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Teaching Law in Medical Schools: First, Reflect

Amy T. Campbell

Introduction

[T]each the law to empower physicians individually and collectively *to use the law and law colleagues to serve patients and promote public welfare*; in short to better foster the goals of the medical profession.¹

And yet:

[A]ntipathy appears to be deeper and more pervasive than ever before, making it hard to imagine that relations between attorneys and physicians can get much worse.²

It has long been recognized that an understanding of at least some core legal rules and concepts is an important piece of medical training.³ To address this, law is now typically part of the core medical school curriculum, often incorporated into bioethics and/or practice of medicine coursework — whether as part of a distinct course or series of courses or threaded through the curriculum (or both).⁴ While often this education focuses on rules, some have recommended that it also include fundamentals of legal reasoning,⁵ and go beyond knowledge to include skills, attitudes, and behaviors vis-à-vis the law.⁶ We have also seen innovations in the curriculum to allow joint course-

work between law and medical students,⁷ with recent trends in interdisciplinary collaboration highlighting the effectiveness of enhanced legal understanding and abilities among medical professionals to act in their patients' best interests.⁸

In shaping coursework to address these areas, educators have sought to address key questions, a parallel set from the medical student and faculty perspective:

Medical students

- What should medical students learn about the law?
- When should they learn about the law?
- How should they learn about the law?
- From whom should they learn about the law?

Faculty

- What should faculty teach about the law?
- When should they teach about the law?
- How should they teach about the law?
- Who should be responsible for teaching about the law?

There seems to lack, however, a systematic understanding of *what works* in terms of getting across an effective depth and breadth of legal knowledge for medical students — or what such would even look like. Moreover, and more critically, while some literature addresses these *what*, *when*, *how*, and *who* questions, a more fundamental question is left unanswered: *why* teach law in medical school? This article contends that it is this latter question (*why*) that should be addressed before the other questions (*what*, *when*, *how*, *who*) in order to better ground legal coursework development and provide goals for education by which to measure effectiveness. In making

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this claim, it also offers a potential process by which to reach a more consensual understanding of the *why*.

The article begins with an overview of the U.S. literature on legal education in medical schools (the *what, when, how, and who*) (Section I). Section II then summarizes how the U.K. has approached this issue — a potential process to translate within the U.S. to generate consensus on *why* we should include law in our medical curriculum (the goals and objectives). A caveat — the hidden curriculum — is raised in Section III. Section IV highlights promising trends for incorporation of legal education via collaboration and additional lessons learned that might help to further this discussion. The article concludes, in Section V, with suggested next steps to develop consensus around the *why*.

Endorsed is the premise that a *why* can and should be found. While one could hope that this *why* would add a long-term goal of advancing patient and population health to the goals of reduced tension among professions, lessened liability, or enhanced skills at advocating for professional interests, any such potential goals for legal education in medical schools, it is urged, should be built through an engaged, stakeholder-driven discussion. That is, we should build consensus (through good process and empirical investigation of what *is* as compared to what *should be*) around *why* we teach law. Doing so would better develop meaningful measurable goals to effectively address the *what, when, how, and who* of legal education in medical schools, and measure if the approaches we take do in fact work.

I. Teaching Law in Medical Schools: State of the Evidence

A. Types of Evidence⁹

A limited of literature specifically focuses on teaching law in medical schools; much of what already exists clumps law together with ethics¹⁰ or includes legal-type issues under the rubric of ethics.¹¹ This makes it difficult to determine how medical schools are specifically teaching law (e.g., individual courses or lectures in a single year or across years) — a situation that should be remedied through empirical investigation as a critical first step in formalizing guidance on legal education teaching. What can be found falls into a few broad categories: conceptual pieces with recommendations,¹² empirical pieces (typically surveys),¹³ and institution-specific course reports.¹⁴ There are also a few more general statements that endorse specific approaches to legal coursework, with content recommendations (primarily from outside the U.S.).¹⁵ Collectively, this literature — written for the most part by legally trained scholars¹⁶ — injects into the discus-

sion a focus on the *what, when, how, and who* of law teaching.

1. THE WHAT

Generally, medical school legal coursework covers medical jurisprudence (law impacting medicine) and forensic medicine (medicine impacting law).¹⁷ Some scholars (again, primarily legally trained) urge going beyond this to include more discussion of legal reasoning and the law-making process.¹⁸ Historically, key legal content areas focused on professional liability and court-involvement issues;¹⁹ more recently there has been a shift to legal rules that impact clinical practice (e.g., informed consent, capacity, medical malpractice, confidentiality).²⁰ Surveys reveal consistency among these topics since the 1970s²¹ after a marked increase in law's presence since the 1950s/60s.²² A few articles argue for expanding the typical curriculum to add topics that would better enable physicians to play a more effective role in public policy.²³ Finally, some articles urge going beyond knowledge to include other objectives, i.e., skills and attitudes,²⁴ although this inclusion is not widely reflected in surveys (the “what is”).²⁵ With expansion considerations come understandable concerns over trying to cover too much — in effect making medical students into quasi-health law students; hence academics and a law-medicine professional society have asserted the need to focus on core areas: the physician-patient relationship and day-to-day clinical issues.²⁶

2. THE WHEN

Reviewed literature supports the inclusion of legal education during the pre-clinical and clinical years,²⁷ and that it be integrated horizontally (across one year) and vertically (running through all four years).²⁸ Williams and Winslade also recommend that we put basic legal principles before an applied understanding and testing.²⁹ Unfortunately, notwithstanding recommendations and surveys about legal topics, curriculum time “does not appear to be commensurate with their importance.”³⁰

