Report of a Collaboration Between a Law School and an Emergency Medicine Residency Program for a Full-scale Medical Malpractice Litigation Simulation

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ABSTRACT

Background: Medical malpractice litigation is a prevalent challenge for emergency physicians, but there is a dearth of dedicated training in residency programs on this subject. As a result, when emergency physicians become the subject of a medical malpractice action they often find themselves ill-equipped to successfully navigate the process.

Objectives: We sought to create an in-depth medical malpractice simulation encompassing all key aspects of medical practice litigation. We collaborated with a law school for a semester-long simulation of a fabricated medical malpractice case brought against an emergency medicine (EM) resident.

Discussion: In harnessing the legal expertise of law students and faculty we were able to deliver a months-long medical malpractice simulation to our EM residency program. Similarly, in lending the medical expertise of our residents and faculty to the project, the law students were afforded a unique practical experience in learning to litigate medical malpractice.

Conclusions: The project resulted in a rich educational experience for both the EM residents and the law students. We present a guide for replication by any residency program in collaboration with a law school.

NEED FOR INNOVATION

More than 75% of emergency physicians will be named in a medical malpractice action at least once in their career,¹ but there is a dearth of training in emergency medicine (EM) residency programs on the subject of medical malpractice litigation. Issues such as understanding the components and natural course of a malpractice suit, coping with the anxiety and stress associated with being a defendant, the importance of clinical documentation, giving an

effective deposition, working with one's attorney, and the range of possible outcomes are often opaque to physicians until such time as they must experience them firsthand.

BACKGROUND

Reports of structured medical malpractice litigation education in the literature are scant. Lectures and mock depositions and trials have been reported,²⁻⁴

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although such exercises have been limited in scope and lacked the detail and experiential learning that a full-scale mock litigation provides. There has been reported collaboration between an EM residency program and a law school,⁵ although the purpose was limited to teaching deposition skills. To our knowledge, this is the first collaboration between a law school and EM residency in which all major aspects of medical malpractice litigation have been simulated during a months-long experience.

OBJECTIVE OF THE INNOVATION

We sought to deliver a realistic, immersive experience encompassing all key aspects of medical malpractice litigation. Our collaboration allowed EM faculty and residents to contribute *medical* realism to the law students' learning experience and the law professors and students to contribute *legal* realism to the EM residents experience; the goal was a mutually beneficial learning experience. The project was institutional review board exempt.

DEVELOPMENT PROCESS

The project required a collaborator from both the EM residency and the law school. We developed a course at the law school called "Medical Malpractice Litigation Practicum" and six law students enrolled. Prior coursework in evidence and trial advocacy were prerequisites so as to allow for specific focus on medical malpractice and not on the basics of trial law.

As the law professor was designing the law school course, the EM faculty member created the fact pattern for the case. Realism, clinical uncertainty, and comprehensiveness were paramount in fabricating the medical record. Realism was achieved by beginning with actual medical records from our emergency department and then carefully deidentifying them and altering the content and data to suit our needs. The result was that the fonts, layout, and appearance were authentic. Meticulous attention was paid to every facet of the visit (notes, electrocardiograms [ECGs], orders, etc.) because the medical record would be perused by all parties (especially the law students) and any irregularity would destroy the realism. Clinical uncertainty was the next major consideration, such that a reasonable argument (as judged by the facilitators) could be made by both the plaintiff and the defendant. In our scenario we devised a case of a middle-aged man with chest

pain, risk factors for coronary artery disease, an equivocal ECG, and a minimization of symptoms by the patient. He was discharged only to return hours later with an obvious ST-elevation myocardial infarction. Comprehensiveness was important because it was impossible to predict which data would become relevant during the course of the litigation, so an unabridged medical record was necessary.

The participants were then recruited. An actor was hired by the law school to serve as the plaintiff, two senior faculty members from the EM residency program were to be expert witnesses (one for the plaintiff and one for the defendant), and an EM resident was to be the defendant.

