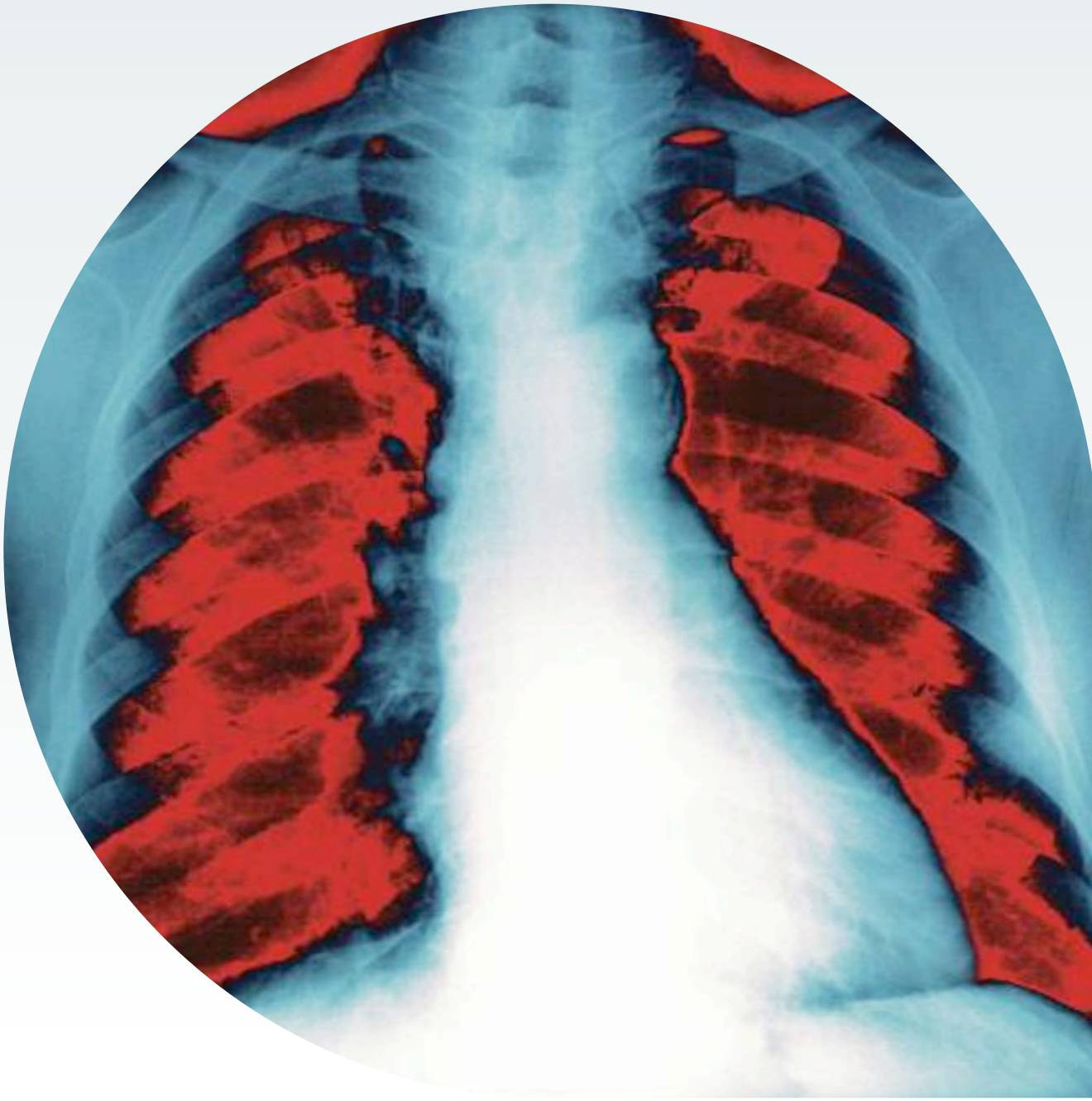
Teaching, Learning and Assessment of Law in Medical Education



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Michael Preston-Shoot and **Judy McKimm**

The Higher Education Academy Medicine, Dentistry and Veterinary Medicine

The Higher Education Academy UK Centre for Legal Education

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Judy McKimm
Visiting Professor of Leadership and Healthcare Education
University of Bedfordshire
Associate Professor and Pro-Dean
Health and Social Practice
Unitec
New Zealand

Michael Preston-Shoot
Professor of Social Work & Dean of Faculty of Health and Social Sciences
University of Bedfordshire

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The Higher Education Academy
UK Centre for Legal Education (UKCLE)
University of Warwick
Coventry
CV4 7AL
T: +44 24 7652 3117
F: +44 24 7652 3290
ukcle@warwick.ac.uk
www.ukcle.ac.uk

The Higher Education Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine (MEDEV)
Newcastle University
Newcastle upon Tyne
NE2 4HH
T: +44 191 222 5888
F: +44 191 222 5026
enquiries@meev.ac.uk
www.medev.ac.uk

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Judy McKimm

www.beds.ac.uk/departments/bhpms/staff/judy-mckimm

Michael Preston-Shoot

www.beds.ac.uk/departments/appliedsocialstudies/staff/michael-preston-shoot

Postscript

Since this knowledge review was completed, the consultation process for the revision of the curriculum for medical ethics and law has been completed and the results published (Stirrat *et al.,* 2010). The core content has been outlined, with an emphasis on recognition of ethical and legal issues, and on the development of knowledge and understanding. The curriculum, in terms of law, foregrounds legal and professional frameworks, patients' rights, consent and capacity, and confidentiality. The legal rules relating to children, people with mental distress, and challenges at the beginning and end of life are highlighted. The curriculum also envisages the development of knowledge and skills as students progress through their training, and the integration of this teaching and learning vertically and horizontally throughout.

Our findings reported in the practice survey would suggest that, to some degree at least, the specifications concerning law in the new curriculum remain aspirational. Our findings reported in the knowledge review, especially relating to the presentation of a generally harmonious relationship between law and ethics, also stand. Key challenges remain. There is welcome emphasis on the ability of students to demonstrate in practice their knowledge and understanding, but this comes in the context of explicit recognition of the power of a hidden curriculum. Further work would appear necessary on how the practice components of this curriculum can be strengthened to ensure that the well-being of patients is safeguarded.

Reference

Stirrat G, Johnston C, Gillon R Boyd K. Medical ethics and law for doctors of tomorrow: the 1998 consensus statement updated. Journal of Medical Ethics. 2010:36;55-60.

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Knowledge review

Judy McKimm
Visiting Professor of Leadership and Healthcare Education
University of Bedfordshire
Associate Professor and Pro-Dean
Health and Social Practice
Unitec
New Zealand

Michael Preston-Shoot
Professor of Social Work & Dean of Faculty of Health and Social Sciences
University of Bedfordshire

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2 Knowledge review

The Higher Education Academy UK Centre for Legal Education (UKCLE) and the Subject Centre for Medicine, Dentistry and Veterinary Medicine (MEDEV) jointly funded a knowledge review and practice survey of teaching, learning and assessment of law in medical education in 2008. The project, awarded to Michael Preston-Shoot and Judy McKimm, was based on the perceived need to develop a robust evidence-base in this area and arose from earlier work carried out by the researchers and other colleagues that examined law teaching, learning and assessment in social work and medical education commissioned by the Social Care Institute for Excellence (SCIE) (Braye et al., 2005). This knowledge review has been followed by a resource guide (Braye and Preston-Shoot, 2006) and the development of reusable electronic learning objects (Braye and Preston-Shoot, 2007), the purpose of which is to provide teaching, learning and assessment materials for use by those involved in facilitating students' academic and practice learning in this field.

