Original Paper

Preclinical Medical Students' Reflections on Physician Litigation Narratives in an Interdisciplinary Online Medico-Legal Workshop: Qualitative Study

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Abstract

Background: The transition from clinical care to medico-legal conflict inflicts lasting psychological strain on physicians, and the culture of malpractice fear is absorbed by medical students long before they face independent liability. Most medical curricula address this risk through abstract legal instruction rather than the emotional and relational realities that students will encounter, leaving a critical gap in early professional identity formation.

Objective: This study aimed to explore preclinical medical students' self-reported reflections on physician litigation narratives and expert judicial perspectives, focusing on their malpractice anxiety, communication mindsets, legal literacy, and perceived coping mechanisms during formative training.

Methods: A 120-minute synchronous workshop connected physician narrators, a mediating judge, and a lawyer with fourth-year preclinical students at the National Defense Medical University in Taipei, Taiwan, in August 2021. The workshop was delivered online via Google Meet due to pandemic-related campus restrictions. The workshop combined physician testimonials describing civil and criminal litigation experiences, perspectives from a mediating judge and a lawyer, and an open discussion forum. Of the 171 enrolled students, 139 (81.3%) submitted written reflections addressing communication barriers, conflict-related stress and support, and mediation dynamics. Reflections were analyzed using inductive thematic analysis, with social learning theory applied as an interpretive lens to guide the discussion of the findings.

Results: Three dominant themes emerged: communication breakdown rooted in mutual informational and emotional misunderstandings between physicians and patients; the psychological isolation physicians face during litigation, which is offset by institutional, legal, and peer support structures; and a marked divide between students inclined toward compassionate compromise

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and those committed to defending their professional integrity against unfounded claims. A subset of students responded to the material with rigid, adversarial framing, suggesting that exposure to litigation realities does not uniformly foster adaptive coping.

Conclusions: Students' reflections following exposure to authentic physician narratives revealed perceived conceptual shifts in how preclinical students view malpractice anxieties, with students describing a reframing of litigation stress from an isolating personal concern toward a broader understanding of structured communication and mediation. Nevertheless, a small subgroup of students expressed lingering self-protective concerns regarding legal settlement, highlighting the importance of providing psychologically supportive and debriefed learning environments. These findings support integrating narrative-based, interdisciplinary medico-legal education into early clinical training to strengthen both communication competence and professional identity formation. Synchronous online conferencing provided a feasible delivery mechanism under distance learning constraints.

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KEYWORDS

medical malpractice; physician-patient communication; social learning theory; professional identity formation; qualitative research; videoconferencing

Introduction

The physician-patient relationship is the foundation of health care, representing a unique covenant of trust, in which the physician acts as both a technical expert and a compassionate healer. The quality of this dyad significantly affects clinical outcomes [1,2]. However, a breakdown in this relationship, particularly when the relationship transitions into medico-legal litigation, causes significant psychological distress for physicians. This systemic strain often forces clinicians to discontinue their careers early or adopt defensive practices, ultimately contributing to a critical depletion of the national health care workforce [3-6].

This destructive shift from cooperation to confrontation exposes a deep vulnerability in clinical training [7]. Compounding this tension is the widespread unfamiliarity with legal procedures among practicing physicians. Many are uncertain about how to navigate a lawsuit and erroneously believe they must cease all communication with the outside world once a dispute begins, a misconception that contributes to profound professional and personal isolation [8-10]. This enduring culture of malpractice fear does not remain contained among senior staff; it is subtly transmitted through clinical role modeling and institutional culture to junior physicians and medical students who are just beginning their training [11,12].

This pervasive anxiety creates a critical intervention window during the early stages of professional identity formation (PIF), the developmental period during which students internalize the core values and behaviors of the medical profession [13]. As medical students do not yet hold independent licenses or bear direct legal liability, they rarely worry about being sued themselves at this stage. However, continued exposure to an institutional culture of litigation fear may lead them to prematurely adopt defensive medical practices intended to avoid legal warfare rather than prioritize patient care [14,15]. This negative introduction to the medical profession not only dampens their clinical enthusiasm but also drives them away from high-risk specialties, ultimately threatening to deplete the future health care workforce [16].

Addressing this looming workforce crisis necessitates a fundamental paradigm shift in how medical ethics and clinical conflict are taught [8]. Traditional didactic lectures often fail to deeply engage students or reflect the nuanced, high-stakes realities of legal and emotional confrontation in the hospital [11]. To bridge the gap between abstract textbook theory and the chaotic realities of clinical practice, experiential and simulation-based learning environments are essential. By integrating authentic medico-legal scenarios, role-playing, and interdisciplinary expert insights, this structured approach can reframe a traditionally dry subject into a relatable, memorable, and psychologically safe learning experience [17,18].

The evaluation of this experiential curriculum is grounded in complementary pedagogical frameworks that explain how professional mindsets are acquired and internalized. Rather than relying on passive legal instruction, the workshop leverages social learning theory through the strategic use of physicians' authentic litigation narratives as influential examples of professional role modeling [19]. Through this approach, students engage in vicarious learning by observing how seasoned mentors have navigated real-world professional vulnerabilities and legal crises. By listening to these lived narratives and interacting directly with legal and medical experts, trainees are guided to reflect on clinical vulnerabilities and conceptualize practical, real-world communication strategies, translating others' lived experiences into their own professional insights.

By providing a psychologically safe environment in which students can explore these professional vulnerabilities, this narrative-driven approach seeks to facilitate dialogue on clinical communication and encourage self-directed reflection. By bringing together medical expertise and legal-ethical perspectives, this structured interaction offers preclinical students an opportunity to engage with the complex realities of modern health care. Building on this premise, this study aimed to explore preclinical medical students' self-reported reflections following an interdisciplinary workshop featuring physicians' litigation narratives and expert judicial perspectives, focusing on how they conceptualize their malpractice anxiety, communication mindsets, legal literacy, and perceived coping mechanisms during their formative training.