3. THE HOW

Given how frequently legal topics are clumped with ethics and professionalism teaching, it is not surprising that law also is more common as a sub-unit within a larger course or given as lectures interspersed within other courses.³¹ Felthous and Miller³² showed that only two out of five medical schools then surveyed had a separate course on medicine and law, with even fewer of those requiring the course. Legal topics are often presented via a mix of lecture and small group discussion,³³ with some innovations such as inclusion of a mock trial.³⁴ Of note, there are some calls to join

law and medical students for interdisciplinary training³⁵ (and also interdisciplinary practice³⁶), with a few examples offered as models in the literature.³⁷

4. THE WHO

And finally, there is also mention of recommended faculty for this coursework, perhaps addressing a concern that may impede its delivery: clinical and basic science faculty's lack of a sufficient knowledge base and ability to address skills and attitudinal needs.³⁸ A frequent refrain in the literature is that lawyers are or should be included in the teaching and be part of a

liability risks by enhancing knowledge;⁵⁰ to lessen inter-professional tensions and help build relationships;⁵¹ and at times, to better enable patient advocacy and enhance patient health.⁵² Yet, addressing the *why* is not the focus in the literature; critically, too, suggested whys are not consensually developed (e.g., via surveys and convening groups of key respondents) but rather are put forward as understood goals or others' justifications.⁵³

This article argues that the *why* should move front and center — that it should be much more fully reflected upon by key stakeholders (including medi-

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team teaching model (that is, add a J.D. to an M.D. or Ph.D.);³⁹ surveys indicate that a majority involves lawyers in some fashion,⁴⁰ with faculty appointments within medical schools ranging from full-time to adjunct,⁴¹ many of whom are in legal practice⁴², and some among these also holding appointments in sister/nearby law schools.⁴³ As with the *what*, *when*, and *how*, variety seems to be the norm.⁴⁴

B. Some Themes

Certain common themes could be said to emerge from the literature, e.g., a need for adequate resources to achieve aims,⁴⁵ an openness to interdisciplinary learning (adding legally trained faculty and at times joining medical and law students),⁴⁶ attempts for more integration (horizontal and vertical) in the curriculum,⁴⁷ and inclusion of knowledge (especially clinical practice-related issues), skills, and attitudes objectives.⁴⁸ And yet, largely absent is discussion of the how or why of student assessment or ongoing course/lecture evaluation, and a corollary lack of empirical data to confirm approaches taken to answering *what*, *when*, *how*, and *who* are in fact effective in reaching desired ends.⁴⁹ Perhaps this is because of the primary missing piece: an overarching understanding of the *why* for law's inclusion.

C. What of the Why?

The literature is not devoid of mentioning why we should include law teaching, particularly those articles that recommend the "what could be" (vs. just survey the "what is"). Reiterated *whys* include: to lessen

cal students and even patients) to gauge if our presumptive *whys* are in fact widely held and beneficial to professional development. Moreover, if we want to enhance legal education by learning what works (via empirical testing), then understanding and agreeing upon goals for inclusion of legal education in medical schools — the *why* — is critical to developing measures to test effectiveness (i.e., to see what works as defined by meeting the *why*). To accomplish goal clarification, we can model after the U.K. to help guide our way in reaching consensus on the *why*.

II. Teaching Law in U.K. Medical Schools

A. Developing a Core Curriculum

In the U.K., the Institute of Medical Ethics (IME) has taken the lead in covering how medical ethics and law should be taught, learned, and assessed.⁵⁴ Since 1996, IME has used a consultation process to build consensus, resulting in the first Consensus Statement on a core ethics and law curriculum in 1998.⁵⁵ The statement was updated in 2010⁵⁶ due to concerns over lack of progress in implementing earlier recommendations. Of note in the 2010 Statement is the inclusion of aims (potential "whys") for law teaching up front,⁵⁷ after which the Statement discusses how to meet the aims.

It is not clear how much consensus backs the aims. Importantly, however: (1) approximately 25 individuals comprised the subgroup developing the aims; (2) these aims guided the curriculum development process; (3) a broad consultative process was used to identify best practices; and (4) draft core curriculum

learning outcomes were posted on the IME website for additional input prior to finalization. Moreover, dissemination and implementation of the standards has been placed in one central body (IME), and it is also expected that additional work will be done related to assessment of the proposed learning outcomes.⁵⁸ As of this writing, it is not clear if the curricular goals have been routinely and systematically adopted by U.K. medical schools, which will be critical to assess and is especially important for the purposes herein to see if any lessons can be learned in the U.S. with the admittedly greater number and diversity of our medical schools.

This restatement is part of a larger IME education project to develop and implement best practices in the teaching, learning, and assessment of medical ethics and law in the U.K.'s 32 medical schools.⁵⁹ Notably, the project utilizes a consultation process that includes a hub-and-spoke model. This means that a steering group (hub), by maintaining fidelity to aim and provide oversight, works with a consultative panel comprised of major medical association and medical education leaders to create a new network of six regional medical school groups (spoke).⁶⁰ Interestingly, from the outset, it was envisioned that early-career doctors and medical students would be consulted.

