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Doctors and Lawyers: Pathways to Collaboration

***299** "HE'S SUCH A JERK!!" EDUCATION AS A RESPONSE TO PROFESSIONALLY INAPPROPRIATE
BEHAVIOR

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I. Presenting Symptoms

The room is hot and cramped, and a dozen highly trained people are performing at their peak. At the center of this activity is a single individual whose very wellbeing hangs on the resolution of this unfolding drama. The professional in charge is a seasoned veteran of "the wars." He [\[FN2\]](#) has participated in dozens of these proceedings, and his competence is unquestioned. And. . .he is a very, very difficult person to be around. He is belligerent, condescending, and disrespectful to all around him. He has an unremittingly aggressive attitude, insists on being right, and will listen to no one. Others describe him as "a screamer." He is especially hard on those with less power or status, using crude language and playing into the most banal stereotypes. He may be your preferred person for this crisis; but a dinner guest in your home - never!

Now, consider this question: Where are we? Here is one possibility: We could be in the operating room of a major medical center, watching a surgeon of international standing at work. Here is another, equally likely location: We could be in the conference room of a large metropolitan law firm, where the senior litigation partner is taking an adversary's deposition. Remarkably, the ***300** appropriateness of the observed behavior may turn largely on whether our actor is a lawyer or a doctor.

II. Diagnosis

This scenario describes only one of a host of behaviors considered unprofessional by the legal and the medical professions. Lawyers and doctors both treat entrusted funds inappropriately; put their own interests above those of their clients or patients; keep poor, misleading or fraudulent records; have drug or alcohol problems; or fail to meet their continuing education requirements. While the expectations of each profession may be different, this essay focuses on traits in a particular category of behaviors that demonstrate poorly developed interpersonal communication skills, poor anger management, incivility, or related inappropriate behavior. The behavior of these professionals is disruptive to the work environment in which they act, and it frequently has a profoundly negative impact on the lives of those within their orbit.

Our example describes only one of the venues for disruptive behavior in these professions. Lawyers can be uncivil to their secretaries, they can be insensitive and thoughtless to clients, and partners can be beastly to associates. Doctors can treat the billing office person with disdain, act condescendingly to colleagues, and fail to give their patients even the most basic human compassion in times of need. This unprofessional behavior is frequently not limited to the job site either. Nevertheless this essay focuses on one of the most acute points of contact between the disruptive professional and others: the intimate interpersonal relationship that exists in settings such as the surgical suite or the deposition.

The principal reason for the difference in the professional approach towards these behaviors lies in the differing work settings of lawyers and doctors. The doctor's early professional indoctrination stresses individual decision making in a profoundly *301 hierarchical power environment. [FN3] Nonetheless, physicians usually work as members of a team, and the profession struggles to respond to the "disruptive physician," one who impedes the collaboration necessary to fulfill the healer's role. [FN4] Disruptive physicians who attract the attention of their colleagues may place their clinical privileges in jeopardy, and they certainly can cause problems for administrators. It is hard to retain nurses and other technical staff when they must interact with a disruptive physician. [FN5] Institutions have drafted protocols defining unacceptable physician behavior and outlining adverse consequences for the offending doctors. Rarely, however, do these sanctions serve as a cost-free mechanism to deal with the problem. If for no other reason, it is often difficult to separate out passionate advocacy on the patient's behalf from disruptive professional conduct. [FN6]

Lawyers, especially litigators, operate much more overtly in an individualistic milieu. [FN7] To provide the zealous advocacy *302 required by their professional codes, [FN8] they frequently take on a disruptive role, attempting to catch a witness or opposing party off guard, or making them respond from anger, nervousness, or fear. Even here, however, controlling the inappropriate behavior of lawyers is difficult. [FN9] Formal sanctions from the court are available in theory but not much in practice. [FN10] State licensing bodies have jurisdiction to regulate the disruptive, dysfunctionally aggressive attorney, but reported examples are rare. Again, there is just no clear line between the zealous advocacy required by the official regulatory rules and inappropriate behavior. There is often no bright line distinction between "Rambo" lawyering, which may be considered bad form but is still within minimally acceptable norms, and professionally sanctionable behavior. [FN11]

We do have more evidence of what constitutes unacceptable behavior for lawyers in this respect than for physicians, mainly because of a few reported cases dealing with the problem. In one such case, a judge criticized a lawyer for sending a letter threatening to "conduct the legal equivalent of a proctology exam" on opposing counsel's finances unless he settled a case. [FN12] The reviewing court considered this phrase "offensive and distinctly lacking in grace and civility" and "reflective of a general decline in the decorum level of even polite public discourse." [FN13] In another case, the infamous Texas trial attorney *303 Joe Jamail engaged in the following colloquy with opposing counsel in a deposition:

Q (by Mr. Jo--): Do you have any idea why Mr. [O] was calling that material to your attention?