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Methods

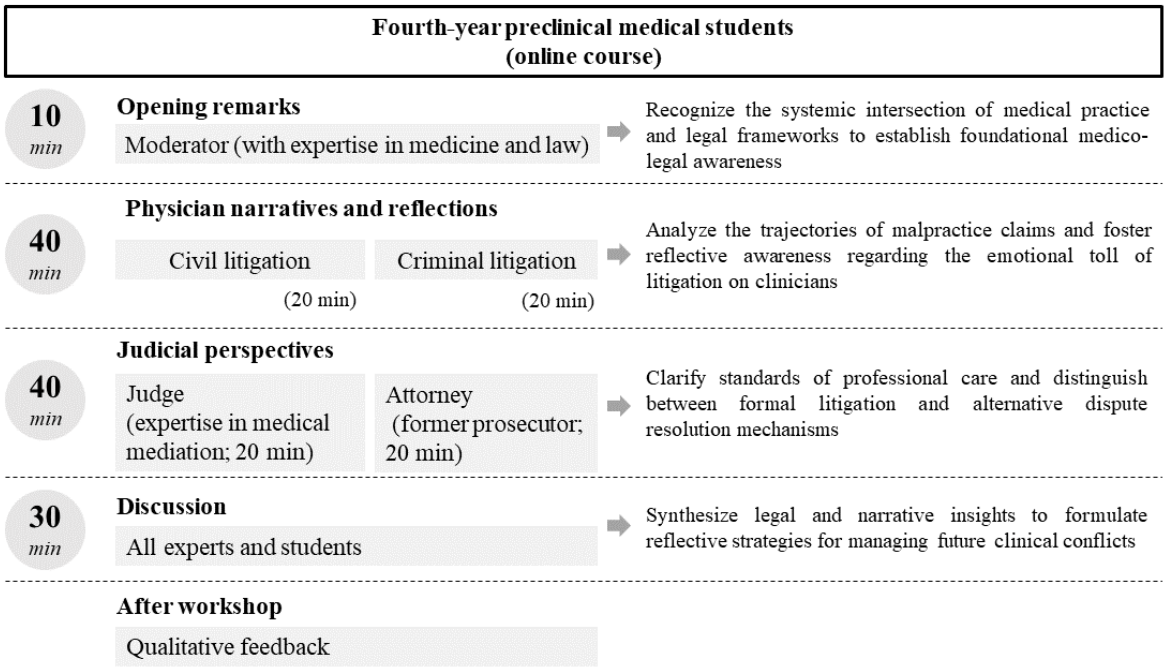
Study Design

This study used a qualitative exploratory design, grounded in a constructivist research paradigm, to evaluate how an interdisciplinary medico-legal workshop shaped fourth-year preclinical medical students' professional anxieties, communication mindsets, and educational needs at the National Defense Medical University (NDMU). The investigation focused on how students perceive and internalize the litigation narratives of experienced physicians to develop adaptive coping mechanisms and practical legal literacy relevant to their emerging clinical identities.

The workshop was conducted in August 2021 using a synchronous videoconferencing platform (Google Meet; Alphabet Inc), a delivery mode necessitated by Taiwan's level 2 pandemic restrictions on campus capacity and requirements for remote instruction in higher education at the time. This technology-mediated format enabled the real-time participation of a geographically and professionally dispersed panel, including physician narrators, a judge, and a lawyer, within a single synchronous session, illustrating how videoconferencing infrastructure can support interdisciplinary medico-legal education beyond the constraints of physical colocation [20].

A structured 120-minute workshop (Figure 1) was developed to elucidate the complexities of physician-patient communication through four sequential segments:

Figure 1. Interdisciplinary medico-legal workshop for preclinical medical students (120 minutes).



First, in the opening remarks, a moderator with dual expertise in medicine and law provided an overview of the medico-legal landscape (10 minutes).

Second, 2 physicians shared their firsthand experiences with litigation, focusing separately on civil and criminal liability. Each physician was given 20 minutes to describe their personal case trajectories and the profound emotional impact of the legal process (40 minutes total).

Third, a judge specializing in medical mediation and a lawyer with a prosecutorial background provided practical legal insights on procedural and defensive strategies (40 minutes total).

Fourth, the workshop included an interactive discourse forum, in which there was a direct exchange between the expert panel and the students (30 minutes).

Reflection documents were received via email by a coinvestigator with no teaching or grading role in the course, who replaced student names with the last 3 digits of each student's institutional ID prior to coding. This narrative-based reflection exercise provided a psychologically unconstrained space for trainees to engage in thoughtful, in-depth reflection, capturing the nuanced evolution of their professional mindsets and the perceived relevance of legal literacy to their future clinical practice.

Participants

Rather than selecting a purposive subset, the study population comprised all 171 fourth-year medical students (n=125, 73.1% male; n=46, 26.9% female) enrolled in a medical ethics and law course, as all enrolled students were invited to participate. Among these students, 139 (81.3%) submitted written reflection reports.

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Measurement: Qualitative Instruments

To understand the pedagogical impact of the workshop, the study used 3 open-ended reflection prompts. Rather than serving as a rigid examination, these questions were designed to guide students in linking the clinicians' narratives and legal frameworks to their own developing professional identities.

To encourage authentic and meaningful reflection, a flexible response model was used. Students were allowed to choose the specific themes that felt most relevant to their individual learning needs and priorities and write about them. The three reflection prompts focused on three areas:

(1) communication barriers and competencies (What are the potential causes of difficult communication between physicians and patients? Which skills are necessary to effectively navigate challenging physician-patient interactions?); (2) conflict stress and support systems (In instances of conflict with a patient, what types of stress might you encounter, and what forms of support do you deem essential to mitigate these pressures?); and (3) the dynamics defining the concepts of mediation and resolution (During a mediation session, under which circumstances would you anticipate a successful resolution? Conversely, in what situations would you prefer the mediation to conclude unsuccessfully?).