B. Focusing on Law: An Additional Project

Similar to what we see in the U.S., the above endeavors joined law with medical ethics; however, a separate project honed in on legal teaching.⁶¹ With funding from legal and medicine education bodies, Preston-Shoot and McKimm undertook a literature review⁶² and survey⁶³ to fill in the gap in the U.K.'s "systematic understanding of where and how law is taught and assessed in undergraduate medical education."⁶⁴ Specifically,

The medical profession is undergoing further reform...around ensuring fitness to practice, regulation and licensing and there is an increasing research and practice emphasis on professionalism. It was therefore timely to review and evaluate how medical students acquire their knowledge and understanding of the law relating to medical practice.⁶⁵

The article provided an expansive review of literature addressing law teaching in medicine (much of which is mentioned within this article, but with additional international examples).⁶⁶ Their review reiterated what this article's review also found: it is not easy to identify articles that emphasize solely legal education, or that prioritize law above ethics teaching.⁶⁷

This clumping "tends to mask rather than critically explore the complexities or difficulties within the relationship between law and ethics."⁶⁸ Ultimately, their review identified "the need for more rigorous studies to evaluate medico-legal knowledge and skills development and retention."⁶⁹ Their survey also highlighted the degree to which law teaching is linked with ethics and focused on clinical contexts, reiterating the review in questioning support for the effectiveness of this approach.⁷⁰

Collectively, the literature review and survey revealed how little is empirically tested, bringing us back to the "what works" and "is it working" questions. "[F]urther research is required into whether a particular curriculum approach, or combination of teaching, learning and assessment activities, is effective in enabling students to embed and then skillfully apply their legal knowledge in a way that positively impacts on the experiences of patients and carers."⁷¹

It is not clear to date if the Preston-Shoot and McKimm project has led to additional action beyond informing key stakeholders and the public (as with the U.K. IME Project, it is important to track for lessons for within our shores), but the process undertaken, its results, and its recommendations are worthy of attention within our borders. When considered alongside the IME Education Project, we see interesting ways to fund and otherwise support (via a legal and medical education arms) a collaborative and consultative process (hub-and-spoke model) as a means to develop aims for legal education in medical schools — and as an antecedent to developing curricula models and testing their efficacy in achieving those aims.⁷²

III. What about the Elephant in the Room?

Sadly, despite our best intentions, the "real world" of medical education may undermine our efforts. "[M]edical training at root is a process of moral enculturation."⁷³ Moreover, "some students and researchers across jurisdictions report that legal knowledge derived from non-clinical education is trained out by clinical teachers."⁷⁴ Thus, our task is not as simple as designing a perfect law curriculum: what are we to do about a "hidden curriculum" that teaches through observation rather than a formal education?⁷⁵ While this age-old dilemma risks seeming so overwhelming an issue as to frustrate any attempts at change, the "elephant in the room" of any curricular reform requires overt attention.

Addressing the hidden curriculum allows us to recognize that while knowledge matters, equally (if not more) important are attitudes and behaviors observed on a daily basis. If clinicians espouse and openly reveal an attitude of contempt for the law or a simplistic

vision of what legal rules say, this may undermine any efforts to change student attitudes and behaviors vis-à-vis participation in the policy community. Succinctly put: “Even the development of an exquisite, multidisciplinary, four-year formal ethics [law] curriculum, staffed by the best role models dollars and commitment can ensure, will afford students little more than a temporary haven in what amounts to a stormy ethical [legal] sea.”⁷⁶ (One can imagine substituting law for ethics [as bracketed] with the same result.) Ultimately, the *why* we teach is deeply impacted by the culture in which we teach; unhelpful (or antithetical) cultures must be addressed before meaningful positive educational change can happen.

IV. What Have We to Learn?

A. Some Models for Interdisciplinary Education

Before turning to some lessons learned and vision for next steps, it is worth identifying promising trends within the U.S., which build upon a vision of an interdisciplinary, collaborative, and problem-solving education as a means for enhanced legal understanding among medical professionals (and vice versa).⁷⁷ As mentioned earlier, there have been innovations in teaching law and medical students together.⁷⁸ The Consortium for Culture and Medicine (CCM)⁷⁹ is another interesting model. Founded in 1978, CCM is a collaborative among a state medical university, a private university, and a private liberal arts college (within the same community) to address issues in medicine from an interdisciplinary approach. Courses such as Bioethics and the Law; Child Health Policy; Interdisciplinary Approaches to Aging; Global Health; and Genetics, Disability, and Law are open to a students from a diverse mix of disciplinary backgrounds, including, but not limited to, law and medicine (e.g., nursing, public health, anthropology, psychology, etc.). Through course interactions, students engage with other professional students versus simply opening up a law course to a medical student or two, and vice versa.

For example, in the Child Health Policy course,⁸⁰ legal and health professional students — including those in medical, nursing, and public health fields — learn about vexing policy dilemmas impacting child health, and work collaboratively to develop policy solutions by bringing their own profession’s expertise to bear on the issues. The intent is to move us beyond mere “Law 101 for Doctors” to truly collaborative work whereby each profession learns to better respect the role (and limits on such role) of their other-professional colleagues. Furthermore, the course uses a case-

based approach to learning, which roots discussion and encourages more engaged interaction among students. This builds on a learning method common in medical schools, the so-called “problem-based learning” or PBL.⁸¹ And its development with faculty from a local Medical-Legal Partnership (MLP) connects to the next trend: interdisciplinary education that fosters collaboration to address social determinants of health and social justice concerns of patients/clients.⁸²

MLPs,⁸³ which have grown in scope and breadth the past 10 years, are “collaborative endeavors between health care clinicians and lawyers to more effectively address issues impacting health care,”⁸⁴ specifically to “address social determinants of health and seek to eliminate barriers to healthcare in order to help vulnerable populations meet their basic needs and stay healthy.”⁸⁵ This novel approach to law and medicine is

MLPs offer an ideal forum through which to support cross-education and highlight how law is about more than “liability” (and its avoidance), with an explicit goal for MLPs’ work being the advancement of patient care through interdisciplinary teamwork.