Mr. Jamail: Don't answer that. How would he know what was in Mr. O's mind? Don't answer it. Go on to your next question.

Mr. [Jo--]: No, Joe -

Mr. Jamail: He's not going to answer that. Certify it. I'm going to shut it down if you don't go to your next question.

Mr. Jo--: No, Joe, Joe---

Mr. Jamail: Don't "Joe" me, asshole. You can ask some questions, but get off of that. I'm tired of you. You could gag a maggot off a meat wagon. Now, we've helped you in every way we can.

* * *

Mr. Jo--: Are you finished?

Mr. Jamail: I may be and you may be. Now you want to sit here and talk to me, fine. This deposition is going to be over with. You don't know what you're doing. Obviously someone wrote out a long outline of stuff for you to ask. You have no concept of what you are doing. Now, I've tolerated you for three hours. If you've got another question, *304 get on with it. This is going to stop one hour from now, period. Go. [FN14] The Delaware Supreme Court called this display "extraordinarily rude, uncivil and vulgar," and threatened to bar Mr. Jamail from appearing in any other case in Delaware. [FN15]

III. Contributing cause: The Industrialization of the Professions

What accounts for the increasing sensitivity to disruptive behavior in both the medical and legal professions? Many factors conspire, of course. Here is one idea: Over the past twenty years there has been a transformation of each field from what traditionally has been considered a profession to one more properly analyzed as a business. [FN16] A commentator from the UK uses language that is equally applicable to the American context: "Three intertwined and mutually reinforcing trends - the medicalization of life, the industrialization of health care, and the politicization of medicine--are actively promoting disease and fear of disease, while at the same time corroding the theory and practice of medicine." [FN17] Likewise, strong social forces have *305 advanced the legalization of life, the industrialization of legal practice, and the politicization of legal culture.

Consequences flow from this industrialization of medicine and law. The one most intriguing consequence for this essay is the subordination of an ethic of altruism. Until the early 1980s, the somewhat romanticized picture was that lawyers and doctors were members of a guild of like-minded practitioners, governed by internalized norms of service, and spurred by a substantial dose of altruism. They had a shared understanding of appropriate decorum, the boundaries of trust and professional courtesy, and their participation in a practice with a marked commitment to service.

As the socioeconomics of the professions became industrialized, the connection between the practitioner and "the other" became attenuated. How should the professions respond to this new reality? Specifically, do those who train new entrants to these professions have any responsibility to give voice to these earlier traditions of altruism, compassion and empathy? Jack Coulehan, M.D., has recently surveyed the state of professionalism training in medicine. He concludes:

Over the past several decades, medicine in the United States has evolved into a vast, increasingly expensive technological profit center, in which self-interest is all too easily conflated with altruism. . . . While specialists spent more time wielding the mighty machine, they spent less time listening to or connecting with their patients. Meanwhile, commercialism began to run rampant in medicine, including the rapid development of for-profit hospital systems and managed care organizations and the appearance of a vast array of opportunities for physicians to make money from commercial relationships, especially with

pharmaceutical companies. . . . [O]ur lingering cultural belief in equitable and relationship-based medicine haunts us *306 and casts a pall over today's machine-based medical practice. [FN18]

Coulehan sees much of contemporary medical education moving away from a “narrative-based professionalism” that integrates the interpersonal orientation expected of physicians to a “rule-based professionalism” that focuses on measurable behaviors but does little to foster virtue. [FN19] This phenomenon is also observable in legal education. A quick glance at the competencies tested by the Multistate Professional Responsibility Examination (the “ethics exam” taken as a condition of bar admission) attests to this focus on rule-based professionalism in legal education and training.

It would be surprising if this industrialization of the professions, with its diminution of altruism toward the client or the patient, did not also cause a diminution in altruism toward fellow professionals. There is a direct link between altruism, a concern for the other, and related intrapsychic phenomena such as empathy, compassion and connection. [FN20] If this is true for the professional's relationship to the person needing help, it must also be true for the professional's relation to colleagues.