By using open-ended text reflections rather than standardized multiple-choice surveys, this approach gave students the freedom to express their genuine insights and personal anxieties in their own words. Allowing students to freely choose their reflection prompts ensured that their responses directly captured the specific issues and practical challenges they naturally prioritized when conceptualizing medical conflict at this stage of their training.

Data Analysis

A triangulation approach was used to integrate the findings and provide a comprehensive understanding of the intervention's impact [21]. To ensure methodological rigor, the design and reporting of this qualitative study were guided by the SRQR (Standards for Reporting Qualitative Research) guidelines [22] (the completed checklist is provided in Multimedia Appendix 1 [22]). These reports underwent a thematic analysis to identify how the workshop shaped students' communication mindsets, legal literacy, and emotional coping mechanisms [23,24].

Two investigators (DYN and HJS) had received formal training in qualitative research methods prior to undertaking this analysis. Both investigators independently performed initial open coding and iteratively refined the categories through constant comparison, using Microsoft Excel to systematically manage line-by-line coding and data categorization. Themes were generated inductively from the data. Social learning theory was subsequently used as an interpretive lens during the discussion of the findings and did not inform the initial coding framework.

Regarding language processing, line-by-line coding and thematic development were performed directly on the original traditional Chinese reflection texts to preserve subtle contextual nuances. Exemplar quotations were subsequently translated into English by a bilingual researcher (DYN) and independently cross-checked for conceptual accuracy and semantic equivalence by a second bilingual investigator (HJS).

To manage researcher positionality and reflexivity, DYN was affiliated with the study institution but held no teaching, supervisory, or grading role over participants, while HJS was based at an external institution. This composition was intended to balance contextual familiarity with an outsider perspective during interpretation. Both authors compared and challenged each other's categorizations during regular debriefing sessions. Coding disagreements between the 2 primary coders were first discussed iteratively by the investigators. Where consensus could not be readily reached, the fourth author (YLT), who has extensive experience in qualitative analysis, and the principal investigator (CCW) were consulted to reach consensus on the categorization of ambiguous excerpts and the final formulation of themes, thereby enhancing the confirmability of the findings [25]. Thematic saturation was reached prior to the completion of coding, with no new primary themes or subthemes emerging in the latter portion of the dataset; nonetheless, all 139 reflection reports were coded in full to ensure comprehensive representation of the entire cohort. To ensure the rigor and trustworthiness of the findings, the researchers implemented a comprehensive suite of analytical safeguards guided by the 4 criteria of trustworthiness developed by Lincoln and Guba [26], including researcher triangulation and peer debriefing during coding, thick descriptions of the study context, and the maintenance of a detailed audit trail spanning from raw submissions to final themes (Multimedia Appendix 2).

Ethical Considerations

This study was approved by the institutional review board of Tri-Service General Hospital (B202105040) and conducted in accordance with the Declaration of Helsinki. The qualitative reflection exercise was embedded as a routine, nongraded pedagogical component within the formal course curriculum. To eliminate any potential perception of coercion or grading pressure, informed consent for research participation was sought after students had completed and submitted their reflection reports. Students were explicitly informed that participation was entirely voluntary, that opting in or out would have no bearing on their course grades or academic standing, and that they could decline or withdraw at any time without penalty. Participants received no financial or material compensation for their involvement. All reflection documents were deidentified prior to analysis and stored securely, with access restricted to the research team.

Results

Overview

Demographic characteristics of the 139 participating students are presented in Table 1. The majority were male (n=104, 74.8%), with a mean age of 21.96 (SD 1.12) years. Most were military cadets (n=84, 60.4%), followed by government-funded students (n=18, 12.9%), commissioned agency trainees (n=15, 10.8%), general civilian students (n=12, 8.6%), and self-funded overseas Chinese students (n=10, 7.2%). All participants were informed of the study's objectives, and strict anonymity was maintained throughout the research process. To ensure ethical

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integrity and minimize social desirability bias, students were explicitly informed that participation was entirely voluntary and would have no bearing on their academic evaluations, course grades, or professional standing within the NDMU.

Table 1. Demographic characteristics of participants (N=139).

Variables	Participants
Sex, n (%)	
Male	104 (74.8)
Female	35 (25.2)
Age (years), mean (SD)	21.96 (1.12)
Student status, n (%)	
Military cadets	84 (60.4)
Commissioned agency trainees	15 (10.8)
Government-funded students	18 (12.9)
General civilian students	12 (8.6)
Self-funded overseas Chinese students	10 (7.2)

Qualitative Reflections on Medico-Legal Communication in a Preclinical Cohort

As some students responded to more than 1 prompt, a total of 148 reflection entries submitted by 139 students were analyzed. Students exhibited varying levels of engagement across the 3 thematic prompts. Most reflections focused on the causes of communication difficulties and the skills needed to address them, followed by reflections on conflict-related stress and support and the complexities of legal mediation (Multimedia Appendix 3).

Bridging the Chasm of "Mutual Ignorance"

The primary domain of inquiry centered on how preclinical medical students conceptualize communication barriers and the competencies required to navigate them (response rate=56.7%). This theme comprised 2 major subthemes: the multidimensional breakdown of communication and the practical translation of clinical competencies.