The knowledge review found only limited empirical evidence on the effectiveness of different approaches to teaching, learning and assessment of law in social work education, which is a core and required curriculum subject on social work degrees, and has been a prescribed subject on social work qualifying programmes since 1989. A variety of curriculum designs, and teaching and assessment methods were described in the literature and found in the practice survey. However, there was little systematic research into processes of teaching or of assessing law learning. Major challenges included teaching and learning about law in practice placements, and involving service users and carers in students' law learning. The knowledge review concluded that there was an urgent need for an evidence-based approach to student learning in this area.

A National Teaching Fellowship (NTF) awarded to Michael Preston-Shoot has been used by the researchers to develop the evidence base for outcomes of law learning in social work education and medical education, the latter primarily involving student surveys. Specifically, in combination, the different research strands involving medical education have focused on:

- What enables students to acquire and to retain knowledge of the legal rules relating to medical practice, and skills in using law in medicine;
- How to engage student interest and effort in a subject about which students are often anxious or doubtful of its relevance;
- The effectiveness of different ways of organising the academic curriculum, in particular the question of discrete law modules versus integrated curricula which include law teaching within other areas of learning;
- The effectiveness of different ways of organising practice learning, in particular the impact on student learning of service and agency procedures, targets and attitudes;
- The balance between codifying specific law competencies and integrating law within broader statements of clinical competence;
- How to engage patients, service users' and carers' experiences into student law learning and assessment;
- Student reactions to different methods of teaching, learning and assessment of law;
- How students 'position' themselves towards the law and how this relates to their future professional practice.

The NTF project has attempted to evaluate the quality and effectiveness of different teaching, learning and assessment methods on medical students' attitudes towards law. It has sought evidence for change during student learning and outcomes at and beyond the conclusion of their qualifying degrees. This report contains the findings of the knowledge review and the practice survey, to which UKCLE and MEDEV have contributed funding. The survey of medical students carried out under the NTF funding will be reported upon separately. In addition, since the methodology adopted in respect of law in medical education has mirrored that used in relation to outcomes of law learning in social work education, it has been possible to explore differences and commonalities between medical and social work students' perceptions of law, and between different curricular structures, content and approaches to teaching law. This comparative aspect will also be reported separately.

2.1 Introduction

In medical education, the acknowledgement that students and practising doctors need a good understanding and application of the law is enshrined in a series of strategy and policy documents, including curriculum standards and benchmark statements. An assumption that doctors work within and understand relevant legal frameworks also underpins the patient safety agenda which is a strong theme running through Department of Health and other policy documents. The General Medical Council (GMC), in *Tomorrow's Doctors* (1993), identifies law as a core component of the undergraduate curriculum in the UK. This is framed as knowledge and understanding of the legal process and the legal obligations of medical practitioners, to ensure effective and safe practice. It includes appreciation of legal reasoning as an integral component of decision-making and practice, and an understanding of the main ethical and legal issues that doctors will encounter. It acknowledges a legal underpinning to practice in relationships with patients and other professionals, and in matters of consent to treatment, confidentiality, protection of children, human reproduction, death and dying, detention as a consequence of mental ill-health, and resource allocation. The 2003 revision of *Tomorrow's Doctors* included a greater emphasis on medical ethics and law.

The GMC latest recommendations on undergraduate medical education – *Tomorrow's Doctors (2009)* – structures its recommendations and learning outcomes around three areas: Doctor as Scholar and Scientist; Doctor as Practitioner and Doctor as Professional. It also sets out patient safety as a core underpinning principle. The section on the 'doctor as a professional' notes that the graduate will be able to behave according to ethical and legal principles. This entails understanding and accepting the legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients, their families and the wider public. This includes groups perceived as potentially vulnerable, such as children, older people and those with mental distress. Graduates should also demonstrate knowledge of laws and systems of professional regulation, including the ability to complete legal documents and to liaise where appropriate with relevant other professionals.

In addition to GMC recommendations, the QAA Subject Benchmark for Medicine (2002a) also requires that graduates should demonstrate a knowledge and understanding of the ethical and legal background for practice, and be able to apply this knowledge to practice. This is seen as applying particularly to confidentiality, consent to treatment, dealing with complaints, complying with legal responsibilities concerning death and dying, drug prescribing, mental health, abortion and the abuse of children and adults. Graduates must also have demonstrated knowledge and skills regarding respect for patients' rights, remaining up-to-date, and complying with clinical governance. Similarly, the QAA Subject Benchmark for Dentistry (2002b) includes medico-legal and ethical principles, especially regarding treatment and the involvement of patients in research. Dentists must be able to understand ethics and legal rules surrounding confidentiality, and demonstrate knowledge of health and safety legislation.

In postgraduate education and training, the Foundation Curriculum (which applies to all foundation trainees) specifies that "*At the heart of the Curriculum is the need to promote patient safety and high-quality care within the framework of clinical governance. The emphasis on developing doctors who are judgement-safe, patient-focused and accountable to the public for delivering evidence-based, effective medical care remains fundamental to creating the medical workforce of the future*" (UK Foundation Programme Office, 2007). Later in the curriculum, the following areas are specified:

- A basic knowledge and understanding of equalities legislation – including race, disability, religion, gender, sexuality and age – will be reinforced in the foundation years. Doctors will show an understanding of the impact on medical practice of this legislation, including how individual and communities' experience of discrimination and abuse may impact on health outcomes;
- In work-based learning – clinical accountability, governance and risk management; safe prescribing in clinical practice; the frameworks needed to ensure patient safety and legal responsibilities in ensuring safe patient care; patients rights;
- Specific competencies in ethical and legal issues, including:
    - medical ethical principles and confidentiality (including Data Protection Act and Freedom of Information Act);
    - valid consent (including the legal framework; children's rights and Gillick competency; mental health and incapacity);

- legal framework of medical practice (including legal responsibilities for completing death certificates; referral to coroner; compulsory detention regards mental health; patient reporting to DVLA; equality legislation; child protection and referral procedures; ionising radiation; living wills and advance directives.

Medical ethics and law topics are also included in all speciality curricula (many of which were under revision at the time of the knowledge review) although there is no systematic identification of core topics or key pieces of legislation. From a review of a range of speciality curricula (McKimm, unpublished report, 2008), topics identified include employment law; clinical governance and adverse incident reporting requirements; health law; medicolegal issues; *Bolam* principle; informed consent; competence; competent adult; child protection duties; *Gillick* principle; confidentiality; record keeping; coroner's court and when to refer; end of life decisions; DNR; limits of treatment; withdrawing and withholding treatment; criminal law and ethical principles relating to research (see for example the curricula of Medical Royal Colleges of Psychiatrists, Paediatrics and Child Health, Pathologists, General Practice, Obstetrics and Gynaecologists, Surgeons, Physicians and Anaesthetists).

