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Law and Medicine: Myths and Realities in the Medical School Classroom*

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One way to increase cooperation between the professions of law and medicine is to teach law in medical schools in a way that emphasizes methods of approaching problems, and seeks to dispel the major myths that doctors have about the law. In this Article, Professor George Annas presents an outline of a core course in legal medicine "tailor-made" for inclusion in the medical (and, with appropriate modifications, dental) school curriculum.

I. INTRODUCTION

The goal of legal education in a nutshell is to get the student to "think like a lawyer." The goal of medicolegal courses in medical schools, on the other hand, has often seemed to be to get the medical student to think bad things about lawyers. While the total solution to the legendary distrust between these two professions may not be an understanding of methodology, this article will suggest that one way to increase cooperation between the professions is to teach law in medical schools in a way that emphasizes methods of approaching problems and which seeks to dispel the major myths that many, if not most, doctors have about the law.

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The different methods of problem-solving employed by the two professions have often been oversimplified. One lawyer has used the following illustration, although it is perhaps more misleading than instructive:

> If a doctor were called upon to treat typhoid fever he would probably try to find out what kind of water the patient drank, and clean out the well so that no one else would get typhoid from the same source. But if a lawyer were called on to treat a typhoid patient, he would give him thirty days in jail, and then he would think that nobody else would ever dare to drink the impure water . . . lawyers think that there is only one way to make men good, and that is to put them in such terror that they do not dare to be bad.[1]

This type of rhetoric, unfortunately, is taken seriously by many. Furthermore, many medicolegal courses seemingly are designed to follow this "legal model" by putting the medical student in terror of being sued for malpractice and by instructing the student to regard lawyers as wicked adversaries. As Professor William J. Curran of Harvard University has noted, when a legal medicine course is badly taught (and this is probably the rule rather than the exception), the student comes away with three messages:

1. Lawyers are out to get you if you don't watch out;
2. Law is very, very dull; and
3. If you do show an interest in legal medicine, you must be a little strange.[2]

Legal medicine is therefore faced with a problem that is unique to the humanities, many of which are currently fighting for places in the medical school curriculum. There have traditionally been

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1 LEVIN, COMPULSION (1956) quoted by W. CURRAN & E. SHAPIRO, LAW, MEDICINE & FORENSIC SCIENCES (1970) at 35 (taken from the defense attorney's closing argument to the jury).

2 Curran, *The Medical Witness: Availability, Willingness to Testify, and Some Comments on Medico-Legal Training of Physicians,* reprinted in W. CURRAN & E. SHAPIRO, LAW, MEDICINE & FORENSIC SCIENCES (1970) at 18. *See also* Power, *Interprofessional Education and Medicolegal Conflict As Seen from the Other Side,* 40 AM. J. MED. ED. 233 (1965); Powers, *Interprofessional Education and the Reduction of Medico-Legal Tensions,* 17 J. LEGAL ED. 167 (1965); Borillo & Ebaugh, *Medicolegal Liaison: A Need for Dialogue in the Criminal Law,* 37 COLO. L. REV. 169 (1965); Cohn, *Medical Malpractice Litigation: A Plague on Both Your Houses,* 52 A.B.A.J. 32 (1966); Schroeder, *Medicolegal Education: Bridging the Chasm,* LAW-MED LETTER, 51 (Aug. 1972); Spies, Weiss & Campbell, *Teaching Law Students in the Medical Schools,* 77 SURGERY 793 (1975).

and continue to be courses in forensic medicine or medical jurisprudence in a majority of the medical schools in this country.[3] The problem is therefore not usually to justify the place of law in the curriculum. However, because legal medicine courses have been taught poorly in the past, with an overemphasis on malpractice and criminology, a rationale for continuing to teach legal medicine requires both that the old negative feelings be removed and that a redefinition of the term legal medicine (once called "medical jurisprudence") be formulated to encompass issues relevant to today's doctor.[4] The challenge, in short, is to define carefully *what* should be taught in such a course and *how* it should be taught. Lest one not be convinced that such training is essential to medical education, however, it is useful to begin with a discussion of *why* such a course is important.

