertension, upper respiratory infections, psychosocial problems, diabetes and general practice.
[95] *Id.* at 92.
[96] *Id*. at 93.
[97] *Id*. at 95.
[98] *Id*. at 119.

physical distance, tone of voice, smiling, nodding -- make a difference to patients. 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.[99] Computers, too, can come between doctor and patient, so doctors should endeavor to use the computer collaboratively with the patient.

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 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 mutually understood common ground.[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 empathy, 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]

Various studies have shown that patients are more satisfied and have improved health outcomes with doctors who express empathy.[108] In contrast, simple reassurance (the most common response by doctors) led to no improvements.[109]

The final skill in rapport building was the sharing of thoughts and providing a rationale for questions or parts of the examination.[110]

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[99] *Id.* at 132-33.
[100] *Id*. at 133.
[101] *Id.* at 133-34.
[102] *Id*. at 134.
[103] *Id*. at 135.
[104] *Id.* at 137.
[105] *Id.* at 137-38.
[106] *Id.* at 138.
[107] *Id.* at 140.
[108] *Id.* at 143-45.
[109] *Id.* at 144.
[110] *Id.* at 146-48.

4. Explanation and Planning

Research has identified significant difficulties in the explanation and planning stage of the consultation.[111] Doctors generally give little information to their patients, and often use medical jargon.[112] Patients often do not recall or understand what they have been told, and many patients do not comply with the treatment regime decided upon.[113] Doctors frequently underestimate the amount of information their patients want, or rely on studies of poor patient recall to justify providing less information.[114] 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.[115]

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."[116] Other studies link the "provision of information to substantial benefits in health outcomes."[117] However, studies also show differences in preference, with 80% of the population wanting to be fully informed and 20% wanting less information.[118]

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."[119] 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.[120] A common problem is giving advice, information or reassurance prematurely -- the doctor must complete the information-gathering phase before beginning to advise.[121]

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.[122] Repetition by the doctor has been shown to improve recall as does patient restatement.[123] A collaborative request that

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[111] *Id.* at 149.
[112] *Id*. at 149-51.
[113] *Id*. at 152-53.
[114] Id. at 161-64
[115] *Id*. at 165-67.
[116] *Id*. at 167.
[117] *Id.*
[118] *Id*. at 167-68.
[119] *Id*. at 169.
[120] *Id.* at 169-70.
[121] *Id.* at 170.
[122] *Id.* at 173-74.
[123] *Id*. at 174-75.

the patient recount what she has understood was more effective than a yes/no question or a directive requirement to repeat the information.[124]

Studies have identified the use of medical jargon as a major problem and note that patients rarely ask for clarification.[125] Recall can be improved with clarity and simplicity, specificity (specific information is better remembered than general information), and using visual methods, including audio- or video-recordings of the consultation.[126]

While the doctor must convey the information that she thinks the patient needs, the patient's own perspective must be taken into account to match information to the patient's perceived needs.[127] Studies have shown this is rarely done.[128] However, patients often covertly seek clarification, express doubt, ask for reasons or indicate their own theories.[129] When patients did these things overtly, they often got answers; but they did not feel it was their place to ask.[130] A key study found about 90% of important information was recalled by the patient and about 73% was correctly understood; an overwhelming majority (75%) who had remembered and made sense of the information were committed to the doctor's view.[131] Patients had particular difficulty with recall and understanding when there was a mismatch with their own (unexpressed) explanatory framework.[132] 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.[133] 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 to enhance patient acceptance.[134]

The SKILLS FOR COMMUNICATING WITH PATIENTS text recommends a collaborative approach to decision-making in order to improve patient outcomes, both with respect to patient satisfaction and adherence to the treatment regime, citing numerous studies that support this conclusion.[135] Recent studies have shown that patients increasingly prefer a shared decision-