IV. “Treatment” Options

A. The Unfortunate History of “Cure”

If we are concerned about mitigating the harmful effects of disruptive professional behavior, we could begin by sanctioning its perpetrators. A traditional hallmark of a “professional” group is its *307 ability to self-regulate, and we would expect the trade associations of medicine and law to perform this function.

A profession is highly specialized and grounded in a body of knowledge and skills that is given special status in the labor force, its members are certified through a formal educational program controlled by the profession, and qualified members are granted exclusive jurisdiction and a sheltered position in the labor market. Perhaps most important, professionals have an ideology that assigns a higher priority to doing useful and needed work than to economic rewards, an ideology that focuses more on the quality and social benefits of work than its profitability. [FN21]

Here again, consequences will flow from professional self-regulation. The official gatekeepers maintain tight control over requirements for professional entry, using education, fitness reporting and examination as screening devices. After admitting candidates to membership, however, both professions have a spotty record of sanctioning misconduct.

The reason for this is clear: Sanctioning professionals can be accomplished only with significant transaction costs. Invoking sanctions generally invokes due process considerations, and due process is costly. Due process requires notice and hearing, the right to be heard, stringent allocation of the burden of proof, and the right of appeal. All of these procedures conspire to make invoking formal sanctions cumbersome, costly, time consuming, and the process is invariably plagued by an uncertain outcome.

There also exists an informal conspiracy of silence that inhibits reporting a colleague's disruptive behavior. All professionals, it seems, are reluctant to squeal on their peers and *308 report to official bodies information that could adversely affect a colleague's professional standing. Perhaps we think these matters are best handled by a polite request to cease, even if ineffective. Furthermore, a formal complaint, if found unwarranted, could

leave the reporter exposed to liability.

Finally, those who are most likely to be aware of the disruptive behavior may well have profound economic disincentives to invoke sanctions. The “Rambo” attorney may carry a substantial book of business, keeping several partners and many more associates gainfully occupied. The management committee of a large litigation firm may stare blankly at the person who explains the problem and demands action. The physician who makes the operating room a seriously unpleasant place for others may be the leader of a practice group, or hold a ranking administrative position. If the anesthesiology team wants to continue to work with this doctor, they must just grin and bear it when the suite explodes with expletives. This phenomenon can be especially acute in academic medicine, where one person may control the grant stream that keeps scores of other researchers busy. If this person's behavior is unacceptable at one medical center, undoubtedly another one will welcome the bounty of money, status and publicity associated with the new hiring.

B. “Prevention” Through Education

If sanctions are an unsatisfactory remedy to cure this problem, perhaps no remedy could be more promising. We could simply wait, hoping that the perceived epidemic in inappropriate professional behavior will run its course, and in the next few years we will see a return to the idealized halcyon years of civility, decorum and manifested respect. This is, of course, a possibility. One glimmer of hope in this direction might be the increasing presence of women in both the medical and legal professions. [FN22] *309 Men have dominated these professions for centuries. Now as a thought experiment, imagine if the gender demographic of both doctors and lawyers had been overwhelmingly female from the beginning of time, with men just now reaching the higher levels of responsibility and power. Would you anticipate seeing the current level of disruptive behavior?

Merely waiting passively for change is an unpromising solution to the problem of disruptive individuals. Instead, the professions must take proactive steps to address the kinds of behaviors expected of new entrants. To be effective, this means moving responsibility for inculcating norms of respect and empathy upstream in the candidate's professional development. The development of clinical legal education provides a useful model of how this strategy can yield results.

For over a generation, the legal profession has tried to address professionalism concerns at the beginning of each candidate's career. Law schools throughout the country now routinely provide clinical legal skills training to a significant cohort of their students. This training speaks explicitly to the matter of appropriate professional behavior. [FN23] With this emphasis on professional skills training, many law students learn to apply principles of collaborative and problem solving negotiation techniques. They take courses that develop effective interviewing skills and address the role of lawyer as counselor. Certainly this professional skill-building education must be a more effective control mechanism for disruptive behavior than formal sanctioning has been, or than waiting will be.

*310 Beginning in the early 1970s, many initial clinical law practitioners came from the legal aid movement, the publicly funded program designed to provide basic legal services for the poor. This work attracted people with a progressive sociopolitical orientation and a desire to “do good.” More traditionally oriented academics viewed this new type of teacher as an illegitimate infiltrating vector. It has taken a generation plus for clinicians to work their way into the legal academy and receive the status and job security their traditional cousins have enjoyed for centuries.