II. WHY LEGAL MEDICINE IS A REQUISITE COMPONENT OF THE MEDICAL SCHOOL CURRICULUM

Almost everything the doctor does in the practice of medicine is in some manner governed by the legal system. The law defines what the doctor can or cannot do in terms of medical practice and the geographic bounds of his authority. It defines his relationship with his patient in terms of contract and implied contract, and it defines his duty to his patients in terms of obtaining both consent and informed consent. The law governs what drugs a doctor may prescribe and in what quantities. It defines the rights of patients and prescribes remedies for patients who are injured by doctors. This list is easily broadened to include staff privileges and duties, human experimentation regulations, privacy, confidentiality, privileged communications, abortion, sterilization, euthanasia, consultation, abandonment, referral, admission to hospital, emergency room duties, discharge from hospital, Medicare, Medicaid, private health insurance plans, comprehensive health planning, certificate of need, PSRO, licensing, physician assistants, anatomical gifts, and autopsy. Wherever a doctor turns, he is confronted by law—statutory, case, and constitutional—which governs or limits his conduct in one way or another. A similar (but probably not so extensive) list could, of course, be constructed for policemen,

3 Dunn, *Legal Medicine in American Law and Medical Schools: A Survey*, 9 COL. COLLEGE PRE-MED 4 (1970); Hirsch, *Educational Opportunities in Forensic Medicine in Medical Schools*, 65 PHI DELTA EPSILON NEWS 2 (Winter, 1973).

4 *See generally* Curran, *Titles in the Medicolegal Field: A Proposal for Reform*, 1 A.J.L.M. 1 (1975).

dairy farmers, bankers, oil drillers, or for that matter any American citizen.

Like any other citizen, the doctor who does not understand the law and the obligations and limitations it puts on his practice is at an extreme disadvantage. He may, for example, not tell his patient about all of the serious potential side-effects of a surgical procedure and then find himself being sued for failure to obtain an informed consent. He may improperly use a restricted drug and find his license to use such drugs revoked. He may disclose information learned in confidence to a spouse, relative, or friend and find himself being sued for breach of confidence. He may refuse to treat a teenage girl who has been raped because he does not understand the law of consent regarding minors. He may put a terminally ill patient on a respirator against the patient's wishes because he mistakenly believes that the law requires him to take all steps in his power to preserve the patient's life. As with the previous list, this one is almost endless.[5]

Two further examples, however, deserve more extensive comment. First, when physicians see a person injured while on the road or elsewhere outside of their office or hospital settings, they are often reluctant to stop and render aid. This reluctance is said to be the result of their having been taught to fear lawsuits and to believe that if they try to help, they may be opening themselves up to a malpractice suit. Although the American Medical Association, together with local medical societies, has been successful in getting so-called "Good Samaritan" statutes passed which protect physicians from suit for professional negligence (other than gross negligence) in such a situation, this reluctance continues to this day. The fact is, however, that there is not a single reported case in which a physician in this country has had to pay any money damages to anyone suing him for stopping and rendering aid (and allegedly aggravating the patient's condition). Moreover, one survey of 40,000 physicians found that fewer than 10 had any difficulties at all arising out of this type of situation, and none had resulted in any formal legal action.[6]

[5] A 1972 study of the Boston University Center for Law and Health Sciences, for example, found that many physicians were "ignorant of the law in the very important area relating to treatment of minors." Fewer than 20% of a sample of physicians were able to define correctly the law as it related to treatment of a minor for sore throat, stomach cramps, or venereal disease. *See* Glantz, Feldman, Parker & Weisbuch, *Medical Practice, Medical Education, and the Law,* 49 J. MED. ED. 899, 900 (1974).

[6] Chayet, oral presentation, First National Conference on the Medicolegal Aspects of Emergency Care, sponsored by the American Society of Law & Medicine, Inc., Washington, D.C., June, 1975.