IMPLEMENTATION

At the law school, each class meeting was divided into lecture and skills performance for each component of a medical malpractice case. Practitioner lecturers from both the defense and the plaintiff's bar were guest instructors. Following the initial plaintiff/client interview simulation, the students drafted the complaint that was subsequently served to the defendant as he was in the midst of a clinical shift. Word soon spread through the department that a resident was being sued in a mock malpractice case and interest in the process among his colleagues peaked (evidenced by informal but numerous questions posed to the faculty and the "defendant" resident). The next step would be an initial defense/client meeting between the defendant and his lawyers (i.e., the law students assigned to the defense team). The client meetings were in the law school classroom setting and mentored by the law professor.

As the mock litigation progressed we engaged the EM residency at large, so that the proceedings involving their colleague could be translated vicariously into an immersive learning experience for all. We utilized lectures and discussions in weekly conference, reflective writing, and "individualized interactive instruction" (for example, each resident was tasked with drafting an expert witness report). All documents (i.e., complaint, medical record, deposition transcripts) were made available online. Through these various didactic activities (Table 1) the residents learned the components malpractice litigation, followed the progress of the case, and tracked the impact it had on their colleague. The law students, meanwhile, learned and performed the various steps of pretrial litigation with the benefit of actual physician participants.

Table 1
Topics Covered for EM Residents

Topic	Delivery
Components of a medical malpractice claim	L, D, M
The litigation process	L, D, M
Emotional/professional response to litigation	L, RW
Effective deposition techniques	L, D
Effective testimony in court	L, D, M
Expert witness reports and testimony	L, D, III, M
Courtroom process and procedure	M
Possible outcomes of litigation	L, M

Delivery methods included: Lectures and small-group discussions (L), online review of the documents and transcripts (video and print) generated during the mock litigation process (D), reflective writing assignments (RW), individualized interactive instruction assignments (III), and the mock trial (M).

The culmination was a trial before a judge and jury in a mock courtroom at the law school (held in lieu of our regularly scheduled EM conference). The residents in the gallery, although acquainted with the details of the case, self-reported being unsettled by the sight of their friend and colleague seated with his attorneys at the defense table. As the morning progressed, they appeared captivated by the direct and cross-examinations of the plaintiff, defendant, and both expert witnesses.

OUTCOMES

The desired outcome was that residents, if ever involved in a medical malpractice action, will be prepared to participate in their defense with a knowledge of the process and an awareness of common mistakes and also that they will react to a malpractice action with emotional temperance. While those outcomes are not measurable, feedback from residents indicated that this immersive experience was successful in demystifying the malpractice milieu and demonstrating the factors involved in successfully navigating it. They commented specifically on empathy with the “defendant” and an increased appreciation for importance of careful clinical documentation. Course evaluations from the law students demonstrated appreciation for the challenge of litigating a mock case with actual medical experts.

REFLECTIVE DISCUSSION

We identify three potential limitations involved in replicating this project:

1. The law school may wish to offer the course every year, but repeating the full exercise annually would be of limited benefit to the EM residents. To address this, we have maintained the relationship between the law school and the residency by supplying faculty and resident volunteers to participate in the law school class annually, but to repeat the full simulation (for the residency program) every 3 to 4 years.
2. There were financial costs. We utilized a professional actor to portray the plaintiff and a stenographer to record the depositions; the law school paid their fees. Where this funding is unavailable, it is possible to depend on a volunteer plaintiff and to record/transcribe depositions.
3. While an argument could be made against physicians participating in the training of future plaintiff malpractice litigators, we believe that the civil justice system benefits from competent advocacy for all parties and also that the transfer of knowledge should not be limited by the hypothetical possibility that a learner might later use that knowledge to litigate a frivolous suit against a physician.

The collaboration described here is transferrable to any EM residency program in which a law school exists within reasonable geographical proximity. Interdisciplinary cooperation can add value to both legal and medical education,⁶ and knowledge sharing among EM learners and law learners (and their respective teachers) is as natural as it is mutually beneficial. The legal expertise rendered by the law school participants and the medical expertise rendered by the EM residency participants yielded a rich learning experience for all parties. The project was well adapted to the time constraints involved for an EM residency curriculum and also to the requirements and schedule for a law school elective.

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