premised on collaborative practice, and holds promise in featuring different sorts of role models for medical and legal trainees, thereby shaping a different medical (and legal) culture. Thus, MLPs offer an ideal forum through which to support cross-education and highlight how law is about more than “liability” (and its avoidance), with an explicit goal for MLPs’ work being the advancement of patient care through interdisciplinary teamwork.⁸⁶ Given the model’s successes and expansion (present at over 235 health institutions at 83 MLP sites across the U.S. as of this writing⁸⁷), in June 2010, the American Medical Association (AMA) adopted a policy encouraging formation and participation in MLPs by physicians.⁸⁸ The American Bar Association (ABA) also encourages its members’ participation.⁸⁹ The trend is even moving beyond our borders, e.g., Canada.⁹⁰

Finally, most recently we have seen emerge medical-legal centers as distinguished from health law centers within law schools. In 2010, the Florida State University Center for Innovative Collaboration in Medicine & Law was created through the efforts of the medical and law schools,

...to identify and facilitate (through education, the conduct and dissemination of scholarship, and performance of service activities) opportunities for members of the medical and legal professions, working together and with others, to foster improvements in the quality of life enjoyed by individuals and to promote public health in Florida, the United States, and globally.⁹¹

“[T]he Center’s constituents aspire to implement the level of respected research, education and service projects that will ultimately benefit the healthcare consumer, who represents the physician’s patient and the lawyer’s client.”⁹² This grounds the work of the Center in a shared goal — individual (and population) health and well-being. “Innovation” and “collaboration” are promising words to guide its work, which has already begun to address policy issues in aging.

Then, in February 2011 it was announced that Johns Hopkins University School of Medicine and nearby University of Baltimore School of Law would open a new collaborative center in July 2011 “that will be part academic institution focused on educating practitioners and students of medicine and law, and part think tank aimed at influencing health care policy.”⁹³ Again, unlike a traditional health law center (law school) or bioethics center (medical school), it will straddle both institutions and undertake a collaborative effort to enhance health versus simply focus on education of a single profession.⁹⁴ In addition to educational, policy influencing, and publication goals, the center seeks to develop “a set of core competencies in law and medicine for health care providers.”⁹⁵

These trends hold great promise for innovations in education and practice — and provide convenient staging grounds through which to develop, implement, and evaluate the tangibly experienced *why* of legal education for medical students (and professionals). For our purposes herein, most promising are opportunities to work with students to explicitly and implicitly influence perceptions of how the law can be a tool to improve health — the sort of thinking taking hold of legal scholarship and policymaking via a re-framing by therapeutic jurisprudence.⁹⁶ Moreover, enhanced opportunities for meaningful collaboration might address the problem of the hidden curriculum and acculturation in negative stereotypes or in ways that build walls. In sum, innovations like the above hold great promise for shaping the culture and the curriculum of medical *and* law schools to promote cross- *and* integrated training.

B. Lessons Learned to Offer Formation of the Why

The work of joint medical-law centers and innovative coursework involving the two professions highlight the need for active engagement of law schools, law societies, and legal professionals. Areas of common ground between the two professions in training and outlook have been highlighted⁹⁷ — similarities that can serve to open doors among professions in training. And yet, witnessing curriculum reform efforts first hand (within two different academic medical institutions in upstate New York — one private and one public) has clarified how complex these renewal endeavors are, and how tricky it will be to inject law into the existing and evolving curriculum.⁹⁸ Medical colleagues have asserted to this author that the law is intrusive, overly regulatory/burdensome, and derives out of “nowhere” (i.e., without “good” or perhaps any foundation). An oft-heard complaint is that there is too much law in medicine — and medical education.

With this in mind, perhaps our approach is off-target: Arguing that *more* (time, faculty) is necessary may be counter-productive. Rather, we need a transparent approach to reform, with a good dose of humility among law colleagues who should be willing to negotiate the nature of and appropriate place for law (with less focus on how much time and more on how to make the best use of available time and resources). An ability to recognize law’s limits and shortcomings helps as well.

To guide these efforts, we need to shift our approach from that of demystifying “the enemy” to deconstructing the enemy imagery. That is, many law professors may fear wholly adopting a defensive (on behalf of self and the legal profession) or an overly deferential default posture in the medical setting. Such stances may lead to more anger, fear, distrust, or uncritical analysis of the law among trainees, which is not ideal in an educational environment. Instead, by re-visioning law’s role as less the enemy or complex beast than a potential tool in advancing health, we might place law in its proper context for medical education. Consider, for example, the MLP model: building relationships through which physicians come to see lawyers as potential partners in advocacy (and not just someone to consult when something goes wrong) might serve to defuse the acrimony felt by physicians.⁹⁹

V. Next Steps: A Different Prism through Which to View Law Teaching in Medical Schools

A. To Do

We must seek to develop consensus around a richer and more complex vision of *why* we seek to include law teaching in medical schools, with our U.K. col-

leagues offering a potential process for such development. Only then can we adequately think more proactively about how to assess that what we teach is in fact effective, and with a mindset to continuously improve what we do. And only through more explicit engagement can we also address the power the hidden curriculum holds over the medical culture in which we teach.

B. What Is the Goal of Effective Legal Education in Medical Schools?: Potential Process and Partners

What might a consensus-seeking process look like? First we should gather input on potential *whys* and test their value among a broad stakeholder base. Respondents should be asked, “what is” and “what should be” (vis-à-vis the *why*, or goals for law teaching in medical schools). Following this, we should unearth what drives the “what should be” responses, and flesh out reasons for any divergence between “what should be” and “what is” responses. Next, we should envision how implementation of the goals (the *why*) might best be achieved, including if suggested promising trends and innovations (e.g., MLPs, interdisciplinary courses) could/do make a meaningful difference. (This also suggests a critical way to evaluate models’ effectiveness: do they effectively address the *why* of legal teaching of medical students?)