Although it is not clear from this survey how many, other than those who had difficulties, had ever stopped at the scene of an accident, the reason that apparently no lawsuits on this subject have been filed is rather easy to discern if one thinks the matter through. It is extremely difficult for a jury to vote to penalize a doctor for doing what most of us want all doctors to do—stop and render what aid they can in an emergency. One state, Vermont, has even passed a statute making a failure to stop and render aid punishable by a fine.[7]

While there are other reasons doctors may not stop (e.g., like the rest of us, they may simply not want to "get involved," or they may not know anything about emergency medicine), it is probably fair to say that a deep-rooted misunderstanding of the law by the vast majority of doctors has led to much unnecessary suffering and has probably contributed directly to a number of unnecessary deaths.

A second example worthy of more extensive comment is provided by the controversy surrounding the withholding of heroic treatment from infants suffering from certain types of physical or mental defects. Two physicians at the Yale-New Haven Hospital, for example, reported in the fall of 1973 that this practice had been going on, with the consent of the children's parents, in that institution's pediatric intensive care unit since 1971. Over 40 infants had died after treatment efforts were terminated. The doctors concluded their announcement by saying: "If working out these dilemmas in ways such as those we suggest is in violation of the law, we believe the law should be changed."[8]

When questioned later, one of the Yale physicians revealed a profound misunderstanding of the function of law when he replied that they had purposely not asked a lawyer for his opinion as to the legality of their actions because they were afraid that the lawyer would tell them that what they had in mind was against the law![9] Somehow, he seemed to believe that disobeying the law was proper so long as he was not personally informed of the law by an attorney prior to the time of his actions. The same logic would make speeding permis-

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7 Vt. Stat. Ann. Title 12 & 519(a)-(c).

8 Duff & Campbell, *Moral and Ethical Dilemmas in the Special Care Nursery,* 289 NEW ENG. J. MED. 891 (1973). For a legal analysis of this type of treatment decision see Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis,* 27 STAN. L. REV. 213 (1975).

9 Conversation at a Symposium on "The Ethics of Newborn Intensive Care: The Decision-Making Process," Massachusetts General Hospital, Feb. 26, 1974.

sible as long as the driver did not look at any of the speed limit signs on the highway.

I trust the point is made. Law is such a pervasive force in the practice of medicine today that to proceed without some basic understanding of its design, purposes, and limits can place both the doctor and his patients in unnecessary peril. Moreover, many areas of medical practice are probably *under*-regulated, and the physician should be able both to anticipate and to help shape future regulations regarding both access to and the quality of health care.

III. DESCRIPTION OF A CORE COURSE IN LEGAL MEDICINE

A. Goals Which a Course in Legal Medicine Should Have

While many potential goals could be listed, perhaps the most important and fundamental goals of a core course in legal medicine are:

1. To develop an accurate picture of the role of the attorney in society;
2. To impart some basic legal concepts—enough so that the student knows when to and when not to consult an attorney; and
3. To impart a basic understanding of the legal model of decision-making.

B. What Should Be Taught

It is ironic, but one of the most important subject matters of even a restructured course in legal medicine must be medical malpractice. The approach, however, must be completely different from the "scare them to death" tactics of the past. Specifically, the prevailing myths about malpractice should be exposed and replaced by a careful examination of the "real" problems of the current system of compensation for doctor-induced medical injury. Moreover, blaming lawyers for the current malpractice "crisis" is akin to blaming firemen for arson. Lawyers arrive *after* the injury and seek to ameliorate, not exacerbate, its effects.

For example, it is simply not true that most malpractice actions are "nuisance suits." Even malpractice insurers estimate more than 45% to be fully justified.[10] In addition, the contingency fee system (an

[10] DHEW, Medical Malpractice: Report of the Secretary's Commission on Medi-

arrangement whereby the attorney receives as his fee a percentage—usually 30 to 50%—of the total award) does not spawn unjustified suits. On the contrary, since 30% of nothing is nothing, the attorney actually helps to screen meritless claims. Plaintiffs' attorneys, for example, take only 1 in every 8 malpractice cases that clients bring them.[11] The simple fact is that patients, not attorneys, initiate law suits. Furthermore, there is no hard data supporting the claim that malpractice suits are forcing many physicians to practice positive "defensive medicine" by prescribing too many tests. Indeed, some studies done in the emergency room context indicate that doctors usually perform too few rather than too many diagnostic tests.[12] A more significant fact about malpractice litigation is that the most recent statistics available show that only *one* claim is asserted for every 226,000 doctor-patient contacts.[13] Although specialties like anesthesiology, neurosurgery, and orthopedics do have relatively higher risks of suit, this means that the average physician will get sued only once every 69 years —and explains why most doctors *never* have a malpractice action brought against them during their entire careers.[14]