The Anatomy of Communication Breakdown

Students analyzed this breakdown through the lens of persistent information and knowledge asymmetries, a structural imbalance increasingly exacerbated by modern media and unverified online content:

> *[T]he primary driver remains the inequality of information. Whenever there is an unknown, it creates an inherent feeling of uncertainty.* [Student 138]

This baseline asymmetry is further exacerbated when patients substitute professional authority with digital rumors, directly undermining clinical quality. Ultimately, this dual blindness culminates in a total breakdown in mutual understanding:

> *The internet is rife with unverified medical misinformation.... They then use these errors to challenge our expertise.* [Student 12]
>
> *They [the patients] do not know what they do not know; we [the physicians] do not know what they do not know.... Communication can easily descend into a "dialogue of the deaf."* [Student 25]

Beyond structural information gaps, communication also fractures because of cognitive divergence, which is manifested in fundamental misalignments in medical literacy and therapeutic expectations held by patients and their families. Preclinical students noted that laypersons frequently misunderstand the scientific limitations of medicine, expecting immediate outcomes when clinical reality mandates caution. This discrepancy may lead patients to perceive appropriate treatment as ineffective. When these unrealistic expectations are unmet, patients routinely externalize their disappointment, shifting responsibility entirely onto the clinician:

> *[S]ome patients do not understand that effective drugs have toxicity limits and cannot be given in doses that show immediate effects.* [Student 23]

The pervasive urgency and anxiety of the clinical environment frequently compromise patients' emotional regulation, leading them to engage under intense psychological strain and inquire about their status with heightened volatility. Crucially, this emotional tension is bidirectional; structural or triage pressures on physicians can easily be misconstrued by anxious, impatient families, thereby shattering mutual empathy and rapport:

> *Some physicians lack empathy and cannot put themselves in the patient's shoes. Similarly, some patients also lack empathy; at times, the physician's prioritization of emergency treatments may cause psychological dissatisfaction in the patient.* [Student 58]

Translating Competencies

In response to these communication barriers, the primary mechanism for addressing knowledge gaps is linguistic translation. This involves the deliberate conversion of complex medical jargon into clear, lay language to foster interpersonal rapport and clinical compliance. Students emphasized that although communication flows naturally within groups of

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individuals with similar backgrounds, clinical practice demands adaptive communication strategies:

> *If one can first translate professional knowledge into simple language and express it appropriately, the patient will perceive a greater sense of rapport and be more inclined to listen to the physician's advice, resulting in a win-win scenario.* [Student 35]

To counter emotional friction, students advocated for bidirectional perspective-taking and active listening, rejecting rigid paternalistic approaches. This requires clinicians to recognize the baseline asymmetry of experience between a seasoned professional and a panicked patient facing an illness for the first time:

> *Although a doctor may have encountered many cases similar to this patient's problem, it might be the patient's first time facing such a situation; their panic and urgency are entirely predictable...we must strive to stand in the patient's shoes.* [Student 51]

> *To ensure patient understanding, one must patiently use colloquial language to explain medical technicalities and learn to listen to the other party's thoughts rather than relying solely on a rigid stance.* [Student 68]

Students also recognized that interpersonal soft skills must be anchored by professional self-strengthening and experiential modeling. Effective communication must be systematically observed and internalized from clinical role models to ensure absolute procedural accuracy and enable clinicians to successfully navigate potential medico-legal disputes:

> *What we can do is properly enrich ourselves, ensure that every procedure and interaction is handled correctly, and learn how to properly face disputes that have already occurred.* [Student 80]

The Isolated Island and the Beacon in the Mist

The aftermath of a medical dispute often triggers a difficult psychological journey for medical students, leading to an eventual transition from deep professional isolation to an active search for systemic support (response rate=37.2%).

Multidimensional Stressors in Legal Conflict

Medical disputes can inflict a severe internal identity crisis and profound self-doubt. The anxiety of litigation can force clinicians to question their career choices and create lasting psychological barriers to performing the same clinical procedures in the future:

> *One might fall into self-doubt: Is it true that I should not have become a doctor? Will I be able to overcome the psychological barrier the next time I undergo the same surgery?* [Student 83]

This erosion of professional confidence often intensifies and worsens as the legal process drags on. Compounding this internal strain is the pure exhaustion associated with managing heavy daily clinical workloads alongside active legal proceedings. This combination leaves physicians with a state of chronic fatigue that is difficult to eliminate even after the dispute is resolved, leading to deep emotional distress:

> *If the medical workload is heavy and one must simultaneously handle legal matters, one may become physically and mentally exhausted; the fatigue remains difficult to fully eliminate even after the incident is finally resolved.* [Student 86]

This isolation is further exacerbated by external pressure and social stigma. Public exposure through the media subjects the incident to intense public scrutiny and damages professional reputations, making clinicians feel as though they have been instantly cast as the "villain" as soon as a dispute begins and their actions are questioned:

> *When medical conflict arises, my immediate sensation is that of being cast as the "villain," as the patient side begins to question my actions.* [Student 114]

Institutional, Social, and Psychological Buffers

To counter this isolation, students emphasized the need for formal hospital support and legal protection. Because clinicians involved in disputes cannot face these crises alone, medical institutions must provide specialized staff to help handle the dispute:

> *When encountering a medical dispute, the involved physician will inevitably feel overwhelmed; therefore, medical institutions may need to assign specialized personnel to provide assistance.* [Student 87]

They also emphasized the importance of using alternative dispute resolution (ADR) pathways, such as mediation, supported by hospital resources that integrate legal counsel and social work services to protect physician well-being. Alongside formal systems, informal social buffers and peer mentorship play a vital role. Students explicitly look for psychological preparation from experienced senior physicians to understand what to expect during litigation and how to cope with it, which is essential to prevent career burnout:

> *Identifying trusted individuals to alleviate emotional distress and learning how to recalibrate one's psychological state are paramount for long-term professional well-being.* [Student 118]

This emphasis on support leads to a personal mandate for psychological calibration. Participants believe that responsible physicians must reject defensive avoidance, courageously face conflicts, and adjust their mindsets to achieve closure and professional growth:

> *A responsible physician must bravely fulfill his/her duty to face patients and their families, as avoidance is never an ideal solution. Beyond expressing concern for the patient, physicians must proactively adjust their mindset to make a fresh start, rather than remaining trapped by the emotional burden of past clinical conflicts.* [Student 133]

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The Trade-Off Between Compassionate Compromise and Defending Innocence

Deciding how to resolve a medical dispute involves a careful balance between professional empathy and the need to protect one's integrity (response rate=6.1%). The findings reveal a clear division in student preferences, ranging from seeking pragmatic harmony to standing firm on legal principles.