Potential goals could be put into the mix up front to stimulate discussion, so long as it is made clear that such are simply put forward as conversation starters and not as the only or preferred goals. With this caveat in mind, possible goals might be to:

- Enhance medical students’ ability to practice within the boundaries of the law (with some basic information on how those boundaries came to be, i.e., a contextual and historical appreciation for the law).
- Enhance medical student’s ability to minimize malpractice exposure through legal understanding plus greater awareness of a host of other proactive measures (e.g., enhanced communication, power of apology).
- Enhance medical students’ understanding of how law influences and shapes health care; how law and ethics relate to each other vis-à-vis health care; and how doctors can leverage this knowledge to develop and/or amend laws in order that they better serve effective clinical care.¹⁰⁰

To accomplish this, the Association of American Medical Colleges (AAMC)¹⁰¹ and the Association of American Law Schools (AALS),¹⁰² with input from the AMA and ABA, might unite in such effort, perhaps under

the auspices of an interdisciplinary organization such as the American Society of Law, Medicine & Ethics (ASLME),¹⁰³ an organization that addresses issues in teaching health law.¹⁰⁴ A steering group could guide efforts (hub) — with broad input from curricula and course leadership across the states — and include input from students, graduates (e.g., residents¹⁰⁵), and patients (spokes). Early targets for input could also come from leaders of models described earlier, who are at the vanguard of addressing *why* (even if not explicitly) through *how* in innovative ways. Through collaborative, engaged dialogue and with clearly defined goals and timelines, such group work could lead to guidelines setting forth measurable goals for legal education in medical training.

With ownership placed within AAMC, the resulting *why* could then be disseminated and tailored to fit individual medical schools’ needs (e.g., partnering with a nearby law school and its potential faculty and students; including a rural medicine focus; highlighting medical specialties or primary care). But any such tailoring would have as its foundation a collective sense of *why* medical students should learn about the law, from which we can then build the *what* they should know, *when* and *how* they should learn it, and from *who*. And a collective *why* allows us to build more effective measures against which to test success with our law-related medical education curriculum.

Conclusion

In sum, this is an exciting time to sit at the crossroads of law and medicine. It is understandable why we might want to dive in and develop new models for teaching law in medical schools.¹⁰⁶ Before (further) action, however, should come reflection and a meaningful, stakeholder-driven, consensus-seeking discussion of the goals of legal education: why do we think it matters that medical students learn about the law?

As physicians come into contact with the law and the legal system with growing frequency in future years, it is essential that this contact be as positive and productive as possible, not only for the physicians’ own legal, financial and emotional health *but also for the ultimate welfare of the patients whom the medical profession exists to serve*.¹⁰⁷

Consider the preceding a jumping off point for just such an engaged discussion.