These pioneers began teaching the practical skills of lawyering, such as trial practice and advocacy, cross examination techniques and deposition practice. They also frequently established clinics where students could represent live clients under faculty supervision. Medical education already provides this format in the final years of medical school, internship, and residency, where students move from the classroom to the wards to augment their book learning with direct patient experience.

The second generation of clinical legal skills training, beginning in the 1980s, emphasized the interpersonal aspects of the lawyer's work. As a result, law students can now enroll in such courses as interviewing and counseling, negotiation, mediation, and group facilitation. Law schools like Hamline, Pepperdine, Missouri and Harvard now have strong academic centers devoted to teaching, research, and training in the complete range of conflict resolution process technologies. Several law schools, like Florida and Harvard, even offer credit courses using mindfulness meditation techniques to foster professional self-understanding. For this newer professional skill development practice, the closest education analogue might be to the training of clinical social workers or psychotherapists.

There is little in the training mix of most graduate medical education programs that approaches the level of concentration and sophistication available to many law students today. There are also few medical academics with secure job status who devote their professional lives to this endeavor. Only since 1999 has the Accreditation Council for Graduate Medical Education (ACGME) *311 required that programs certify their residents' competence in professionalism as well as clinical skills. [FN24] Of the "Competencies" residency programs must now integrate into their curriculum, one is titled Interpersonal and Communication Skills. This package of skills includes:

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

- Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- Communicate effectively with physicians, other health professionals, and health related agencies;
- Work effectively as a member or leader of a health care team or other professional group[. . .]. [FN25] This is a welcome sign. Significant data establish that problem professional students become problem professionals. An elegant recent study found:

[D]isciplinary action among practicing physicians by medical boards was strongly associated with unprofessional behavior in medical school. Students with the strongest association were those who were described as irresponsible or as having a *312 diminished ability to improve their behavior. Professionalism should have a central role in medical academics and throughout one's medical career. [FN26]

Failure to take the ACGME directives seriously, and build the capacity to train residents in what they require, can have a significant downside. In 2004, ACGME temporarily withdrew accreditation from the internal medicine residency program at Johns Hopkins Medical Center for failure to comply with its new rules on residents' maximum work hours. [FN27] This was a provocative shot across the bow to all programs, warning of the perils of noncompliance. The Hopkins episode will undoubtedly influence the way in which residency programs comply with the new professional competency requirements. We can also hope that education proves to be an effective preventative. Beginning now, a generation of narrative-based professionalism training could help phys-

icians acquire a generally increased level of interpersonal and communication skills, and a correspondingly decreased incidence of disruptive behavior.

If compliance with the ACGME mandate is to be truly effective, we must rethink the skill set required to be a teacher of doctors. Based on the experience of clinical legal education, it is indisputable that teaching professionalism requires a distinct skill set, and one not necessarily found in great abundance among traditional academics. Those wanting to affect another's interpersonal behavior effectively must master a specialized body of knowledge, and more important, a specialized way of thinking *313 about professional orientation and approach. Traditional routes of entry into all fields of higher education do not cultivate the expertise essential to help others internalize professionalism as an unconscious aspect of their own orientation. [FN28] This is especially true for technically trained academics, most of whom have been concentrating on the natural sciences since adolescence, and may never have seen the inside of a sociology or psychology classroom. At present the ranks of medical educators are not populated by practitioners adept at training others in the interpersonal side of professional skills training.

V. Recommended Treatment

The next few years will provide an instructive case study of professional norm development in medical education. The ACGME mandate is the first step toward a system designed to reduce the number of disruptive physicians through early education. It is yet unclear how residency training programs will meet this new requirement. They have a variety of options. Programs could, and will be tempted to, use current faculty and clinicians to teach these skills. They could enlist senior physicians to share their experiences with residents about these matters. [FN29] They could persuade junior faculty, with already uncertain job security, to give instruction in these methodologies priority over more traditional teaching and research. [FN30] Perhaps academic *314 residency programs will begin to hire for faculty posts professionals trained in and committed to develop their competencies in these subjects. If the story of clinical legal education is any gauge, this approach seems a doubtful path for residency programs committed to providing the same core level of professionalism skills training to those in their charge as they do for the traditional clinical set.

A more promising avenue, at least in the medium run, may be for residency programs to “outsource” this required professionalism training component to people with proven expertise in how to teach these skills to others. A well-developed market sector cadre already exists. Many trainers, coaches, organizational development specialists and the like are expert at helping people become more collaborative, work better in teams, and be effective managers of conflict. There are many factors that clearly make health care “special,” but understanding the basic techniques for running a good meeting, developing good listening and communication skills, negotiating good agreements with peers and administrators, and counseling a grieving person are not among them. Medical centers should increasingly rely on those with demonstrated aptitude to teach professionalism to residents and thereby comply with the new ACGME requirements.