The major problems with the present system are not that it is unfair to doctors, although the underwriting practices of many insurance companies leave much to be desired, but that most injured patients never get compensated, and of those who do, most must pay high

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CAL MALPRACTICE, DHEW Publ. No. (OS) 73-88 (U.S. Gov. Print. Office, Stock #1700 00114) (1973) at 10 [hereinafter cited as "MEDICAL MALPRACTICE"].

11 Dietz, Baird, & Berul, *The Medical Malpractice Legal System,* APPENDIX, MEDICAL MALPRACTICE at 97. It is worth noting that the British experts asked by the Commission to summarize the reasons for Britain's relatively good experience in the malpractice field concluded their report by suggesting that more time be made available in the medical curriculum for law: "We also believe that more attention should be paid to the teaching of legal medicine both to undergraduates and to postgraduates. It is only by constant propaganda—by articles, lectures, conferences, and films on legal medicine—that [physicians and dentists] will be made fully aware and reminded of their medico-legal responsibilities. Before embarking upon their professional careers practitioners must [fully] appreciate their legal obligations to patients and their relationship with lawyers. We do not believe that sufficient instruction is given to practitioners on medico-legal matters. We are of the opinion that much more consideration should be given to legal medicine in medical and dental education than is at present the case." Addison & Baylis, *The Malpractice Problem in Great Britain,* APPENDIX, MEDICAL MALPRACTICE at 854, 870.

12 Brook & Stevenson, *Effectiveness of Patient Care in an Emergency Room,* 283 NEW ENG. J. MED. 904 (1970); Brook & Appel, *Quality-of-Care Assessment: Choosing a Method for Peer Review,* 288 NEW ENG. J. MED. 1323, 1327 (1973).

13 MEDICAL MALPRACTICE, *supra* note 11 at 12.

14 *Id.*

legal fees and wait for years to receive their money. What type of compensation mechanism should be built into a national health insurance scheme and what new types of quality control mechanisms should be developed are issues that young doctors should be thinking about. Why do or do not alternatives or modifications like no-fault,[15] screening panels,[16] and binding arbitration[17] make sense? Wasting time on deprecating "unfair legal rules" or the contingency fee system is both misguided and largely unproductive,[18] if not counterproductive.

Another important concept to teach the medical student is that of decision-making models. Law is an extremely formal system designed to make decisions in a way meant to insure that the interests of all affected parties are taken into account. The emphasis is on the process, specifically on "due process." When a lawyer looks at the doctor's method of decision-making, he is likely to be somewhat horrified at its "anti-due process" characteristics, which commonly include:

1. Ambiguous identification of the decision-maker;
2. Ambiguous identification of the person or entity that commands the decision-maker's loyalty;
3. Control of the pertinent medical information by the attending physician;
4. Lack of reporting or review of the ultimate treatment decision; and
5. Frequent justification of the decision on the basis of public policy.[19]

For example, unlike the doctor treating a terminally ill patient with a close, demanding family, the lawyer is more likely to know exactly who his client is, who has the power to make the relevant decisions, and who is to have access to all pertinent information. In addition, any appeal to public policy is left in the hands of public officials, such as the courts or the legislature. A comparison of the two systems of decision-making should be enlightening for the student.

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[15] *See, e.g.*, Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590 (1973).

[16] *See, e.g.*, Note, *Medical Legal Screening Panels as an Alternative Approach to Malpractice Claims*, 13 WM. & MARY L. REV. 695 (1972).

[17] *See, e.g.*, Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947 (1972).