However, whilst curriculum guidance might increasingly emphasise medical law, little appears to be known about the influence and impact of this curriculum on subsequent practice (Harry *et al.*, 1989; Shorr *et al.*, 1994). Some researchers have suggested that there are few, if any, studies that have specifically evaluated the effectiveness of teaching this curriculum to medical students or measured doctors' medico-legal knowledge (Warren, 1988; Goldie *et al.*, 2002; Saltstone *et al.*, 1997). Others suggest that there is only a limited consensus on how to teach and assess this curriculum within medical education (Weiss Roberts *et al.*, 2003) and limited exposure of UK and US students to medico-legal and ethics teaching despite the need for adequate knowledge of legal rules concerning the work of doctors (Knight and Thompson, 1986; McAbee *et al.*, 2006). Indeed, one paper (Darvall *et al.*, 2001) bemoans the lack of interest in Australia in researching doctors' knowledge of law. It is therefore timely to review and evaluate how medical students acquire their knowledge and understanding of the law relating to medical practice; of legal rules, concepts and constructs; and the skills needed to apply the law in a range of potentially complex clinical and community situations, including consulting with and referring to other professionals.

2.2 Literature sources

The main purpose of the knowledge review has been to assess the nature and the strength of the evidence base relating to teaching, learning and assessment of law in medical education. In so doing it provides an overview of trends in the literature and offers an opportunity to analyse the content of the best available papers.

The search strategy to retrieve material on medical education and law is outlined in detail in Appendix One. The search terms used are detailed in Appendix Two. This strategy retrieved 177 sources. The retrieved material clustered under four main themes:

- Those relating primarily to law teaching, learning or assessment or consideration of issues in medical education from a legal standpoint;
- Those relating primarily to ethics teaching, learning or assessment or consideration of issues in medical education from an ethical perspective;
- Those relating to the teaching, development and assessment of medical professionalism;
- Those relating to ensuring patient safety, including risk assessment and developing clinical judgement.

It was often unclear from reading the abstracts the degree to which law teaching/learning was a feature in discussion of ethics, professionalism and specific issues such as patient safety. Where there was any doubt after reading an abstract, acknowledging that legal issues have often been collapsed in the medical education literature into a broader discussion and evaluation of teaching ethics and/or professionalism, the full paper was read before a final decision regarding inclusion or exclusion.

Through a process of decision-making relating to inclusion and exclusion, the criteria for which are described in Appendix One, 134 papers were excluded and one was found to be unavailable within the time frame of the project.

Of those not considered relevant or suitable for inclusion, 69 were excluded after reading the abstracts, either because there was no reference to teaching, learning and assessment in medical education, and/or because the focus was on medico-legal issues in practice. The remainder were excluded after reading the full manuscript, where there was no reference to teaching, learning and assessment of law in medical education or where the approach taken was descriptive without any reported evaluation of the data being relied upon. A total of 42 articles were, therefore, included in the knowledge review. These publications are summarised in Appendix Three. The balance within the included publications is markedly towards the empirical, in line with the purpose of appraising the quality of the evidence. However, conceptual papers have been included where they have drawn upon evidence to advance understanding of teaching or assessing law in medical education, or assess how best to facilitate students' law learning as a prelude to, or within clinical practice.

The interest in the outcomes of teaching, learning and assessment of law in medical education predates, but has been greatly stimulated by, the generation of core curricula in the UK and elsewhere. The search strategy retrieved both a number of core curricula and also some editorial comment about them. Since these curricula underpin more recent publications about why law should form part of the curriculum for medical education, of what the curriculum should comprise, by whom it should be taught and how it might be assessed, these four publications have been listed separately for convenience in Appendix Four.[1]

What is the quality of reported research in this field? One model for evaluating the quality of published work (Baernstein *et al.*, 2007) suggests that features of rigorous methods included:

- Greater number of participants;
- Multi-institutional focus;
- Control or comparison group;
- Measuring objective outcomes;
- Measuring validated outcomes;
- Measuring outcomes at least one month after the intervention;
- Conducting the intervention more than once;
- Estimating statistical power.

Measuring objective outcomes means evaluation other than solely self-report or self-assessment. Measuring validated outcomes requires authors to have stated that their evaluation tool was validated beyond face validity or to have used instruments generally known to be validated. Against these measures, the 42 included studies do not perform particularly strongly. The full picture is given in Appendix 5. In summary, of the 42 included studies, 31 are based on empirical research. Of these:

- The number of participants ranges between 8 and 732, with response rates also varying markedly;
- Only 8 have a multi-institutional focus and of these all except one are surveys of academics in medical schools;
- Only one study has a control or comparison group;
- 18 studies include measures other than self-report by students or staff;
- Only 7 studies could be ascertained as having uses a validated instrument;
- Only 3 studies measures outcomes one month or beyond the intervention, reflecting a lack of follow-up to evaluate whether improvements in knowledge, attitudes or skills had been sustained;
- Only 2 studies used repeated interventions;
- 20 studies gave some estimates for statistical power of their findings.

1. Another curriculum was retrieved from Australia (Braunack-Mayer *et al.*, 2001), together with editorial comment (Breen, 2001), but the emphasis was found to be almost exclusively on ethics.

Types of outcomes have been classified by Kirkpatrick (1967) into a hierarchy which runs from modification of attitudes and perceptions, through modification of knowledge and skills, behaviour change in the workplace, and change in organisational practice, to benefit to patients. Overwhelmingly, the included studies focused on researching changes in attitudes and perceptions, and to a lesser degree modification of knowledge and skills. The lack of follow-up meant that few studies could demonstrate the impact of teaching and learning on actual changes to individual or organisational practice, or lasting benefit to patients.

Overall, a familiar conclusion may be reached (Baernstein *et al.*, 2007), namely that much published research focuses on local processes and relies on student satisfaction and short term acquisition of knowledge. In addition to concerns about the lack of generalisability of the findings, which may be circumvented to some degree by the frequency with which different studies report similar conclusions, notable by its absence is any reference in the included studies to insider research. Most of the studies exploring the degree to which teaching interventions impacted on student attitudes, behaviours and knowledge were conducted solely by members of staff either directly involved in that teaching or working within the same institution. This raises issues relating to insider research (Preston-Shoot, 2009b) and, whilst these might have been addressed in the research methodology adopted, the published papers remain silent on the ethics surrounding this practice.

2.3 Law and ethics

The UK core curriculum for teaching medical ethics and law (Ashcroft *et al.*, 1998) is based on the belief that good medical practice requires an understanding of both. There is, however, nothing to suggest that this relationship is complex or could prove difficult. Doyal and Gillon (1998) refer approvingly to medical ethics and law being a core component of UK medical education but a harmonious picture is presented of students participating in ethical and legal reasoning. A slightly different tone is set in respect of commentary upon a core ethics and law curriculum in dental education (Bridgman *et al.*, 1999) where it is proposed that both academic and clinical training might explore the relationship and tensions between them.