This effort in residency programs may be simply the beta test for a more comprehensive approach to enhancing physician professionalism skills competency. Several certifying entities are considering adopting an approach similar to that of ACGME, expanded to include physicians applying for periodic certification. If these boards can overcome the power of entrenched interests, so eventually all physicians will have to demonstrate professionalism skills competency as a condition of retaining their specialty qualification, we will see many outsourced providers interested in helping. Increasing the interpersonal skill level of all physicians *315 will de-

crease the incidence of disruptive behavior by some. If that happens, then fewer who are called to the health care sector will be tempted to say, "He's such a jerk!!" about our professional colleagues.

VI. Conclusion

Disruptive behavior by both doctors and lawyers is more than just unpleasant. It can be counterproductive, injurious to others, and corrosive of the aspirations at the core of both disciplines. If there is a remedy for the behavior that causes this disease, it will undoubtedly be found in the challenge of a novel approach to training professionals effectively. Clinical legal education provides one model. Its practitioners have developed a body of knowledge and a battery of techniques to address the tension between preparing for an industrialized profession and keeping alive the interpersonal dynamic so critical to the altruistic and empathic aspects of the work. Medical education now faces a similar challenge. Those charged with teaching medical professionalism skills must respond effectively. They could do worse than looking at existing models and seeking professional help.

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[FN2]. Yes, I know these difficult professionals are not always male. However, experience, and data, suggest that this stereotype is more accurate than not. The reader can mentally substitute a gender-neutral pronoun if helpful. See, e.g., Neal D. Kohatsu, et al., Characteristics Associated with Physician Discipline: A Case-Control Study, 164 Arch. Int. Med. 653 (2004).

[FN3]. While the explicit curriculum focuses on empathy, communication, relief of suffering, trust, fidelity, and pursuing the patient's best interest, in the hospital and clinic environment these values are largely pushed aside by the tacit learning of objectivity, detachment, self-interest, and distrust - of emotions, patients, insurance companies, administrators, and the state. Jack Coulehan, Today's Professionalism: Engaging the Mind But Not the Heart, 80 (10) Acad. Med. 892, 893 (2005).

[FN4]. See e.g., American Medical Association (AMA), Policy H 140.918 (The Disruptive Physician) and E-9.045 (Physicians With Disruptive Behavior), available at <http://www.ama-assn.org/ama/pub/category/print/8533.html> (last visited Apr. 6, 2008); see also Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

[FN5]. See Allen Rosenstein & Michelle O'Daniel, Disruptive Behavior & Clinical Outcomes: Perceptions of Nurses and Physicians, 36 (1) Am. J. Nursing 18 (2005).

[FN6]. In fact, threatening to label a doctor "disruptive" can be an effective control weapon for the institutional administrator. See Lawrence R. Huntoon, Abuse of the "Disruptive Physician" Clause, 9 (3) J. Amer. Physicians & Surgeons 68 (2004).

[FN7]. They, too, can work in teams with others in their firm, specialists or other professionals. Normally, however, these teams function to support the individualistic attorney on the point of the litigation.

[FN8]. See Model Code Of Prof'l Responsibility (1980); Model Rules Of Prof'l Conduct (1983).

[FN9]. David B. Wilkins, Who Should Regulate Lawyers?, 105 Harv. L. Rev. 801 (1992).

[FN10]. Here is how noted legal ethics expert Professor Steven Gillers of NYU puts it: "It's recognized that if lawyers' aggressive tactics and threats are going to be curtailed, judges have to do it. There's no other way. Most judges do not do it." Benjamin Weiser, A Judge Moves to Strike a Blow for Legal Decorum, N.Y. Times, June 1, 1999, at B5, available at <http://query.nytimes.com/gst/fullpage.html?res=9903E0DE1330F932A35755C0A96F958260>.

[FN11]. Peter M. Appleton, Is Winning Everything? 'Professionalism' Doesn't Have to Mean 'Doormat', Or. St. Bar Bull. (Apr. 2002), available at <http://www.osbar.org/publications/bulletin/02apr/winning.htm>.

[FN12]. *Revson v. Cinque & Cinque*, 221 F.3d 71, 79 (2d Cir. 2000).