The Sanctuary of Concord

Choosing to settle a dispute often stems from a combination of relational care and realistic risk management. Some students view settlement as a means to heal the physician-patient relationship through radical transparency. By honestly explaining procedural risks and admitting the limitations of modern medicine, they believe they can foster mutual understanding and help families find closure despite a poor clinical outcome:

> *After sincerely explaining the reasons, considerations, and potential risks of all treatment-related medical procedures, if a problem unfortunately occurs that current medical standards cannot overcome, I would express regret and understanding for such a situation as a future healthcare professional.* [Student 135]

Others view settlement as a purely pragmatic choice to limit professional damage. If the hospital is clearly at fault or if the patient is highly influential but makes reasonable financial demands, an early settlement is viewed as a strategic way of maintaining peace and protecting the institution's reputation. Furthermore, when facing a minor lawsuit that threatens to cause severe physical and mental exhaustion, compromise is considered a sensible way to avoid the substantial costs and time required for court attendance:

> *If, after evaluation through the relevant channels, I am found to have little fault, and the patient's family is seeking "justice," I would, if financially feasible and after weighing the time cost involved, carefully state that my medical conduct was found to comply with standard practice under expert appraisal. However, out of empathy for the patient's family facing the physical and emotional toll of illness, I would be willing to provide a reasonable amount of compensation as a gesture of goodwill.* [Student 134]

The Crucible of Truth

In sharp contrast, when faced with unreasonable or extortionate demands, students strongly reject compromise to protect their professional integrity. If the medical team had committed no clinical errors, students advocated for principled resistance, choosing to pursue legal action to prove their innocence with factual evidence rather than succumbing to financial pressure:

> *When the medical side clearly did not commit any errors or improper procedures, yet the patient's side persistently demands unreasonable compensation, I hope the mediation fails. I hope that the patient's side can resolve this issue. I would take it to court and hire a lawyer to prove the physician's innocence with factual evidence, while simultaneously using a successful case to warn others that one cannot win against the medical profession simply by being unreasonable.* [Student 137]

They view the courtroom not just as a burden but as a necessary tool for judicial deterrence; a successful case can serve as a warning that unreasonable demands will not compel the medical profession to back down. This uncompromising stance is deeply tied to the defense of professional dignity. Because legal battles consume valuable time that should be spent saving lives, students expressed a strong willingness to contest groundless claims to the very end and even countersue for defamation to ensure that the legal literacy of physicians is no longer underestimated:

> *If it is purely the patient being unreasonable or exaggerating the situation, then I would prefer the mediation to fail, because I have done nothing wrong. If I agreed to a settlement, it would be equivalent to admitting fault, which could actually invite greater trouble later on. Therefore, sometimes one must stand firm and argue on principle.* [Student 140]

Discussion

Principal Findings

This study suggests that an interdisciplinary workshop centered on firsthand physician narratives may support medical students in reframing their perceptions of clinical conflict from an internalized source of anxiety toward a manageable professional concern. Students' reflections revealed 4 perceived conceptual shifts relevant to early PIF: (1) the reframing of malpractice anxiety, (2) the role of narratives in demystifying legal processes, (3) the hierarchy of developmental concerns, and (4) the internalization of ethical honesty as a component of professional identity.

Long before entering the clinical environment, preclinical medical students harbor deep-seated anxieties regarding medical litigation, fueled by pervasive societal rumors and sensationalized media reports. This environment fosters an informal transmission of anxiety, whereby students inherit a profound fear of malpractice from the broader medical culture even before their first patient encounter [12]. Such vicarious anxiety can lead to significant self-doubt, with students questioning their career choices prior to clinical entry [27]. Within medical education literature, this phenomenon exemplifies the impact of the hidden curriculum, through which unstructured narratives and cultural anxieties inadvertently shape students' emotional baseline and threat perceptions prior to formal training.

The use of personal narratives served as a protective framework against this culture of anxiety. By sharing narratives of litigation survival, senior physicians humanized the legal process, allowing students to see that even respected experts can face and, more importantly, recover from legal challenges [28,29]. Through the lens of social learning theory [19], these structured narratives from senior physicians counter the negative impressions of the hidden curriculum by providing explicit behavioral models. In this context, students' exposure represents

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a constructive form of vicarious learning. Rather than passively absorbing unmediated anxiety, they could observe a professional roadmap for survival and coping. Students' reflections suggest that this process supported a shift from an informal, rumor-based understanding of litigation toward a more informed clinical awareness, in which legal complexities came to be evaluated more objectively, and medico-legal literacy was reframed not as a burden but as a professional necessity.

Qualitative data reveal that the core of communication failure is a "paradox of mutual ignorance"—a state where neither party understands the boundaries of the other's knowledge. As student 25 noted, "'They' do not know what 'they' do not know; 'we' do not know what 'they' do not know." This reflects a deep-seated physician-patient perception gap, in which both parties interpret the same clinical outcome through vastly different lenses [30,31]. By providing specific relational strategies [32] and demystifying technical complexities, the workshop may have helped students reframe this communicative barrier, encouraging a shift toward empathetic transparency and enhanced self-efficacy in conflict management [33].

The distribution of students' responses highlights a clear hierarchy of developmental concerns. The concentration of feedback around communication barriers and competencies indicates that preclinical students naturally prioritize controllable interpersonal skills over complex legal procedures [34]. Additionally, their strong engagement with topics surrounding conflict-related stress and support systems reflects the persistent psychological burden associated with the future prospect of medical litigation.