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7. M. L. Norton, "Development of an Interdisciplinary Program of Instruction in Medicine and Law," *Journal of Medical Education* 46, no. 5 (1971): 405-411; B. J. Naitove, "Note and Comment: Medicolegal Education and the Crisis in Interprofessional Relations," *American Journal of Law & Medicine* 8 (Fall 1982): 293-304 (building on Norton article to discuss model interdisciplinary law and medicine course); C. M. Lawson, "Teaching Legal Medicine: An Interdisciplinary Seminar in Professional Ethics for Medical Students and Law Students," *Journal of Legal Medicine* 8, no. 1 (1987): 123-133; D. B. Wilkins, "Redefining the 'Professional' in Professional Ethics: An Interdisciplinary Approach to Teaching Professionalism," *Law and Contemporary Problems* 58, nos. 3 & 4 (1995): 241-258; E. Tobin Tyler, "Allies Not Adversaries: Teaching Collaboration to the Next Generation of Doctors and Lawyers to Address Social Inequality," *Journal of Health Care Law & Policy* 11 (September 2008): 249-291; S. B. Apel, "Teaching Law and Medicine on the Interdisciplinary Cutting Edge: Assisted Reproductive Technologies," *Journal of Law, Medicine & Ethics* (Summer 2010): 420-426; E. T. Tyler, M. A. Rodgers, D. L. Weintraub, "Bridging the Health and Legal Professions through Education and Training," in E. T. Tyler, E. Lawton, and K. Conroy et al., eds., *Poverty, Health and Law: Readings and Case Studies for Medical-Legal Partnership* (Durham, N.C.: Carolina Academic Press, 2011): 97-123, at 105-112.
8. See Tyler (Allies Not Adversaries), *supra* note 7; Tyler et al. (Bridging the Health and Legal Professions), *supra* note 7. See also the numerous articles describing the work of medical legal partnerships, an updated listing of which may be found on the website of the National Medical Legal Partnership (NMLP), available at <<http://www.medical-legalpartnership.org/resources/academic-articles>> (last visited December 30, 2011).
9. This section summarizes findings from the U.S. literature related to teaching law in medical schools. Its intent is to highlight key parts (as relevant to this article); readers desiring additional or more in-depth information are encouraged to read the full articles (see accompanying references).
10. See Olick, *supra* note 4.
11. See Lehmann et al., *supra* note 4; DuBois and Burkemper, *supra* note 4.
12. See Williams and Winslade, *supra* note 1; Schwartz, *supra* note 3; Olick, *supra* note 4; M. B. Kapp, "Teaching Health Law: Health Law Teaching in Medical Schools: Balancing the Different Roles," *Journal of Law, Medicine & Ethics* 54, no. 4 (2010): 863-869.
13. B. R. Grumet, "Legal Medicine in Medical Schools: A Survey of the State of the Art," *Journal of Medical Education* 54, no. 10 (1979): 755-758; A. R. Felthous and R. D. Miller, "Health Law and Mental Health Law Courses in U.S. Medical Schools," *Bulletin of the American Academy of Psychiatry and the Law* 15, no. 4 (1987): 319-327; B. Harry, A. R. Felthous, and R. D. Miller, "A Multivariate Analysis of Health Law Education in American Medical Schools," *New Directions for Mental Health Services* 1989, no. 41 (Spring 1989): 109-118; G. C. Persad, L. Elder, L. Sedig, L. Flores, and E. J. Emanuel, "The Current State of Medical School Education in Bioethics, Health Law, and Health Economics," *Journal of Law, Medicine & Ethics* 36, no. 1 (2008): 89-94; M. Preston-Shoot and J. McKimm, "Prepared for Practice? Law Teaching and Assessment in U.K. Medical Schools," *Journal of Medical Ethics* 36, no. 11 (2010): 694-699.
14. See Olick, *supra* note 4; LeBlang et al., *supra* note 6.
15. See Stirrat et al., *supra* note 6; Task Force on Health Law Curricula of the American Society of Law and Medicine, *Health Law and Professional Education* American Society of Law and Medicine, Boston, Massachusetts, 1985; M. Preston-Shoot and J. McKimm, "Teaching, Learning, and Assessment of Law in Medical Education," Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine, and Higher Education Academy U.K. Centre for Legal Education, 2010; A. J. Braunack-Mayer, L. H. Gillam, and E. F. Vance et al., "An Ethics Core Curriculum for Australasian Medical Schools," *Medical Journal of Australia* 175, no. 4 (2001): 205-210.
16. That the literature comes primarily from legally-trained scholars highlights another need: to investigate what our medically-trained and -based colleagues consider the importance of legal training and why.
17. M. B. Kapp, "The Interface of Law and Medical Ethics in Medical Intensive Care," *Chest* 136, no. 3 (2009): 904-909.
18. See Schwartz, *supra* note 3; Kapp, *supra* note 12; Task Force, *supra* note 15.
19. See Harry et al., *supra* note 13, at 111.
20. See Williams and Winslade, *supra* note 1; Grumet, *supra* note 13; Felthous and Miller, *supra* note 13; Harry et al., *supra* note 13.
21. See Williams and Winslade, *supra* note 1; Grumet, *supra* note 13; Felthous et al., *supra* note 13; Harry et al., *supra* note 13.
22. See Felthous and Miller, *supra* note 13; see also Williams and Winslade, *supra* note 1.
23. See Williams and Winslade, *supra* note 1, at 778.
24. See Harry et al., *supra* note 13; Task Force, *supra* note 15.
25. See Williams and Winslade, *supra* note 1; Olick, *supra* note 4; LeBlang et al., *supra* note 6; Stirrat et al., *supra* note 6.
26. See Williams and Winslade, *supra* note 1; Grumet, *supra* note 13; Harry et al., *supra* note 13.
27. See Williams and Winslade, *supra* note 1; Stirrat et al., *supra* note 6.
28. See Williams and Winslade, *supra* note 1; Olick, *supra* note 4; Stirrat et al., *supra* note 6.
29. See Williams and Winslade, *supra* note 1, at 783.