[FN13]. *Id.*

[FN14]. *Paramount Commc'ns, Inc. v. QVC Network, Inc.*, 637 A.2d 34, 53 (Del. 1994) (citing Jean M. Cray, *Rambo Depositions: Controlling an Ethical Cancer in Civil Litigation* 25 *Hofstra L. Rev.* 561, 566-69 (1996)).

[FN15]. *Id.*

[FN16]. Arnold S. Relman, Medical Professionalism in a Commercialized Health Care Market, 298 (12) *JAMA* 2668, 2668 (2007); see also Valeria A. Fontaine, "Transformation: From Profession to Business," *The Bottom Line*, St. Bar of Cal. Law Prac. Mgmt. & Tech. Sec., Vol. 26, No. 5, (2005); David Segal, In the Business of Billing?, *Wash. Post*, Mar. 22, 1998; Richard G. Stefanacci, From Profession to Business: The Corporatizing of American Medicine, *Medpac Report to the Congress: Medicare Payment Policy* (2006); George D. Lundberg & James Stacey, *Severed Trust: Why American Medicine Hasn't Been Fixed* (Basic Books 2001).

[FN17]. Iona Heath, Promotion of Disease and Corrosion of Medicine, 51 (10) *Canadian Fam. Physician* 1320, 1320-22 (2005).

[FN18]. Coulehan, *supra* note 3, at 893.

[FN19]. *Id.*

[FN20]. See e.g., Robert B. Cialdini et al., Reinterpreting the Empathy-Altruism Relationship: When One Into One Equals Oneness, 73 (3) *J. Personality & Soc. Psychol.* 481 (1997); Daniel Goleman, *Destructive Emotions: A Scientific Dialogue With the Dalai Lama* (Bantam Dell 2003).

[FN21]. Arnold S. Relman, Medical Professionalism in a Commercialized Health Care Market, 298 (22) *JAMA* 2668, 2668 (2007).

[FN22]. In 2006, 32.6% of lawyers and 32.2% of physicians were women. United States Department of Labor, Bureau of Labor Statistics, 2007.

[FN23]. What was initially a voluntary movement in legal education is now receiving formal prodding from the accrediting body for legal education, the American Bar Association. American Bar Association, 2007-2008 Standards for Approval of Law Schools § 302, [hereinafter ABA Standard], available at <http://www.abanet.org/legaled/standards/20072008StandardsWebContent/Chapter%203.pdf>. CURRICULUM requires

in part, “(a) a law school shall require that each student receive substantial instruction in ... (4) other professional skills generally regarded as necessary for effective and responsible participation in the legal profession.”

[FN24]. Accreditation Council for Graduate Medical Education, Common Program Requirements (formerly called General Competencies), <http://www.acgme.org> (last visited Apr. 6, 2008).

[FN25]. Id.

[FN26]. Maxine A. Papadakis et al., Disciplinary Action by Medical Boards and Prior Behavior in Medical School, 353 (25) *New Eng. J. Med.* 2673 (2005) (abstract) (citing id. at 2667-72).

[FN27]. For a good summary of the episode, from the Hopkins perspective, see Patrick Gilbert & Mary Ellen Miller, Out of Time, *Hopkins Mag.* (Winter 2004), available at <http://www.hopkinsmedicine.org/hmn/W04/top.cfm>; see also Edward D. Miller, Dean of the Hopkins Medical Faculty, Times of Trouble, *Hopkins Mag.* (Winter 2004), available at <http://www.hopkinsmedicine.org/hmn/W04/postop.cfm>.

[FN28]. See e.g., Leonard L. Riskin, *The Contemplative Lawyer: On the Potential Contributions of Mindfulness Meditation to Law Students, Lawyers, and Their Clients*, 7 *Harv. Negot. L. Rev.* 1 (2002).

[FN29]. In the clinical skills training trade, this approach leads to what is called “sharing war stories” and is a demonstrably ineffective method of building appropriate professional behavior. If nothing else, the generation gap between senior faculty and residents usually puts a damper on learning in this context. It requires dramatically different skills to teach surgical residents how to open the chest of a morbidly obese patient and how to talk with that patient with sensitivity and compassion.

[FN30]. These untenured faculty members might be persuaded that taking on these training responsibilities will be as important to their career prospects as writing that grant application or completing that article. Again, the effort to legitimate clinical legal skills training suggests to the contrary. See Lawrence G. Smith, Medical Professionalism and the Generation Gap, 118 (4) *Am. J. Med.* 439 (2005).