Conversely, the relatively low engagement with mediation and conflict resolution suggests that formal legal processes remain a distant concern for students yet to enter full-time clinical practice. However, the qualitative depth within this smaller group reveals that interdisciplinary exposure may help bridge this gap, with students describing a move beyond immediate, affective communication concerns toward a more structured understanding of professional legal navigation [35,36].

Rather than viewing mediation as a tool for mere appeasement, students expressed a commitment to upholding medical standards [37]. They expressed a strategic preference for allowing mediation to fail when no clinical error had occurred, viewing the legal process as a platform through which professional innocence could be established on factual grounds. As prompt 3 posed a hypothetical mediation scenario, these responses are best interpreted as espoused attitudes toward mediation rather than evidence of a fully internalized professional identity. Within this framing, students' reflections nonetheless suggest that empathy and professional integrity are viewed as complementary, rather than competing, values in conflict resolution [38,39]. Students' reported perceptions of the workshop's value further suggest that interdisciplinary exposure may support the development of an understanding of ethical honesty as an intrinsic professional value rather than merely an externally imposed rule intended to avoid punishment [40,41].

However, a small minority of reflections revealed a more conditional stance, with students expressing a preference for mediation to fail when they believed no error had occurred, out of concern that settlement would be misread as an admission of fault. This response admits more than one interpretation. It may reflect a legitimate concern for professional integrity and fairness, namely, a reluctance to accept blame for outcomes that students did not believe were the physician's fault. At the same time, it may also indicate an early tension in PIF, in which litigation anxiety can prompt a retreat into self-protective reasoning. Although this represented a minor pattern in our cohort, it nonetheless points to a need for structured psychological support, such as facilitated debriefing, to ensure that exposure to malpractice realities fosters constructive professional reflection rather than defensive medical attitudes.

Importantly, these 2021 prereform findings gain added relevance when contextualized within Taiwan's Medical Accident Prevention and Dispute Resolution Act, passed in 2022 and effective from January 1, 2024, which now mandates mediation as a prerequisite to both civil and criminal medical dispute proceedings. As the present workshop was conducted prior to this reform, students' reflections offer a rare empirical baseline assessment of preclinical mindsets before institutionalized mediation became mandatory. Students' early apprehensions, particularly their concern that agreeing to mediation might be misconstrued as a tacit admission of fault, point to specific psychological barriers that institutional reforms will need to address. As mediation becomes a structural requirement rather than an optional pathway, incorporating these prereform qualitative insights into early medical education may help trainees approach institutional mediation not as a compromise of professional integrity but as a structured, equitable framework for transparent communication.

Limitations

Despite the insights gained from this study, several limitations warrant consideration. First, as a single-institution study conducted at a military medical university, the findings may not be fully generalizable to civilian health care systems or educational institutions with different organizational cultures. Specifically, the unique environment of military medicine, characterized by a heightened respect for hierarchy, a strong sense of collective responsibility, and distinct norms around conflict resolution, may have uniquely shaped how students conceptualized authority, legal exposure, and professional duty.

Second, although the workshop centered on managing physician-patient communication during conflicts, the qualitative data analyzed herein were derived exclusively from medical students' and medico-legal professionals' reflections and did not include firsthand accounts from patients or their families. This absence limits our understanding of whether the communication strategies formulated by students fully align with patient expectations.

Third, because the reflection prompts were embedded within a formal course structure, student responses may have been subject to social desirability bias, whereby participants articulated perspectives that aligned with perceived institutional, grading, or ethical expectations. Additionally, the qualitative prompts may have introduced response-selection bias by primarily capturing the views of students who were already inclined

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toward medical humanities or ethics. Furthermore, this study explored immediate conceptual shifts rather than longitudinal behavioral changes in long-term clinical practice.

Fourth, although the workshop was delivered via videoconferencing because of COVID-19 pandemic restrictions, this study did not collect specific comparative modality data or participant feedback regarding the online delivery format itself. Consequently, no conclusions can be drawn regarding the unique efficacy or scalability of the virtual platform compared with in-person instruction [42].

Finally, the absence of a randomized control group prevents a direct comparison between this narrative-driven model and traditional didactic instruction. However, given the integrated nature of the curriculum, a control group was not included, as withholding the intervention from a comparison group has resulted in unequal educational opportunities for students during their training.

Conclusions

This qualitative study offers insight into how narrative-driven, interdisciplinary workshops can support preclinical students as they navigate the conceptual vulnerabilities associated with litigation fear. The intervention appears to address students' reflective needs by leveraging senior physician narratives as a supportive framework, with students describing a perceived shift toward relational clarity and professional integrity as part of early PIF. By creating a psychologically safe space for exploring clinical vulnerability within the medical curriculum, such narrative-based learning may support future practitioners in developing more nuanced conceptual approaches to medico-legal complexities and patient communication.

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Data Availability

Data from this study are available upon reasonable request from the corresponding author.

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Generative AI Use

The authors declare that generative AI was used in the creation of this manuscript. Generative AI (Gemini Pro; Google and Claude Sonnet 4.6; Anthropic) was used for proofreading, editing, or language polishing and translation. The authors verified all outputs of the tools used in the preparation of this manuscript and take full responsibility for the final content of the manuscript.

Authors' Contributions

CCW and DYN conceived the study and were responsible for data collection. CPF contributed to data collection. THL, CCK, and CPF contributed to the study methodology. DYN, CCK, and HJS conducted the data analysis. DYN, YLT, and HJS performed data processing and deidentification. DYN and CCW wrote the original draft. CCW, THL, and YLT reviewed and edited the manuscript. CCW obtained ethics approval and secured funding.

Conflicts of Interest

None declared.