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[124] *Id.* at 175.
[125] *Id*.
[126] *Id*. at 176-77.
[127] *Id*. at 177.
[128] *Id*. at 178-79. *See* TUCKETT ET AL. MEETINGS BETWEEN EXPERTS: AN APPROACH TO SHARING IDEA IN MEDICAL CONSULTATIONS (1985).
[129] *Id.* at 180.
[130] *Id*. at 180-81.
[131] *Id*. at 183.
[132] *Id.*
[133] *Id*. at 183-84.
[134] *Id*. at 184-85. *See* Douglas W. Maynard, *Bearing Bad News* 7 MED. ENCOUNTER 2-3 (1990).
[135] *Id.* at 194-98.

making approach.[136] 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.[137]

Doctors are advised to share their own thinking and questions, offer choices, and encourage the patient to contribute ideas.[138] A challenge is explaining risks in a way the patient can understand and use in decision-making.[139] 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 (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.)[140]

Balanced against the information the doctor has are the attitudes, values and preferences of the patient. The patient's "views about perceived benefits, barriers and motivations" need to be elicited for a shared, informed decision to be reached.[141] This may lead to "motivational interviewing" where the doctor fosters the patient's desire to make behavior changes to improve his health.[142]

5. Closing the Consultation

The SKILLS FOR COMMUNICATING WITH PATIENTS text suggests that problems in closing the session -- the patient raising a new concern or confusion about the treatment plan -- arise from communication issues that occurred earlier in the consultation.[143] 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.[144]

The 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

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[136] *Id*. at 199.
[137] *Id*. at 199-200.
[138] *Id.* at 202.
[139] *Id*. at 203-05.
[140] *Id*. at 203.
[141] *Id*. at 209.
[142] *Id*. at 210.
[143] *Id*. at 215.
[144] *Id.* at 219-20.

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.[145]

6. Particular Issues

The SKILLS FOR COMMUNICATING WITH PATIENTS text concludes by raising core communication skills related to breaking bad news, cultural and social diversity, age-related issues, communicating with minor children and their parents, interviewing by telephone, and patients with mental illness.

Breaking bad news is one skill that even experienced doctors find difficult. Many studies have been conducted and continue to be conducted, and today the techniques for breaking bad news are widely taught in medical school. There are also cultural differences to be navigated, with some cultures preferring that the patient not be told the bad news. (Doctors must ascertain what their actual patient desires in this regard.) The text provides a comprehensive set of 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 in small chunks, respond sensitively to the patient's reactions, offer help and support, and ally themselves with the patient.[146]

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.[147]

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."[148]

When treating children, the doctor must engage in a triadic consultation, involving both the parents and the child. There has been very little research on this interactional dynamic.

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[145] *Id.* at 220-21.
[146] *Id*. at 226-28. *See* Linda F. Smith, *Medical Paradigms for Counseling: Giving Clients Bad News*, 4 CLIN. L. REV. 391 (1998) which relies on medical literature in recommending approaches to "bad news" legal counseling.
[147] *Id.* at 233-40.
[148] *Id.* at 240-41.

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.[149]

The telephone consultation "is now becoming a common mode of doctor-patient communication."[150] 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.[151] 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 skills of gathering information and building the relationship.[152] 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.[153] Patients with delusions and hallucinations present even more communication challenges.[154] It is important to empathize with the patient's situation without necessarily agreeing or colluding with his or her interpretation of reality.[155] It is often important to gather information from others who know the patient.

IV. CONVERSATION ANALYSIS OFFERS RICH OPPORTUNITIES TO STUDY CLIENT CONSULTATIONS IN THE LAW SCHOOL

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 argue that law schools' clinical and pro bono programs should and can endeavor to produce social science studies of legal consultations using conversation analysis and related inquiries.

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.[156] This 1980 article begins by making this point:

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[149] *Id*. at 244-47.
[150] *Id.* at 248.
[151] *Id.*
[152] *Id.* at 251.
[153] *Id*. at 252.
[154] *Id*. at 254.
[155] *Id*. at 257.
[156] Brenda Danet, Kenneth B. Hoffmann, & Nicole C. Kermish, *Obstacles to the Study of Lawyer-Client Interaction: The Biography of Failure,* 14 LAW & SOCIETY REV. 905 (1980).