[18] Annas, *Medical Malpractice: Are the Doctors Right?*, 10 TRIAL 59 (July, 1974).

[19] Annas, *Medical Remedies and Human Rights*, 2 HUMAN RTS. 151, 156-157 (1972). And see BECKER, GEER, HUGHES & STRAUSS, BOYS IN WHITE: STUDENT CULTURE IN MEDICAL SCHOOL (1961); and Katz, *The Education of the Physician-Investigator*, 98 DAEDALUS 485 (1969).

The doctor, for example, is often taught that he must make the decision because his training and expertise make it probable that his decision will be better than anyone else's. The lawyer, on the other hand, is taught to be an advocate for the cause of the client in a context where someone else will make the ultimate decision. His role is to present his client's case in the best possible light, knowing that his opponent will do the same for his client, and that through this exchange the judge or jury will determine which party should prevail. He is not a scientist, but an advocate. If the law is against him, he will argue the facts; if the facts are against him, he will argue the law; and if they are both against him, he will find some other basis upon which his client's case may prevail. The point of his activity is not to identify some ultimate "truth," but to make a persuasive presentation of the merits of his client's case.

Finally, it is extremely important to begin to familiarize the medical student with the types of legal issues he will face in day-to-day medical practice. While corporate, tax, securities, and real estate attorneys can probably practice their entire lives without needing to know anything about medicine, no doctor can get through a day of active practice without facing, in knowledge or ignorance, significant legal issues.

Perhaps the most fruitful way of discussing the types of issues that are likely to be of concern to the practicing physician is to present an outline, organized by subject matter, of a legal medicine course designed for the final year of the medical school curriculum. While course content must remain basically a personal decision of the instructor, it is hoped that this topical listing will provide a basis for effective course planning. The course is subdivided by general subject matter and the time allotments are suggested as a rough guide only. Modifications can be made based on desired content, goals, and time constraints. One would also expect that certain of these subject areas may be replaced by new ones as progress is made in both law and medicine. Most materials for such a course would consist of xeroxed cases and articles since there currently is no satisfactory medicolegal text specifically designed for medical school use.

C. Topical Outline of a Model Legal Medicine Course

1. *Sources of Law.* Case law; statutes; regulations; hospital by-laws; medical ethics; relationship of law and morality; positive

vs. natural law; organization of courts and legislative bodies; adversary procedure in litigation; medical and hospital records as evidence; privileged communication; and the role of the attorney. (2 hours)

2. *Medical Licensure and Practice Regulation.* Granting and revocation of licenses; licensure and registration of paramedical personnel; granting and revocation of staff privileges; control of narcotics and dangerous drugs; public health regulations; contagious diseases; and venereal disease control. (1 hour)
3. *Compensation for Personal Injuries.* Medical aspects of tort liability; negligent and intentional injuries; contributory and comparative negligence; measure and items of damages; statutory compensation under federal and state law; occupational disease laws; insurance coverage for compensation or liability; workmen's compensation; the use of medical records and reports; medical testimony and expert opinion; causation from the legal viewpoint; and disability evaluation from the medical and legal viewpoints. (2 hours)
4. *Medical Professional Liability.* Tort law in medical practice; legal establishment of a physician-patient relationship; defining standards of medical care; liability for acts of employees; physician's liability for acts of interns, substitutes, consultants, and other treating physicians; consent and informed consent; assault and battery; the doctrine of *res ipsa loquitur* ("the thing speaks for itself"); contract and warranty of cure; invasion of privacy; why patients sue; medical injury prevention; insurance; statute of limitations; medical evidence; and proposed remedies and alternatives to the present malpractice system (arbitration, screening boards, no-fault compensation). (4 hours)
5. *Cooperation with Law Enforcement Agencies.* Duty to report evidence of suspected crimes, poisonings, and gunshot and stabbing wounds; suspected or possible homicide and suicide; narcotics and dangerous drugs violations; sex offenses; neglected child statutes; rape; and preservation of evidence. (1 hour)
6. *Rights and Duties concerning Emergency Medical Care.* The emergency ward; Good Samaritan Laws; immunity statutes; consent; minors; physician and patient responsibility; and payment. (1 hour)