The draft revised core curriculum (Institute of Medical Ethics, 2009) maintains the close association of medical ethics and law in terms of understanding and awareness of issues in medical practice and decision-making. There is little to disturb this proximity, although perhaps implicitly it resides in the statement that students should be able to reflect critically on the ethical, legal and professional bases for clinical decisions. Yet, some emerging and some more longstanding health care issues challenge current law, examples being the separation of conjoined twins where both may otherwise die but where operating will also entail risk to life and may run counter to parents' wishes *(Re A (Children) (Conjoined Twins: Surgical Separation)* [2000] 4 All ER 961), and attempts to use the right to life in the European Convention to change UK law prohibiting assisted suicide (*R (Dianne Pretty) v Director of Public Prosecutions and the Secretary of State for the Home Department (interested party)* [2001] UKHL 61). The revised core curriculum reflects the change in emphasis of the GMC recommendations on undergraduate medical education, statements in *Good Medical Practice* (GMC, 2006), broader legal shifts and the patient involvement and empowerment agendas, setting out the curriculum under the following core elements:

- Professionalism – 'good medical practice';
- Informed choice and valid consent/refusal;
- Patients – values, narratives, rights and responsibilities;
- Confidentiality;
- Rights, justice and public health;
- Mental health and vulnerable patients
- Beginnings of life
- Children and young people
- Towards the end of life

(www.instituteofmedicalethics.org:80/edu_consult.html)

Legal knowledge and medico-legal skills are learned and discussed in the literature alongside ethics. Understanding of the law tends to be coupled with medical ethics[2] (Ashcroft *et al.*, 1998) or with the development of professionalism (Goldie *et al.*, 2007; Jha *et al.*, 2007). For example, Goldie and colleagues (2003) opine that whistle blowing should be addressed as part of professionalism. The focus to date has been much more on the ethical and regulatory dimensions of practice than the legal aspects which, in curriculum and learning terms, are often assumed, tacit and implicit rather than overt and explicit.

The Medicine Benchmark (QAA, 2002a) speaks of knowledge and understanding of the ethical and legal background for practice. It also refers to the application of ethical and legal knowledge to practice. The benchmark does not question this twinning. The Dentistry Benchmark (QAA, 2002b) also conflates these two sources of principles and knowledge. However, it also refers to graduates being able to make decisions on sound ethical principles, and to manage ethical issues in practice, without mention of possibly relevant legal knowledge and understanding.

The literature is generally silent on the relationship between ethics and law.[3] However, the paper by Olick (2001) explores the common and uncommon ground between the two disciplines whilst also observing that, in the United States, legal issues are subsumed within broader curriculum offerings. The paper notes that ethically appropriate medical responses may not necessarily be lawful, whilst compliance with legal rules will not always be synonymous with moral behaviour. The paper does not discuss in detail how doctors should respond when ethics and the legal rules diverge in their approach to a clinical situation. The relationship between law and ethics may also be problematic in practice. Students' personal beliefs may influence, and possibly even distort, how legal rules are implemented. As a result tutors may regard increasing students' knowledge of the law as an important precursor to behavioural change (Liu *et al.*, 2005). This observation points to the important distinction between the law-in-theory and the law-in practice (Braye and Preston-Shoot, 2009). What legislators intend is mediated by practitioners' personal assessments and organisational contexts. Neither this complexity, nor the assumption that increased knowledge directly impacts on individual and organisational practice, is really tested within the literature.

One example of the implicit manner in which law is discussed is the paper by Cordingley and colleagues (2007). They refer to the core curriculum for ethically and legally informed practice and investigate students' confidence in their knowledge, with particular reference to managing challenging situations. Whilst finding that students' perceived knowledge of ethical and legal principles is reported as good, and whilst asserting that understanding and knowledge of both ethical and legal issues is part of a doctor's toolkit, there are only three references to law in the entire article. This is despite the researchers finding evidence of some alarming student experiences, with both legal and ethical ramifications, including treatment without consent, breaches of confidentiality, and bullying by senior staff.

Similarly, Campbell and colleagues (2007) assert that there is much to recommend that medical ethics and law are taught together but their paper focuses mainly on ethics and does not interrogate the complexities surrounding the relationship between law and ethics. Moreover, they provide no evidence to support their opening assertion. Johnson and Haughton (2007) report student perceptions of what they find valuable when learning about ethics and law but it is difficult to discern from their paper how much emphasis on law there has been in the taught module that they are evaluating. What content was taught remains difficult to uncover. Students appear to suggest that doctors should follow what is stated in law rather than what they think is ethically right. However, this position is not interrogated. Elsewhere, within the literature included in this knowledge review, ethics is usually the dominant partner, with just occasional glimpses or minimal reference to legal rules (Goldie *et al.*, 2002; Weiss Roberts *et al.*, 2003). That this is not unproblematic is recognised by Hayes and colleagues (1999) who identified through their research on assessment of ethical knowledge a need for more explicit attention to law. Less developed is a reference by Wlasienko (2005) to legislation no longer being sufficient to deal with rapid change in bio-technology and medicine.

When discussing professionalism, there are suggestions that legal knowledge can reduce the likelihood of litigation (Gilbert *et al.*, 2003) and strengthen respect for patients' autonomy, decision-making capacity and access to health care resources (Notzer *et al.*, 2005). Once again, these statements are not followed up with detailed investigation.[4]

Thus, whilst presented as conceptual companions, for instance in core curricula (Ashcroft *et al.*, 1998; Bridgman *et al.*, 1999), the relationship between ethics and law is under-theorised in the literature, which has yet to engage critically with consensus statements about what students should be taught.

2. This is the approach adopted in a report of medical education in Italy (Giusti and Bacci, 1986).

3. Parker (2008) outlined some distinctions and connections, illustrating the interface between ethics and law with examples concerning decision-making capacity, in vitro fertilisation and care planning. He saw both law and ethics as imposing standards of conduct and as drawing on concepts such as duty and rights. However, law and ethics may provide different answers to policy and practice conundrums.

2.4 Why law?

Some authors view understanding of, and one's position towards the law as part of the development of a professional identity. This could be captured in the obligation to be better doctors (Johnston and Haughton, 2007), enhancing and promoting the health and medical welfare of patients, including respecting their dignity, autonomy and rights, by being able to participate in legal reasoning (Doyal and Gillon, 1998). Thus, the GMC in *Tomorrow's Doctors* (1993) frames the debate in terms of being clinically relevant and promoting the health and welfare of patients. Others argue that graduates must be equipped with a relevant understanding of the legal rules and be able to identify health care law issues for analysis. There are three levels here – medico-legal knowledge and skills to practise medicine well in respect of individual patients (the micro sphere), to collaborate with lawyers and other professionals (the interprofessional sphere), and to engage effectively in public debates about health care (the macro sphere), particularly with lawyers (Williams and Winslade, 1995).

Taking the micro sphere first, medical education teachers and researchers argue that front line clinical staff face many issues with major legal implications. These include child protection, informed consent, HIV testing and assessment of decision-making capacity (Darvall *et al.*, 2001; Simpson *et al.*, 2002; Weiss Roberts *et al.*, 2003; Hariharan *et al.*, 2006; Ashtekar *et al.*, 2007; Campbell *et al.*, 2007). Alongside this recognition, they have found widespread deficiencies in knowledge and understanding of legal principles and practice, for instance of child protection powers and duties (Ashtekar *et al.*, 2007), advance directives (Darvall *et al.*, 2001; Furman *et al.*, 2006), obtaining consent (Schildmann *et al.*, 2005), mental distress (Darvall *et al.*, 2001) and confidentiality (Elger and Harding, 2005). Students report feeling, or are assessed by researchers as being inadequately prepared for the medico-legal aspects of clinical practice (Furman *et al.*, 2006; Hariharan *et al.*, 2006; Gome *et al.*, 2008). This appears to suggest that teaching, learning and assessment of the core curriculum (Ashcroft *et al.*, 1998) in respect of law is proving less than effective, for example in enabling students to develop problem solving skills and to avoid being compromised by naivity and lack of preparedness (Knight and Thompson, 1986).