> 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.[157]

Danet, a sociologist and sociolinguist, added a lawyer collaborator, 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.[158] Another concern was complying with Clinical Research Review Committee requirements for informed consent.[159] 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.[160] 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.[161]

More recently, a law professor-anthropologist team recorded and studied initial student-client conferences regarding disability cases.[162] 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.[163] This study also sought informed consent from the participating students.[164]

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157 *Id.* at 906.

158 *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.

159 *Id*. at 910-11.

160 *Id*. at 921.

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

162 Gellhorn, Robins & Roth, *supra* note 42.

163 *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. n 83.

164 *Id*. at n. 76.

The iconic and comprehensive study of attorney-client consultations by Felstiner and Sarat does not address the process they used for obtaining consent from the subjects (clients and lawyers) and does not address how the issue of privilege was resolved.

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.

It is likely that many clinics 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.[165] 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."[166] 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."[167] 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 may reasonable 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

[165] 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).
[166] 45 C.F.R. § 46.111(b).
[167] 45 C.F.R. § 46.116.

time . . . ."[168] If the research involves more than minimal risk,[169] the informed consent must also address whether compensation is available in the event of injury.[170] 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.[171]

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[172] 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 listens to the recordings. There are three ways to deal with this concern. First, the law faculty researcher may wish to remain the sole researcher with access to the recordings. If guidance from a social scientist is desired, it could be obtained after the recordings have been transcribed[173] and names and identifying details changed. In that

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[168] *Id.*

[169] "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).

[170] 45 C.F.R. § 46.116(a)(6).

[171] 45 C.F.R. § 46.109.

[172] 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).

[173] The law students themselves might be tasked with transcribing the conversations. Professor Gellhorn had anthropology students produce transcripts using the system devised by Sack, Schegloff and Jefferson. See Harvey Sacks, Emmanuel A. Schegloff, &Gail Jefferson, A *Simplest Systematics for the Organization of Turn-Taking in Conversation* in STUDIES IN THE ORGANIZATION OF CONVERSATIONAL INTERACTION 7 (Jim Schenkein, ed. 1978). However, I have use a simplified approach, retaining the requirement of transcribing exactly what was said as well notations for

case, the social scientist would not have been party to the confidential conversation and no privilege would have been lost. Secondly, 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.[174]

The law faculty researcher who wishes to involve a social science researcher from the outset should be prepared to argue that the privilege has not been lost or that such social science research should be protected from discovery as a matter of public policy.[175] 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.[176] A leading case establishes that 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.)[177] Where an attorney asked that the client's friend participate in their conferences in order to provide a "cool head" privilege was not lost; only the client has the power to waive the attorney-client privilege.[178] Thus, there are strong arguments that social science researchers facilitating the best interviewing techniques should not eliminate any attorney-client privilege. However, without a change to the rule or without 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 of privilege should be fully explained to the client in the Informed Consent document if a researcher is to have access to the recordings during the pendency of the case.[179]

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 (e.g. dates, location, court, number of children, gender or ages of persons). In this way, even the subjects may not be able to recognize any excerpts that are published.

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simultaneous talk, silence, and emphasis, but eliminating some of the other nuances. See Smith, *supra* notes 39, 41, 53 and 54. Law students without formal training in conversation analysis could produce transcripts of this sort.

[174] 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. It would be my recommendation that any client with other pending cases for which the recording could have relevance be excluded from the study to eliminate that risk.

[175] This argument is developed in Gellhorn, Robins & Roth *supra* note 42 at 273, n. 85 - 89.

[176] *Id.*

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

[178] *Newman v. State*, 384 Md. 285, 308; 863 A.2d 321, 334 (2004).

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

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 a counseling session scheduled for final decision-making.

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."[180] 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 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.

It would also 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.

Law schools that sponsor pro bono programs might also seek permission to study attorney-client or student-client consultations carried out through those programs. The clinical faculty member / lawyer could become part of the pro bono program, in order that there 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.