7. *Hospital Regulations and Planning.* Joint Commission on Accreditation of Hospitals Guidelines; state licensing regulations; certificate of need; health planning; Hill-Burton compliance requirements; and tax-exempt status of hospitals and clinics. (1 hour)
8. *National Health Insurance.* Proposed federal legislation; Medicare; Medicaid; Blue Cross; Blue Shield; insurance systems in other countries; and workmen's compensation. (2 hours)
9. *Changes in Health Care Delivery.* Health Maintenance Organizations (HMOs); Peer Review; Professional Standards Review Organizations (PSROs); Foundations for Medical Care (FMCs); and Utilization Review (UR). (2 hours)
10. *Business Aspects of Medical Practice.* Incorporation; partnership; taxes; pension plans and other "fringe benefits"; and purchase and rental of office real estate and equipment. (1 hour)
11. *Medical Decision-Making.* Society's mandate to the medical profession; the importance of identifying the decision-maker and the interests involved; who will decide and how; and current models. (1 hour)
12. *Patients' Rights.* The citizen as patient; the right to health care; informed consent; patients' rights in the doctor-patient relationship; the right to the truth; the right to choose one's treatment; the right to refuse treatment; nurses' rights; patients' bills of rights; and a patients' advocate system. (2 hours)
13. *The Beginnings of Life.* Amniocentesis; contraception; abortion; sterilization; genetic screening, intervention, and engineering; asexual reproduction; rights of the developmentally disabled; and infant euthanasia. (1 hour)
14. *Experimentation.* Informed consent; prisoners; children; mental incompetents; rights of the family to consent; new drugs and the F.D.A.; research review committees; surgical innovation; regulation of medical devices; and rights of society. One might also wish to include the law and ethics of transplantation (resource allocation; alternatives; selection; consent; payment; and autopsy procedures) and behavior modification (psychosurgery; chemotherapy; psychotherapy; institutionalization; and use of positive and negative reinforcement) in this block of time. (2-6 hours)
15. *Rights of the Dying Patient.* Resource allocation; refusing

treatment; consent; euthanasia; the "living will"; psychotropic drugs; organ donation; and autopsy. (1 hour)

16. *Confidentiality and Privacy.* Doctor-patient relationship; computerization of hospital and office records; use of patient social security numbers as patient identifiers; access to and ownership of hospital and medical records; use of patients for teaching purposes; and the doctor's "right" to practice medicine. (1 hour)
17. *Creating Law.* The legislative process; how to present scientific material to a legislative committee hearing; and how to present written and oral testimony before the legislature. (3 hours)
18. *Recognizing a Legal Problem.* Summary of what was learned; when to call and not to call a lawyer; how to use the law to help you do what you want to do; and how to avoid the pitfalls of practice. (2 hours)

IV. COURSE PRESENTATION

A. How and By Whom the Course Should Be Taught

The legal medicine course should probably be taught by a university-based attorney who has had a variety of legislative, regulatory, and court experiences of a medicolegal nature and is a member of a law school faculty. This is suggested for two reasons: (1) there is less animosity between academic lawyers and doctors than between practicing lawyers and doctors; and (2) the course is not designed to be a "how to do it" course (e.g., how to preserve evidence, how to testify, how to avoid malpractice), but a "how to think" course. This is to be a course in law, not in how doctors react to their experiences with lawyers.

Since law professors usually teach groups of 90-130 students in a class, a large class would not be a problem. This model, with some utilization of the Socratic method, is also rather effective in drawing students into discussions—something to which the medical student is generally unaccustomed. In addition to transferring the basic law school case method (discussion) technique to the medical school classroom, other approaches also might prove effective. One would be to have two attorneys debate various issues in front of the class, and to follow the debate by a discussion. In one such class in which the author partici-

pated, for example, prior to the debate the medical students (near the end of their first year) were asked to vote "yes" or "no" on two propositions: (1) "Should the doctor follow the wishes of the parents of a five-year-old severely retarded, institutionalized, hydrocephalic child and passively end the child's life by not treating pneumonia?;" and (2) "Should society adopt a program of mandatory sterilization for women on welfare who have given birth to more than four retarded children?" The students were asked to vote again on these two questions following the debate. Fully 40% of the class changed their votes on each question following the presentation.[20] The large reappraisal does not necessarily indicate that first-year medical students are easily swayed, but rather that on their own they had not thought through all of the issues involved. Not only does this approach expose students to a wide variety of issues in a short period of time, it also demonstrates first-hand the legal method of advocacy.