30. See Persad et al., *supra* note 13, at 93. The authors found an average of only 10 hours total for health law across all four years of medical school of the 59% of medical schools that require a health law unit (part of a larger course). *Id.*
31. See Olick, *supra* note 4; Persad et al., *supra* note 13.
32. See Felthous and Miller, *supra* note 13.
33. See Williams and Winslade, *supra* note 1; Olick, *supra* note 4.
34. See LeBlang et al., *supra* note 6.
35. See Schwartz, *supra* note 3; Harry et al., *supra* note 13; E. J. Emanuel, "Changing Premed Requirements and the Medical Curriculum," *JAMA* 296, no. 4 (2006): 1128-1131.
36. B. Zuckerman, M. Sandel, L. Smith, and E. Lawton, "Why Pediatricians Need Lawyers to Keep Children Healthy," *Pediatrics* 114, no. 1 (2004): 224-228.
37. See references at note 7.
38. See Schwartz, *supra* note 3, at 139.
39. See Williams and Winslade, *supra* note 1, at 783-784; Olick, *supra* note 4; Kapp, *supra* note 12; Task Force, *supra* note 15; Preston-Shoot and McKimm, *supra* note 13.
40. See Williams and Winslade, *supra* note 1; Grumet, *supra* note 13.
41. Grumet, *supra* note 13, at 756-757.
42. *Id.*
43. *Id.*
44. *Id.*, at 758.
45. See Harry et al., *supra* note 13, at 116-117; Persad et al., *supra* note 13, at 93.
46. See Williams and Winslade, *supra* note 1, at 783; Persad et al., *supra* note 13, at 93.
47. See Williams and Winslade, *supra* note 1, at 781; Persad et al., *supra* note 13, at 93.
48. See Williams and Winslade, *supra* note 1; Olick, *supra* note 4; LeBlang et al., *supra* note 6.
49. M. Preston-Shoot and J. McKimm, "Towards Effective Outcomes in Teaching, Learning, and Assessment of Law in Medical Education," *Medical Education* 45, no. 4 (2011): 339-346; Preston-Shoot and McKimm, *supra* note 15. For assessment methods in ethics, see J. Savulescu, R. Crisp, K. W. M. Fulford, and T. Hope, "Evaluating Ethics Competence in Medical Education," *Journal of Medical Ethics* 25, no. 5 (1999): 367-374.
50. See Grumet, *supra* note 13; Task Force, *supra* note 15.
51. See Jacobson and Bloche, *supra* note 2; Schwartz, *supra* note 3; Kapp, *supra* note 17.
52. See Jacobson and Bloche, *supra* note 2; Task Force, *supra* note 15; Kapp, *supra* note 17. See also Tobin Tyler (Allies Not Adversaries), *supra* note 7; see Tobin Tyler et al. (Bridging the Health and Legal Professions), *supra* note 7; Zukerman et al., *supra* note 36.
53. See Williams and Winslade, *supra* note 1.
54. Institute of Medical Ethics, "Institute of Medical Ethics Education Project," available at <<http://www.instituteofmedicalethics.org/educational.html>> (last visited March 9, 2012).
55. Consensus statement by teachers of medical ethics and law in U.K. medical schools, "Teaching Medical Ethics and Law within Medical Education: A Model for the U.K. Core Curriculum," *Journal of Medical Ethics* 24, no. 3 (1998): 188-192.
56. See Stirrat et al., *supra* note 6.
57. *Id.*, at 57.
58. *Id.*, at 56.
59. *Id.*
60. Institute of Medical Ethics, Report of the Medical Education Working Group, "Supporting Teaching and Learning of Medical Ethics and Law in U.K. Medical Schools – A Three Programme," available at <http://www.instituteofmedicalethics.org/edu_hist.html> (last visited June 29, 2011). More information on the project may be found in the IME Report of the Medical Education Working Group; the specific stakeholders included are identified in Appendix 2 of the 2010 Consensus Statement (see Stirrat et al., *supra* note 6, at 60).
61. U.K. Centre of Legal Education Project, "A Practice Survey of the Teaching, Learning, and Assessment of Law in Undergraduate Medical Education," available at <<http://www.ukcle.ac.uk/projects/pastprojects/mckimm>> (last visited May 17, 2011).
62. See Preston-Shoot and McKimm, *supra* note 49.
63. See Preston-Shoot and McKimm, *supra* note 13.
64. See U.K. Centre, *supra* note 61.
65. *Id.*
66. See Preston-Shoot and McKimm, *supra* note 49.
67. *Id.*, at 343.
68. *Id.*, at 344; see also Olick, *supra* note 4.
69. See Preston-Shoot and McKimm, *supra* note 49, at 344.
70. See Preston-Shoot and McKimm, *supra* note 13.
71. *Id.*, at 698.
72. A group process among leading educators was used in the U.S. to develop ethics curriculum core content, but this work had a more narrow inclusion and conferral process than the U.K. model. It is also recognized that the number and geographic spread of our medical schools may complicate a U.S. process. See C. M. Culver, K. D. Clouser, and B. Gert et al., "Basic Curricular Goals in Medical Ethics," *New England Journal of Medicine* 312, no. 4 (1985): 253-256.
73. F. W. Hafferty and R. Franks, "The Hidden Curriculum, Ethics Teaching, and the Structure of Medicine," *Academic Medicine* 69, no. 11 (1994): 861-871, at 861.
74. See Preston-Shoot and McKimm, *supra* note 49, at 343, citations omitted.
75. See Hafferty and Franks, *supra* note 73.
76. *Id.*, at 869 (bracketed words added). Other work posits, however, that professional education can positively impact behaviors; see, e.g., M. J. Bebeau, "The Defining Issues Test and the Four Component Model: Contributions to Professional Education," *Journal of Moral Education* 31, no. 3 (2002): 271-296.
77. See Tyler Tobin (Allies Not Adversaries), *supra* note 7, at 285-286. Law curriculum reform discussions have also looked to the medical school curriculum for lessons; for recent musings on this, see, e.g., E. Chemerinsky, "Rethinking Legal Education," *Harvard Civil Rights-Civil Liberties Law Review* 43, no. 2 (2008): 595-598; S. Patrick, C. N. Coughlin, and L. McElroy, "See One, Do One, Teach One: Dissecting the Use of Medical Education's Signature Pedagogy in the Law School Curriculum," *Georgia State University Law Review* 26 (2010): 361-415; J. S. Bard, "Addressing the Challenge of Teaching Skills in Today's Law Schools: How Medical Schools Used to Have the Same Problems We Do and What We Can Learn from Their Efforts to Solve Them," Working Paper Series (July 25, 2011), available at <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1894498> (last visited January 3, 2012). These writings reinforce the symbiotic nature of the two professionals' training and indicates that each has something to learn from the other.
78. See references, *supra* note 7.
79. See Consortium for Culture and Medicine, available at <<http://www.upstate.edu/ccm>> (last visited March 9, 2012).
80. Syllabus on file with author.
81. H. S. Barrows, "Problem-Based Learning in Medicine and Beyond: A Brief Overview," *New Directions For Teaching and Learning*, no. 68 (1996): 3-12; D. F. Wood, "ABC of Learning and Teaching in Medicine: Problem Based Learning," *BMJ* 326 (2003): 328-330; D. T. Vernon and R. L. Blake, "Does Problem-Based Learning Work? A Meta-Analysis of Evaluative Research," *Academic Medicine* 68, no. 7 (1993): 550-563; J. A. Colliver, "Effectiveness of Problem-Based Learning Curricula: Research and Theory," *Academic Medicine* 75, no. 3 (2000): 259-266. See also Tobin (Allies Not Adversaries), *supra* note 7; Tobin et al. (Bridging the Health and Legal Professions), *supra* note 7. For a discussion of how PBL, in turn, was influenced by the case method developed in law schools, see Patrick et al., *supra* note 77, at 369.
82. See Tobin (Allies Not Adversaries), *supra* note 7.
83. National Medical Legal Partnership, available at <<http://www.medical-legalpartnership.org/>> (last visited March 9, 2012).
84. A. T. Campbell, J. Sicklick, P. Galowitz, R. Retkin, and S. B. Fleishman, "How Bioethics Can Enrich Medical-Legal Collab-