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[180] 45 C.F.R. § 46.116.

Professor Smith obtained recordings of student-client and attorney-client consultations through a law school pro bono program, and described the approach she took to this research (together with consent documents used and approved by the Institutional Review Board) in a law review article[181] and published an analysis of four attorney-client.[182]

C. Why 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.[183]

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 sees 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.

V. TOPICS FOR STUDY

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 conversation. Thus, it may be sufficient for the clinical community to begin the process of recording, transcribing and carefully analyzing client consultations to begin to uncover issues we have not yet conceptualized.

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[181] Linda F. Smith, *Community Based Research: Introducing Students to the Lawyer's Public Citizen Role*, 9 ELON L. REV. 67 (2017).
[182] Linda F. Smith, *Drinking from a Firehose supra* note 54.
[183] Gellhorn, Robins & Roth*, supra* note 42 at 283.

Nevertheless, both the extensive medical literature and the few legal studies that have been published suggest many topics for inquiry. Moreover, as the medical literature now makes clear, conversation analysis can be paired with collection of other data (e.g. client satisfaction surveys) to reach conclusions about successful and unsuccessful strategies in client consultations. 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."[184] This phenomenon of early self-revelation was also present (but understood and deftly incorporated in the consultation) in the interview of a young man with Down syndrome.[185] 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 problem that the client may raise an important concern late in the consultation. Medical texts advise to avoid responding to the first issue raised with either further questions or reflection, but to use "attentive listening" giving the patient ample "wait time" to go on with the narrative. They advise making open-ended enquires about other topics or concerns and then confirming the agenda for the consultation before exploring any of the topics. Asking if there is "something else" rather than "anything else" is recommended. In our clinics, we could explore whether these techniques are successful in getting all the concerns on the table early in the consultation.

Medical texts identify the importance of nonverbal actions in establishing rapport and encouraging the patient to share concerns. They 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.[186] It would

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[184] Gellhorn, *Opening Moments, supra* note 46 at 325-26.

[185] Smith, *Always Judged, supra* note 53 at 441-45.

[186] Binder *et al.* opine 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 3 at 121-22; Kreiger & Neuman suggest taking notes while listening to the client's narrative. *Supra* note 10 at 104.

be interesting to experiment with the medical approach (no notes during the narrative) 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. (Professor Smith's study of students and attorneys interviewing actor clients did not result in many T-funnel sequences, yet the actor clients were forthcoming on any topic the interviewer raised irrespective of question form.)[187]

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 outcomes. Legal studies too could identify empathic statements and explore whether empathy is related to high levels of cooperation.

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 patient's feelings (even if the result of mental illness) must be acknowledged before the doctor attempts to inform the patient and ultimately to align the medical science and the patient's world view. Quite consistently 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.

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[187] See Smith, *Interviewing Clients, supra* note 39 at 586-87 and Smith, *Good for You Too, supra* note 41 at 620-26.

Recording client consultations might shed light on the efficacy of fully 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.

Medical texts recommend that doctors provide information in chunks, pause, ask questions to ascertain understanding, and "sign post" the different stages of the consultation. Medical texts reference "explanation and planning" and recommend that doctors share their thinking and diagnosis, share a proposed plan of management (including investigation and alternatives) and then negotiate a plan with the patient.

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, "bad news" medical counseling is successfully conveyed outside of this client-choice conversational structure, and theoretically bad news legal counseling might be successfully structured in a similar way.[188] In one study, attorneys in a brief advice clinic rarely structured their counseling 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 occasionally in the context of that discussion did they give the client choices.[189] 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.

VI. CONCLUSION

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 as a model for using conversation analysis to study--and improve through scholarship--the ways we interact with our clients in our clinics.[190]

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[188] Smith, *Bad News*, *supra* note 147.
[189] Smith, *Drinking from a Firehose, supra* note 54 at 136-37, 149.
[190] See Jerome Frank, Why Not a Clinical-Lawyer School? 81 U. Pa. L. Rev. 907, 916 (1933).