At the level of teamwork, Saltstone and colleagues (1997) suggest that one purpose of the curriculum should be to change students' attitudes towards law and the legal system, so that medical practice is less defensive and less concerned about litigation. Given the increasing and pervasive legal regulation of medical practice, and developments in case law (Beninger *et al.*, 1985; Felthous and Miller, 1987), a lack of understanding of law and lawyers may contribute significantly to negative attitudes (LeBlang *et al.*, 1985) and heightened risks of malpractice litigation.

At the macro level of public policy, Olick (2001) argues that doctors should contribute towards the shaping of legal rules. Less space is devoted in the literature to these two spheres of practice. Given the policy drive, in England in particular (see Preston-Shoot, 2009a), towards integrated services and changing professional roles, wherein different health and social care professionals need to be ever more confident and clear about their legal and professional responsibilities, the paucity of research into interprofessional practice as a rationale for teaching and assessing law within medical education is, perhaps, surprising. There is less discussion still of human rights, in particular Article 2 of the European Convention of Human Rights (the right to life), Article 6 (the right to a fair hearing) and Article 8 (the right to private and family life), and the possible tensions that might then arise between patients and family members and/or between patients and doctors.

To some degree the presented answer is influenced by the national context of the author(s). The US literature is more likely to emphasise the prevalence of litigation, the importance of reaching legally defensible decisions, and how doctors' lack of familiarity with court processes can prove distressing (Felthous and Miller, 1987; Olick, 2001; Gilbert

4. Amongst the excluded papers was also found discussion of the interface between law and ethics. Fallberg (2006) asked whether something could be good ethically when in conflict with the legal rules. Assisted suicide and confidentiality were explored as examples where the answer was suggested in the affirmative. The author also suggested that the medical community kept alive the notion that medical ethics overrode other considerations, including the legal rules. In similar vein, Elger and Harding (2002) found that many physicians justified their decisions by reference to ethics rather than with concern for legal provisions. Sommerville (2003) noted that legal boundaries limit the range of choices available before one examined ethical arguments, but argued for an obligation to look beyond the legal rules, especially where these were open to interpretation. Sokol (2008) argued that it was unwise to coalesce law and ethics completely because the former represented the lowest level of acceptable behaviour and the latter may vanish from decision-making. This knowledge review, however, indicated that the opposite may be a more pressing concern, with legal rules too implicit in academic and practice curricula. One may also argue that standards of decision-making in administrative law provided very clear guidance on the use of professional authority (Braye and Preston-Shoot, 2009). Faunce and Gatenby (2005) identified a possible strain between law and ethics as a basis for professionalism, drawing on the legal rules on sterilisation for an example. A final example of how ethics is seen as inclusive of legal issues emanated from the US, Miles and colleagues (1989), which also presented evidence that some students perceived ethics and law learning as irrelevant and where the legal rules underpinning abortion, obtaining consent for treatment, evaluating decision-making capacity were mainly addressed implicitly.

et al., 2003; Ping Tsao and Layde, 2009). However, this concern also emerges from research in Israel (Notzer *et al.*, 2005) and Japan (Mayeda and Takase, 2005), and is expressed too by UK educators (Johnston and Haughton, 2007). These concerns, providing a rationale for teaching law to medical students, are also found elsewhere in the literature.[5]

2.5 What law?

Tomorrow's Doctors (1993), did not focus on curriculum content. However, the consensus statements for medical education (Ashcroft *et al.*, 1998) and dental education (Bridgman *et al.*, 1999) do identify specific areas where knowledge of, and skills in practising within the legal rules will be relevant. For law in medical education (Ashcroft *et al.*, 1998), the focus is on informed consent and refusal of treatment, the clinical relationship, confidentiality, medical research, human reproduction, genetics, children, mental disorders and disabilities, death and dying, governance and professional regulation (including whistle blowing), resource allocation and rights. These content areas are listed and sub-divided but specific legal rules are implicit rather than explicitly stated. The curriculum is silent on students' thinking critically about the law. The emphasis appears to be on the acquisition and, to a lesser degree application of technical knowledge. Thus, Doyal and Gillon (1998) refer to students knowing their main legal obligations, and being able to participate in legal reasoning when taking decisions. However, they are enjoined to think critically about ethics.

This approach is continued in the draft revised core curriculum (Institute of Medical Ethics, 2009). Students must demonstrate an understanding of the legal framework and the necessity of avoiding unfair (rather than unlawful) discrimination. Criticality does enter the frame, with students required to consider, apply and reflect critically on the legal basis for decisions. There are references to teamwork and to whistle blowing although without specific reference to where these are required or encouraged in specific legal rules. Specific areas are then listed – informed choice and valid consent, patients' rights and responsibilities, confidentiality, rights and public health (including research and allocation of resources), mental health and vulnerability, beginning and end of life, and children and young people.

The dental curriculum (Bridgman *et al.*, 1999) follows the same format. Topics are listed and further sub-divided, the focus being on rights and duties, the clinical relationship, informed consent, vulnerable groups (children and adults with disabilities), standards of care, resource allocation and research. The purpose is seen as the transmission of knowledge and understanding followed by the clarification that daily practice involves legal content, and the development of legal reasoning in clinical decision-making.

Williams and Winslade (1995) provide several tables that illustrate curriculum content in US medical schools and how this has changed over time. Medical educators and researchers with particular clinical backgrounds and interests perhaps inevitably identify specific areas where the legal spotlight should or does shine. Thus, it has been suggested that curriculum content includes:[6]

- Legal system and recognition of legal issues, reasoning and principles (Warren, 1988; Harry et al., 1989; Hope and Fulford, 1994);
- Giving evidence in court and working with lawyers (Warren, 1988; Harry *et al.*, 1989; McAbee *et al.*, 2006);

5. Amongst the excluded papers, Faunce and Gatenby (2005) provide a distinct reason for including law in medical education, namely to explore the tensions between ethics, human rights and legal rules when confronted with corporate globalisation. Relating to the micro sphere of practice with individual patients, writers portrayed the field as increasingly affected by legal rules (Capron, 1988) and the medical profession as ignorant or uncertain about its legal responsibilities (Shaw, 2005; Fallberg, 2006), for instance about decision-making capacity and consent to treatment (Jackson and Warner, 2002; Evans *et al.*, 2007), attitudes towards transfusions (Goodnough *et al.*, 1994), or obligations towards patients with trauma-related injury (McNamee *et al.*, 2009). Students were reported as wanting more attention to be given to legal issues, for example about doctor-patient relationships, end of life decisions and access to health care resources (Jacobson *et al.*, 1989). Sokol (2008) suggests that it would be unwise to allow clinicians to practise without a basic awareness of the medico-legal landscape. Optimistically, Dewar (1994) reported research studies to show that, as doctors increased their legal and ethical knowledge, they become more comfortable dealing with sensitive clinical situations. Within the inter-professional sphere, Jones and colleagues (1990) referred to negative attitudes towards law(yers) and the need for medics to recognise that training on the legal rules and court room procedures and skills were a legitimate part of any residency programme. Without it, practitioners may well remain anxious about appearing in court and disillusioned with how lawyers were perceived to value doctors and medical opinion. They may remain reluctant to become involved with the legal system, for example when faced with having to report concerns about child abuse. Similarly Taha and Ravindran (2003) acknowledged that doctors may act negligently and that a focus on medico-legal training and on workplace culture is an important part of accountability for practice. At the macro level, Musick (1999) regarded one purpose of law teaching as enabling doctors to engage with confidence and expertise in discussions with the public.