Multimedia Appendix 1

SRQR checklist.
[DOCX File , 22 KB-Multimedia Appendix 1]

Multimedia Appendix 2

Methodological rigor and quality control measures.
[DOCX File , 20 KB-Multimedia Appendix 2]

Multimedia Appendix 3

Coding framework and representative quotations from the qualitative thematic analysis.
[DOCX File , 25 KB-Multimedia Appendix 3]

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References

1. Chandra S, Mohammadnezhad M, Ward P. Trust and communication in a doctor-patient relationship: a literature review. J Healthc Commun. 2018;3(3):36. [doi: 10.4172/2472-1654.100146]
2. Ha JF, Longnecker N. Doctor-patient communication: a review. Ochsner J. 2010;10(1):38-43. [FREE Full text] [Medline: 21603354]
3. Mostafapour M, Smith JD, Fortier JH, Garber GE. Beyond medical errors: exploring the interpersonal dynamics in physician-patient relationships linked to medico-legal complaints. BMC Health Serv Res. Aug 29, 2024;24(1):1003. [FREE Full text] [doi: 10.1186/s12913-024-11457-3] [Medline: 39210366]
4. Kee JW, Khoo HS, Lim I, Koh MY. Communication skills in patient-doctor interactions: learning from patient complaints. Health Prof Educ. 2018;4(2):97-106. [doi: 10.1016/j.hpe.2017.03.006]
5. Madan R, Das N, Patley R, Nagpal N, Malik Y, Math SB. Consequences of medical negligence and litigations on health care providers - a narrative review. Indian J Psychiatry. Apr 2024;66(4):317-325. [FREE Full text] [doi: 10.4103/indianjpsychiatry.indianjpsychiatry_799_23] [Medline: 38778854]
6. Ries NM, Johnston B, Jansen J. A qualitative interview study of Australian physicians on defensive practice and low value care: "it's easier to talk about our fear of lawyers than to talk about our fear of looking bad in front of each other". BMC Med Ethics. Mar 04, 2022;23(1):16. [FREE Full text] [doi: 10.1186/s12910-022-00755-2] [Medline: 35246129]
7. Kass J, Rose RV. Medical malpractice reform: historical approaches, alternative models, and communication and resolution programs. AMA J Ethics. Mar 01, 2016;18(3):299-310. [FREE Full text] [doi: 10.1001/journalofethics.2016.18.3.pfor6-1603] [Medline: 27003002]
8. Evans A, Refrow-Rutala D. Medico-legal education: a pilot curriculum to fill the identified knowledge gap. J Grad Med Educ. Dec 2010;2(4):595-599. [FREE Full text] [doi: 10.4300/JGME-D-10-00114.1] [Medline: 22132284]
9. Berry DB. The physician's guide to medical malpractice. Proc (Bayl Univ Med Cent). Jan 2001;14(1):109-112. [FREE Full text] [doi: 10.1080/08998280.2001.11927742] [Medline: 16369598]
10. Feld KA, Feld AD. Understanding legal and regulatory adverse actions: how trouble could come at you. Clin Transl Gastroenterol. Mar 2016;7(3):e158. [doi: 10.1038/ctg.2015.56]
11. Strobel CJ, Oldenburg D, Steinhäuser J. Factors influencing defensive medicine-based decision-making in primary care: a scoping review. J Eval Clin Pract. Apr 2023;29(3):529-538. [doi: 10.1111/jep.13799] [Medline: 36433885]
12. Johnston WF, Rodriguez RM, Suarez D, Fortman J. Study of medical students' malpractice fear and defensive medicine: a "hidden curriculum?". West J Emerg Med. Dec 09, 2013;15(3):293-298. [FREE Full text] [doi: 10.5811/westjem.2013.8.19045] [Medline: 24868307]
13. Mount GR, Kahlke R, Melton J, Varpio L. A critical review of professional identity formation interventions in medical education. Acad Med. Nov 01, 2022;97(11S):S96-106. [FREE Full text] [doi: 10.1097/ACM.0000000000004904] [Medline: 35947478]
14. Schumacher JE, Ritchey FJ, Nelson LJ, Murray S, Martin J. Malpractice litigation fear and risk management beliefs among teaching hospital physicians. South Med J. Dec 1995;88(12):1204-1211. [doi: 10.1097/00007611-199512000-00004] [Medline: 7502111]
15. Eftekhari MH, Parsapoor A, Ahmadi A, Yavari N, Larijani B, Gooshki ES. Exploring defensive medicine: examples, underlying and contextual factors, and potential strategies - a qualitative study. BMC Med Ethics. Oct 10, 2023;24(1):82. [FREE Full text] [doi: 10.1186/s12910-023-00949-2] [Medline: 37817191]
16. Khamees A, Awadi S, Al Sharie S, Faiyoumi BA, Alzu'bi E, Hailat L, et al. Factors affecting medical student's decision in choosing a future career specialty: a cross-sectional study. Ann Med Surg (Lond). Jan 27, 2022;74:103305. [FREE Full text] [doi: 10.1016/j.amsu.2022.103305] [Medline: 35145673]
17. McDougall A, Claudio F, Pound C, Pacheco K, Fortier J, Garber G. From challenge to growth: exploring physician narratives of patient complaints during residency. Med Educ. May 19, 2025;59(11):1204-1213. [doi: 10.1111/medu.15716] [Medline: 40387304]
18. Wolfe AD, Hoang KB, Denniston SF. Teaching conflict resolution in medicine: lessons from business, diplomacy, and theatre. MedEdPORTAL. Jan 25, 2018;14:10672. [FREE Full text] [doi: 10.15766/mep_2374-8265.10672] [Medline: 30800872]
19. Bandura A, Walters RH. Social Learning Theory (Volume 1). Englewood Cliffs, NJ. Prentice Hall; 1977.
20. Rivera R, Smart J, Sakaria S, Wray A, Wiechmann W, Boysen-Osborn M, et al. Planning engaging, remote, synchronous didactics in the COVID-19 pandemic era. JMIR Med Educ. May 11, 2021;7(2):e25213. [FREE Full text] [doi: 10.2196/25213] [Medline: 33872191]
21. Creswell JW, Clark VL. Designing and Conducting Mixed Methods Research. 3rd Edition. Thousand Oaks, CA. SAGE Publications; 2017.
22. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. Sep 2014;89(9):1245-1251. [doi: 10.1097/ACM.0000000000000388] [Medline: 24979285]
23. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nurs Health Sci. Sep 2013;15(3):398-405. [doi: 10.1111/nhs.12048] [Medline: 23480423]