The foregoing should not be construed to imply that small seminars of 12-20 students are not feasible. Indeed, the author has taught small-group courses on "The Legal Rights of Hospital Patients," "Law and Genetics," "Human Experimentation," and "The Dying Patient." These courses have included students enrolled in law, medicine, nursing, and psychology. In such a setting, the mix of students is as important as the subject matter, because it exposes the medical student to a variety of ways of examining issues which commonly confront the practicing physician. The author has found the case method the most successful in the small interdisciplinary seminar. The problem with this approach is that the manpower requirement is tremendous if one is trying to reach all of the students. On the other hand, if what is desired is in-depth study in a specialty area for a few highly motivated students, the seminar approach may be ideal.[21]

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[20] This incident occurred at the Tufts Medical School in the spring of 1972. The other attorney was Professor Charles H. Baron of the Boston College Law School.

[21] There are a number of potential problems, however. Law students, while generally fascinated with scientific and medical information, often complain that the legal analysis was too basic, and that the class discussions tended to be superficial. Non-law students also sometimes tend to view the hypotheticals presented by the law students in class discussions as too farfetched to be taken seriously. An affirmative position on interdisciplinary seminars is taken by Dr. Martin Norton in his *Development of an Interdisciplinary Program of Instruction in Medicine and Law*, 46 J. MED. ED. 405 (1971). As for the experiences of trained attorneys in medical school and trained physicians in law school, see Curran, *Cross-Professional Education in Law and Medicine: The Promise and the Conflict*, 24 J. LEGAL ED. 42 (1971).

B. When the Course Should Be Taught

Because it is difficult for the student to understand the relevance of law to medical practice until the student understands something of medical practice, it is probably best to reserve this course until the fourth year of medical school.[22] The difficulty at this point, of course, is scheduling. The course might meet in the evening for two hours a week for a semester. Alternatively, part of the first month of the year could be set aside for 2-3 hours of lectures a day over a 3-4 week period. Other schedules may suit particular schools better. Another sound approach would be to have the attorney-teacher (one or more) at all basic lectures in the first and second year which involve serious medicolegal issues. In cardiology, for example, questions of disability evaluation, definition of death, transplantation, consent, and legal causation might be discussed by the attorney; while in obstetrics and gynecology the legal issues concerning abortion, sterilization, contraception, and rape, and how these issues relate to minors, might be discussed. While this approach may be "ideal," as a practical matter it would require both a full-time legal faculty member and the close cooperation of *all* members of the medical school faculty, neither of which is easily acquired.

V. CONCLUSION

In conclusion, it must be emphasized that after completing the above-outlined medicolegal course, the medical student's training in legal medicine has only commenced, not concluded. Some hospitals are beginning to offer periodic grand rounds on legal issues; this trend must be encouraged. It should also prove useful to add an attorney to some of the more routine grand rounds for the purpose of seeing what legal issues, if any, the lawyer can spot and of contemporaneously discussing how the medical and the legal communities might resolve them.

Oliver Wendell Holmes once observed: "The life of the law is not logic, it is experience." This observation applies equally to any approach to teaching law in medical schools. Experience will prove the best teacher, and a flexible approach toward achieving carefully-thought-out goals will likely prove to be the most successful.

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22 Some typical comments the author has heard from first and second year medical students concerning a course in medicolegal issues are: "I'll worry about it when I get my license;" "I don't think it's critical, but it's a lot more important than just plain ethics;" "I think we should study it because it's necessary to know to be able to function as a physician." Students should, however, have some role in the development of any new medicolegal course, whether it is proposed as an elective or a requirement.