- Medical malpractice and negligence, including duty of care, doctor-patient relationships and the legal defences available to doctors (Felthous and Miller, 1987; Harry *et al.*, 1989; Goldie *et al.*, 2000; Olick, 2001; Wlasienko, 2005; McAbee *et al.*, 2006; Ping Tsao and Layde, 2009);
- Confidentiality (Felthous and Miller, 1987; Harry *et al.*, 1989; Hope and Fulford, 1994; Goldie *et al.*, 2000; Olick, 2001; QAA, 2002a; Wlasienko, 2005; Persad *et al.*, 2008), including recording and access to information (Goldie *et al.*, 2002);
- Decision-making, for example about allocation of health care resources or end of life issues (QAA, 2002a; Simpson *et al.*, 2002; Wlasienko, 2005; Persad *et al.*, 2008), including being able to construct reasons for decisions (Goldie *et al.*, 2000);
- Consent to treatment (Felthous and Miller, 1987; Harry *et al.*, 1989; Hope and Fulford, 1994; Goldie *et al.*, 2000; Olick, 2001; Goldie *et al.*, 2002; QAA, 2002a; McAbee *et al.*, 2006);
- Management of complaints (QAA, 2002a);
- Safeguarding children and adults from abuse (Hope and Fulford, 1994; Saltstone *et al.*, 1997; QAA, 2002a; Simpson *et al.*, 2002; McAbee *et al.*, 2006) and family law (Goldie *et al.*, 2002);
- Mental health (Felthous and Miller, 1987; Harry *et al.*, 1989; Hashman, 1994; Saltstone *et al.*, 1997; QAA, 2002a; Goldie *et al.*, 2002);
- Abortion (QAA, 2002a) and practice surrounding conception and birth (Felthous and Miller, 1987; Hope and Fulford, 1994);
- Patients' rights (Felthous and Miller, 1987; Harry *et al.*, 1989; Goldie *et al.*, 2000; QAA, 2002a; Simpson *et al.*, 2002), including the law prohibiting discrimination (Goldie *et al.*, 2002);
- Drug prescribing (QAA 2002a; Simpson *et al.*, 2002);
- Whistle blowing (Simpson *et al.*, 2002; Goldie *et al.*, 2003);
- Public health (Saltstone *et al.*, 1997).

It is interesting to note what is foregrounded within curriculum content and what is marginalised. For instance, there is little reference to equal opportunity and anti-discrimination legislation, which has expanded markedly in the UK in the new century. No reference has been found to the legal rules relating to asylum and immigration, and to what extent people who have sought or been refused leave to remain may or should have access to health care. In relation to the content of doctor-patient communication, the emphasis is on confidentiality more than on those occasions when doctors might be required or asked to share information with other agencies, such as in investigations of child abuse or the protection of vulnerable adults.

Beyond identifying particular fields where legal rules are relevant, a focus is also necessary on knowing where to locate such knowledge and how then to apply this learning to problem-solving within clinical issues. Johnston and Haughton (2007) are amongst the few commentators who argue that students want an opportunity to acquire relevant and practical problem-solving skills rather than theory or knowledge for its own sake. However, their observation is framed in terms of ethics rather than the law.[7] Olick (2001) refers to the importance of covering common and uncommon clinical problems and of providing students with initial skills of legal reasoning and sensitivity to how the law frames the rights and duties of patients, families and doctors.

The literature includes little discussion of the purpose of including this content, namely whether the focus is on ensuring legal knowledge (the "what" within teaching and learning) and/or enabling students to engage critically with debates on why particular legal rules do (not) exist, and "why" and "how" they might be employed. In social work and in legal education, this distinction has been captured as a difference between Pericles and the Plumber

6. Not surprisingly, the same focus on discrete subject areas can be found elsewhere in the literature. Hope (1998), for example, emphasises consent to treatment, information sharing, confidentiality, patients' rights and decision-making. Claudot and colleagues (2007), in a discussion of ethics teaching, found that 19 out of 25 programmes offered curriculum content on human rights and 20 on patients' rights. Little detail, however, was provided. Jacobson and colleagues (1989) argued for the inclusion of teaching around issues concerned with life support, allocation of resources and risk-management.

(Twining, 1967; Braye *et al.*, 2005). However, Williams and Winslade (1995) comment that the purpose of medico-legal teaching should be to develop students' skills and to change attitudes towards the law rather than simply imparting knowledge and information.[8]

Little was found in the literature about the balance to be struck between breadth and depth. However, Harry and colleagues (1989) found that students may be less engaged if teaching attempts to cover all subject areas rather than to focus on a nucleus of topics. Hashman (1994) suggests that teaching should convey an understanding of breadth. Warren (1988) argues that single class sessions on particular topics will prove inadequate. However, this practice still appears to be quite dominant in reported curricula. Also noticeable is the absence of critical engagement with the consensus statements on the core curriculum and any explicit reference to the location of the legal rules, such as the Mental Capacity Act 2005 or the Children Act 1989. The law is, therefore, implicit rather than explicitly stated within the proposed content for the curriculum.

2.6 Structure and methods

The consensus statement (Ashcroft *et al.*, 1998) advocates that students should be introduced systematically to their legal responsibilities across the whole of the curriculum, and that sufficient time and resources should be available. It recommends that at least one full-time senior academic in law with relevant professional and academic expertise be used. Doyal and Gillon (1998) advise that it is no longer appropriate to rely only on well-disposed clinicians. The Institute of Medical Ethics (2009) recommends that teaching and learning should be integrated vertically and horizontally throughout the whole curriculum. In dental education (Bridgman *et al.*, 1999) teaching is recommended to commence with a foundation course which is then followed by problem based tuition integrated into the curriculum and applying initial learning to clinical situations. Large and small group tuition is advised, exploring issues in a case based manner. Learning will be sub-optimal if law teaching is seen as optional. Is that what happens in practice?

The literature does devote some attention to how law might be taught and learning facilitated. One aspect to this question relates to how the academic medico-legal curriculum might be structured. Here there is support for integration both horizontally, for instance via special study modules, and vertically (Goldie *et al.*, 2002; Campbell *et al.*, 2007; Johnston and Haughton, 2007) so that legal content is both covered in some depth but also infuses the curriculum. In US medical schools, a shift has been noted away from separate courses towards integrated curricula (Persad *et al.*, 2008). However, more research is required to evaluate whether this approach ensures that law learning is actually infusing medical education and whether it enables students to consolidate and apply their learning. Findings from the practice survey shed more light on this aspect.

Another aspect to the question refers to how the content might be conveyed. Here there is some agreement that learning is better facilitated when grounded in clinical experience and encounters rather than the simple classroom transmission of facts, including patient involvement to bring alive particular clinical issues (Alpert *et al.*, 1998; Gordon, 2003; Furman *et al.*, 2006). There is also support from students and tutors for small problem-based learning group work and individual tutorials (Hope and Fulford, 1994; Goldie *et al.*, 2000; Goldie *et al.*, 2002; Mayeda and Takase, 2005; Johnston and Haughton, 2007; Gome *et al.*, 2008), through which reasoning, policy and values may be probed, and for panel discussions and workshops (Hariharan *et al.*, 2006), rather than for formal lectures. Indeed, one research study found that this method did not lead to an adequate knowledge of the law and that students did not recall lectures even when this had been the primary mode of instruction (Walrond *et al.*, 2006). In their research, Mayeda and Takase (2005) found that students benefitted from using case law precedents because these brought to life actual legal and ethical practice issues, and the perspectives of different parties to an encounter. Case studies as the basis for small group teaching have also been found effective in developing students' professional identity but small group discussion was only found to work when students received more than twenty hours' tuition. (Goldie *et al.*, 2002). Other tutors/researchers indicate the potential value of students presenting cases they have worked with,

7. Jackson (2008), from amongst the excluded material, offered a student perspective, namely that the theoretical teaching of ethical and legal issues was well done but practical advice and knowledge, what to do in particular situations, was rarely covered in any depth. Similarly, Jones and colleagues (1990) suggested that teaching should provide information about courts, procedures and legal process, with a view to enabling students to learn when to access legal advice and to challenge any negative attitudes towards law(yers).