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24. Nowell LS, Norris JM, White DE, Moules NJ. Thematic analysis: striving to meet the trustworthiness criteria. Int J Qual Methods. Oct 02, 2017;16(1):1609406917733847. [doi: 10.1177/1609406917733847]
25. Kurtz JB, Lourie MA, Holman EE, Grob KL, Monrad SU. Creating assessments as an active learning strategy: what are students' perceptions? A mixed methods study. Med Educ Online. Jun 27, 2019;24(1):1630239. [FREE Full text] [doi: 10.1080/10872981.2019.1630239] [Medline: 31248355]
26. Lincoln YS, Guba EG. Establishing trustworthiness. In: Naturalistic Inquiry. Thousand Oaks, CA. SAGE Publications; 1985:289-331.
27. Meyer R, Archer E, Smit L. The positive influence of the hidden curriculum in medical education: a scoping review. Med Sci Educ. Apr 11, 2025;35(3):1817-1826. [doi: 10.1007/s40670-025-02380-1] [Medline: 40625946]
28. Ribeiro LM, de Carvalho Filho MA. From learners to healers: the essential link between student-centred education and patient-centred care. Med Educ. Mar 2026;60(3):215-217. [doi: 10.1111/medu.70096] [Medline: 41318350]
29. Miziara ID, Miziara CS. Medical errors, medical negligence and defensive medicine: a narrative review. Clinics (Sao Paulo). May 28, 2022;77:100053. [FREE Full text] [doi: 10.1016/j.clinsp.2022.100053] [Medline: 35640458]
30. Samarasekera DD, Lee SS, Yeo JH, Yeo SP, Ponnamperuma G. Empathy in health professions education: what works, gaps and areas for improvement. Med Educ. Jan 2023;57(1):86-101. [doi: 10.1111/medu.14865] [Medline: 35790499]
31. Bai H, Li F, He Z. Bridging the trust gap: the mediating role of patient satisfaction in physician empathy. Front Med (Lausanne). Sep 04, 2025;12:1647105. [FREE Full text] [doi: 10.3389/fmed.2025.1647105] [Medline: 40978751]
32. Vogel D, Meyer M, Harendza S. Verbal and non-verbal communication skills including empathy during history taking of undergraduate medical students. BMC Med Educ. Jul 03, 2018;18(1):157. [FREE Full text] [doi: 10.1186/s12909-018-1260-9] [Medline: 29970069]
33. Mathew S, Samant N, Cooksey C, Ramm O. Knowledge, attitudes, and perceptions about medicolegal education: a survey of OB/GYN residents. Perm J. Nov 2020;24:1-7. [doi: 10.7812/tpp/19.217] [Medline: 33482955]
34. Knoster K, Goodboy A, Martin M, Thomay A. What matters most? A prioritization of medical students' preferences for effective teaching. Commun Educ. Nov 04, 2020;70(2):183-200. [doi: 10.1080/03634523.2020.1841254]
35. Abbasi M, Shirazi M, Torkmandi H, Homayoon S, Abdi M. Impact of teaching, learning, and assessment of medical law on cognitive, affective and psychomotor skills of medical students: a systematic review. BMC Med Educ. Sep 26, 2023;23(1):703. [FREE Full text] [doi: 10.1186/s12909-023-04695-2] [Medline: 37752500]
36. Albert M, Rowland P, Friesen F, Laberge S. Barriers to cross-disciplinary knowledge flow: the case of medical education research. Perspect Med Educ. Jun 2022;11(3):149-155. [FREE Full text] [doi: 10.1007/s40037-021-00685-6] [Medline: 34648134]
37. Zhou YC, Tzeng WC, Fu CP, Hung YL, Shiao YC, Ng DY, et al. Effect of a conflict management workshop with simulated mediation and mock court proceedings: a mixed-methods study. BMC Med Educ. Nov 27, 2025;25(1):1763. [FREE Full text] [doi: 10.1186/s12909-025-08345-7] [Medline: 41310689]
38. Allan A, Carroll R. Apologies in a legal setting: insights from research into injured parties' experiences of apologies after an adverse event. Psychiatr Psychol Law. Jun 23, 2016;24(1):10-32. [FREE Full text] [doi: 10.1080/13218719.2016.1196511] [Medline: 31983936]
39. Wald HS. Optimizing resilience and wellbeing for healthcare professions trainees and healthcare professionals during public health crises - practical tips for an 'integrative resilience' approach. Med Teach. Jul 2020;42(7):744-755. [doi: 10.1080/0142159X.2020.1768230] [Medline: 32449867]
40. Neufeld A. Autonomy-supportive teaching in medicine: from motivational theory to educational practice. MedEdPublish (2016). May 10, 2021;10:117. [FREE Full text] [doi: 10.15694/mep.2021.000117.1] [Medline: 38486596]
41. Koh EY, Koh KK, Renganathan Y, Krishna L. Role modelling in professional identity formation: a systematic scoping review. BMC Med Educ. Mar 29, 2023;23(1):194. [FREE Full text] [doi: 10.1186/s12909-023-04144-0] [Medline: 36991373]
42. Huang CS, Tang KP, Wu MS. Synchronous remote teaching for neurological examination training in fifth-year medical students: quasi-experimental study. JMIR Med Educ. Jul 15, 2026;12:e77034. [FREE Full text] [doi: 10.2196/77034] [Medline: 42456133]

Abbreviations

ADR: alternative dispute resolution
NDMU: National Defense Medical University
PIF: professional identity formation
SRQR: Standards for Reporting Qualitative Research

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