- orations," *Journal of Law, Medicine & Ethics* 38, no. 4 (2010): 847-862, at 847.
85. National Medical Legal Partnership, "About Us," *available at* <<http://www.medical-legal-partnership.org/about-us>> (last visited March 9, 2012).
 86. See, e.g., see Tyler Tobin et al. (Bridging the Health and Legal Professions), *supra* note 7; see also references included in NMLP, *supra* note 8.
 87. National Medical Legal Partnership, "MLP Network," *available at* <<http://www.medical-legalpartnership.org/mlp-network>> (last visited March 9, 2012); see also A. L. Sorrel, "Doctor-Lawyer Advocacy: When Medicine Isn't Enough," *American Medical News*, February 21, 2001, *available at* <<http://www.ama-assn.org/amednews/2011/02/21/prsa0221.htm>> (last visited March 9, 2012).
 88. American Medical Association, Policy D-265.989, "Medical-Legal Partnerships to Improve Health and Well Being," *available at* <<https://ssl3.ama-assn.org/apps/ecom/PolicyFinder-Form.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fDIR%2fD-265.989.HTM>> (last visited June 27, 2011).
 89. American Bar Association, Policy 120A, "American Bar Association Medical-Legal Partnerships Pro Bono Support Project," *available at* <http://www.americanbar.org/groups/probono_public_service/projects_awards/medical_legal_partnerships_pro_bono_project.html> (last visited March 9, 2012).
 90. N. Pai, W. Miller, L. A. Chapman, E. L. Ford-Jones, T. McNeill, and S. F. Jackson, "Tipping the Scales: A Lawyer Joins the Health Care Team," *Paediatrics and Child Health* 116, no. 6 (2011): 336.
 91. Florida State University College of Medicine, Center for Innovative Collaboration in Medicine and Law, *available at* <<http://med.fsu.edu/?page=innovativeCollaboration.home>> (last visited March 9, 2012).
 92. D. Dulcie, "Enterprising New Academic Center at FSU: Leading the Country in Innovative Steps to Unite Medical Students + Law Students," *What's Going Round*, a publication from Florida State University's Dean of Students Department's Office of New Student and Family Programs, November 2010, at 3.
 93. M. Cohn, "Johns Hopkins, University of Baltimore Form Medical-Law Center," *Baltimore Sun*, February 15, 2011, *available at* <http://articles.baltimoresun.com/2011-02-15/health/bs-hs-hopkins-ubalt-20110215_1_health-care-phillip-j-closius-medical-law> (last visited May 25, 2011).
 94. Johns Hopkins Medicine Press Release, "Johns Hopkins, University of Baltimore Form New Center for Medicine and Law," *available at* <http://www.hopkinsmedicine.org/news/media/releases/johns_hopkins_university_of_baltimore_form_new_center_for_medicine_and_law> (last visited March 9, 2012).
 95. *Id.*
 96. D. B. Wexler and B. J. Winick, eds., *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Durham, North Carolina: Carolina Academic Press, 1997); A. T. Campbell, "Therapeutic Jurisprudence: A Framework for Evidence-Informed Health Care Policy Making," *International Journal of Law and Psychiatry* 33, nos. 5-6 (2010): 281-292.
 97. See Jacobson and Bloche, *supra* note 2; Schwartz, *supra* note 3; Tyler (Allies Not Adversaries), *supra* note 7.
 98. For readers interested in medical school curricula, a special supplement in *Academic Medicine* featured medical schools' reporting of recent curricular changes. See "Snapshot of Medical Student Education in the United States and Canada," *Academic Medicine* 85, no. 9 (September Supplement 2010): S1-S614.
 99. This description builds on discussion among faculty colleagues in the Center for Bioethics and Humanities about the themes in this paper during a faculty work-in-progress by the author on September 21, 2011. The discussion led to a vision of how relationships that are more value-added vis-à-vis lawyers' value to/for doctors (as doctors may be seen as valuable to lawyers inasmuch as we all need medical care) may enhance collaboration across disciplines. Or, as put by Elizabeth Tobin Tyler, "Interdisciplinary legal and medical education, focused on exploring common goals, also offers students a model of cooperation rather than hostility and distrust at a time when many doctors and lawyers view each other as adversaries rather than allies." See Tyler (Allies Not Adversaries), *supra* note 7, at 291.
 100. These goals are adapted from ones put forward by Kathy Faber-Langendoen, M.D., based on this article's author-led discussion of potential goals during a faculty work-in-progress presentation, *supra* note 99.
 101. Association of American Medical Colleges, *available at* <<http://www.aamc.org/>> (last visited March 9, 2012).
 102. Association of American Law Schools, *available at* <<http://www.aals.org/>> (last visited March 9, 2012).
 103. American Society of Law, Medicine & Ethics, *available at* <<http://www.aslme.org/>> (last visited March 9, 2012).
 104. See Task Force, *supra* note 15.
 105. Resident education, i.e., graduate medical education, has its own core competencies as laid out in by the American College of Graduate Medical Education (ACGME). M. G. Stewart, AGCME Core Competencies, *available at* <http://www.acgme.org/acWebsite/RRC_280/280_coreComp.asp> (last visited March 9, 2012). These core competencies, notably the "professionalism" and "systems-based practice" standards, may be useful in developing standards for undergraduate medical education (medical students) inasmuch as a continuum of training is envisioned.
 106. Future work will examine medical school curricula reform efforts and how law is reflected within such (if at all) – an update to earlier surveys to evaluate the current lay of the land for any trends or expressed goals behind approaches.
 107. See Task Force, *supra* note 15, at 24 (emphasis added).