8. Schanz (1993) suggests that the purpose of teaching law to doctors is to develop a mentality or way of thinking, and problem solving, coupled with an ability to identify legal issues and to use law(yers) well.

or analyses of case law decisions (Warren, 1988; Liu *et al.*, 2005)[9] although LeBlang and colleagues (1985) caution that if used injudiciously, they can raise anxieties. Only one reference has been found to teaching taking account in a formal way of students' preferred learning styles (Williams and Winslade, 1995).

A third aspect to the question relates to particular methods. For example, in one study a mock trial is shown to have benefits in terms of immediate learning. The students appreciate the approach for its practical relevance, which was felt to enhance appreciation of the importance of medical record-keeping. However, the study did not include subsequent follow-up in order to research the impact and consolidation of the learning (Gilbert *et al.*, 2003). Four other studies have supported the use of mock trials, with its benefits of demonstrating legal principles and offering practice experience, although again without subsequent follow-up (Warren, 1988; Mayeda and Takase, 2005; McAbee *et al.*, 2006; Ping Tsao and Layde, 2009).[10]

A fourth aspect relates to whether taught modules should be compulsory or optional. Johnston and Haughton (2007) found student support for making the teaching compulsory to ensure that students accessed what is required as a foundation for practice. Persad and colleagues (2008) found that only 59% of US medical schools required a health law course, with just an average of ten hours across a four-year programme. They suggest that this is inadequate by way of preparation for the challenges of clinical practice.

A related question is how much teaching should be provided. Here there appears to be wide variation and an absence of research into whether there is an optimum amount of time on medico-legal education to enable students to consolidate their learning. Johnston and Haughton (2007) present their programme that involves thirty-two hours across five years. In their survey, Knight and Thompson (1986) found that medical schools reported anything between three and thirty-nine hours. In the US, Persad and colleagues (2008) found a range between two and sixty hours, with a mean of just over ten across four years. This minimal time allocation they assert is not commensurate with the subject's importance, an observation about reprioritising which Harry and colleagues (1989) also make. Persad and colleagues (2008) also highlight that the majority of the teaching falls within the first two years of medical study which is when students are furthest away from the actual legal and ethical dilemmas surrounding patient care. Again, it would be useful to research more thoroughly how the timing of law learning might impact on subsequent clinical practice. The question of how much time and when is also discussed by Wlasienko (2005) who argues that the volume of topics to be covered means that only brief attention can be paid to each, and that the closer transmission of knowledge is located to practice the more students might feel prepared for clinical encounters. Similarly, in a research study of family violence education (Alpert *et al.*, 1998), the researchers found that law learning was delivered in the first two years of medical education but with an expectation that it would be integrated and applied in clinical practice. However, preclinical instruction was not routinely adopted within patient care, partly because the learning was not emphasised within, or reinforced by, a practice curriculum. Once again, however, further research is needed on the question of how much learning should be offered when, including continuing or post registration professional development.[11]

The theme of continuing medico-legal professional development appears but rarely in this literature. This despite the pertinent observation that changes to legislation place an increasing burden on health care providers to update their knowledge continually (Saltstone *et al.*, 1997). Indeed, some researchers have been critical that postgraduate training programmes have not been developed or offered in a structured way, that presumptions are made that doctors are aware of their legal obligations, and that it is both difficult to keep up-to-date with legal developments and potentially unwise simply to rely on colleagues for information (Beninger *et al.*, 1985; Darvall *et al.*, 2001). One area where this is topical in the UK currently is mental capacity, deprivation of liberty and advance directives (Mental Capacity Act 2005; Mental Health Act 2007). Here, physicians may not be aware of recent statutory changes and the effect this will have on their practice (Stark Toller and Budge, 2006). Hashman (1994) recommends a specific core curriculum in relation to mental health legislation to ensure compliance with the legal rules and to avoid haphazard and uncertain knowledge and skill acquisition.[12] McAbee and colleagues (2006) suggest the importance of continuing professional development in paediatric practice, an argument which in the UK is reinforced by the developing legal rules surrounding the Children Act 1989 and the Children Act 2004. A related aspect is the reinforcement of earlier education. Thus, Schildmann and colleagues (2005) found that, despite comprehensive

9. Schanz (1993) refers to the use of case studies, student-led research papers and presentations, and searches of legal databases to assist with the development of legal knowledge, problem solving, and understanding of legal reasoning.

10. See also Jenkins and Lemak (2007).

undergraduate programmes in ethics, law and communication skills, there was a need for applied education on clinical procedures through which pre-registration house officers were obtaining patients' consent to treatment. The majority of respondents perceived some lack of knowledge, coupled with lack of confidence in how to respond to pressure from more senior colleagues.

A final related question here is who might teach medical law. Only a few references were found in the literature and none offer a fully researched evaluation of the effectiveness of different combinations. Williams and Winslade (1995) argue for the benefits of involving lawyers whilst recognising that tutors do not necessarily require legal qualifications to teach law to non-lawyers. Olick (2001) found that the use of practising lawyers could alleviate students' disquiet and foster more positive attitudes about law(yers) as well as communicate a knowledge base. Johnston and Haughton (2007) use dedicated advisers in medical law and ethics as well as other medical school staff, whilst Knight and Thompson (1986) drew on both full-time specialists in legal medicine as well as non-specialists. Goldie and colleagues (2002) used academics and practitioners without special expertise but where some training had been provided, whilst in their research Persad and colleagues (2008) found that just over one-third of teachers had published in the area of medical law. Others also report a combination of doctors and lawyers in curriculum delivery (Felthous and Miller, 1987; Hope and Fulford, 1994), with the argument that this provides students with a breadth of experience and perspectives. This is important because tutors' teaching skills are central to effectiveness, including providing a space for students to develop the ability to feel confident in constructive criticism of the decisions of colleagues in academic debate and clinical practice (Goldie *et al.*, 2000).[13]

2.7 Clinical practice curriculum

One particular feature of the structure for teaching law in medical education is the practice curriculum or clinical training context where students learn to apply what has been the focus of the academic curriculum. This is an under-developed component of teaching, learning and assessing law in medical education, just as it has also been in social work education (Braye *et al.*, 2005; Braye *et al.*, 2007). Olick (2001), for instance, sees the formalisation of legal education in clinical training as being in its formative stages. Knight and Thompson (1986) found that over half of student respondents rated this part of their medical course unsatisfactory, partly because of the variability of consultants pointing out medico-legal and ethical problems. It has also been suggested that most legal instruction takes place in the non-clinical curriculum, with students experiencing very little teaching when they are actually encountering legal and bioethical challenges (Persad *et al.*, 2008) and when they might be more likely to retain knowledge as it is directly relevant to their clinical activities (LeBlang *et al.*, 1985). The practice curriculum, therefore, appears neglected. By contrast, however, in another study (Saltstone *et al.*, 1997), 71% of students had received some medico-legal education during clinical placements. However, second-year residents were no more knowledgeable, suggesting that teaching had been relatively ineffective. This may be because case discussion occurs informally (Beninger *et al.*, 1985; Liu *et al.*, 2005), without legal issues being integrated into clinical rotations (Felthous and Miller, 1987). When, however, non-clinical teaching is returned to during the clinical years and reinforced (Goldie *et al.*, 2000), for example with interactive practical sessions and seminars facilitated by peers and more senior colleagues, case conferences, supervised practice and informal teaching opportunities (Hashman, 1994; Saltstone *et al.*, 1997; Walrond *et al.*, 2006; Gome *et al.*, 2008), it does appear to promote learning since it utilises contact with patients and

11. The literature on teaching professionalism and ethics also contains references to teaching law. On curriculum structure, Claudot and colleagues (2007) found that 21 of 25 programmes offered separate modules on ethics (which may have included some law input) whilst eleven offered an integrated curriculum approach and nine adopted both methods. Miles and colleagues (1989) promote both horizontal and vertical integration, with a theoretical foundation prior to clinical training and the development of practical skills during practice learning. On methods, they propose small group case discussions in order to illustrate the application of legal rules to practice, where possible with students present clinical situations. Jackson (2008) advises that students should reflect on critical incidents with experts in the field. Capron (1988) promotes the benefits of law and health care students learning together, drawing on clinical cases, so that the different values, assumptions and approaches towards decision-making of diverse professions can be debated. However, this approach is not evaluated. Simulated court room experiences as a learning method are once again discussed (Jones *et al.*, 1990). The question of timing is explored by Claudot and colleagues (2007) who found that seven schools offered teaching in the pre-clinical years, four in clinical training and nine in both.
12. Noteworthy here is Dewar's criticism (1994) that too often doctors rely on anecdotal information from non-expert sources for updating their legal knowledge.
13. In their review of ethics teaching, Claudot and colleagues (2007) found a lack of qualified teachers and an absence of true multi-disciplinarity.

experiences from which useful reflections can be achieved. However, for this learning to be effective in impacting on subsequent practice, single interventions with or without feedback may be insufficient (Furman *et al.*, 2006).

More worrying still, some students report that legal education in non-clinical years, for instance relating to domestic violence (Alpert *et al.*, 1998), may actually be "trained out" in clinical rotations by clinical teachers. Hariharan and colleagues (2006) also found that senior staff may signal that some knowledge is unnecessary for successful practice which then discourages students from bringing legal and ethical problems to the notice of clinical tutors. Thus, it appears that some practice learning environments may not reflect or reinforce the values and the content of the academic medical curriculum. To some degree, therefore, student learning may be unsupervised and/or unstructured at clinical sites. It then becomes unclear and uncertain to what degree they are informed about legal rules, participate actively in situations where they can implement legal knowledge, for instance about consent to treatment, and thereby internalise and develop their ethical and legal education (Notzer *et al.*, 2005).

Some researchers go one step further and refer to a hidden curriculum. Thus, Gordon (2003) suggests that in some clinical environments students may experience ethical (and legal knowledge) erosion and, therefore, be vulnerable to professional lapses. She identifies a conspiracy of silence surrounding quality and standards of care and, like others (Goldie *et al.*, 2003; Campbell *et al.*, 2007), points to the impact of role models, the loss of ethical sensitivity, and ambivalence about whistle blowing. In one study (Schildmann *et al.*, 2005), 28% of students experienced situations where they felt pressurised by senior doctors to obtain consent, often without supervision. One area for research, therefore, is to answer the question whether students actually behave in clinical situations as they do with standardised patients (Weiss Roberts *et al.*, 2003) and as they are taught in non clinical medico-legal education.[14]

Besides developing a practice curriculum for medico-legal education, what this analysis points up is the importance of continuing professional development, in law and ethics, for clinical teachers. If training is to be embedded in clinical placements, clinical registrars and house officers will require continuing professional development (Goldie *et al.*, 2004). Put another way, if students perceive legal and ethical problems, and have a heightened awareness obtained from earlier parts of the programme, then it becomes essential to ensure that supervisors too have sufficient legal and ethical knowledge. In one study (Walrond *et al.*, 2006) around half of the supervisors surveyed stated that they knew little of the law pertaining to their work. In such situations students are more likely to consult with colleagues, rather than with supervisors, even when they too know little about the legal rules (Hariharan *et al.*, 2006).

Although each clinical rotation should address legal and ethical issues, the consensus statement (Ashcroft *et al.*, 1998) considerably under-emphasised the practice curriculum. It referred implicitly to continuing professional development of clinical teachers by recommending workshops for tutors but, arguably, too much reliance remains on role models and apprenticeships with variable critical reflection on current practice. The draft revision (Institute of Medical Ethics, 2009) might also be said to give insufficient attention to teaching and learning law within clinical practice given what researchers have found. Neither the medicine nor dental benchmark statements highlight practice education. Within dental education (Bridgman *et al.*, 1999), perhaps marginally greater prominence is given to the practice curriculum, since students must learn to apply their intellectual understanding of ethical and legal knowledge in their evolving clinical experience. However, it remains unclear the degree to which advice, that teaching in ethics and law should feature in students' clinical experience, is heeded or whether learning remains opportunistic in placements as students encounter specialties and different patient groups.

14. Other literature also referred to the hidden curriculum and its impact on student behaviour (for example, Faunce and Gatenby, 2005; Shaw, 2005). Jackson (2008) observed a moral levelling, offering a student experience wherein teaching about the law was eroded during the rest of the curriculum, with students failing to report disagreements with the behaviour of senior colleagues. She argues that students' knowledge of key ethical and legal principles is good but that their confidence and ability to challenge senior colleagues in real life situations is low, with potentially disastrous consequences. She referred to the perceived hazardous consequences of failing to support senior colleagues. The literature excluded from this knowledge review also touched upon legal education within practice settings, suggesting for example that students had little opportunity to practise and reinforce the knowledge and skills learned within the academic curriculum (Goodnough *et al.*, 1994). That the practice curriculum trails the conceptual development of teaching law in pre-clinical years was also referred to (Miles *et al.*, 1989).

2.8 Assessment

The consensus statement (Ashcroft *et al.*, 1998) recommended that law learning should be formally assessed but did not give any indication of how this might be done. The draft revision (Institute of Medical Ethics, 2009) refers to students being able to demonstrate recognition of legal issues and, as their training progresses, conformity to professional and legal obligations in practice and the ability to integrate ethical analysis of clinical encounters with clinical knowledge and skills and legal obligations. This implied that assessment should take place within both academic and practice curricula. Law taught within dental education should also be assessed, with here a more explicit statement about assessment within clinical training. Law should feature within each clinical discipline and be subject to assessment therein (Bridgman *et al.*, 1999).

There are few papers that give detailed consideration to or research the outcomes of assessment practice.[15] Some commentators, for example Johnston and Haughton (2007) suggest that the developmental and conceptual focus on law in medical education should now turn from content to assessment of learning. Indeed, some researchers have suggested that legal knowledge is rarely assessed formally (Saltstone *et al.*, 1997). Others have found variable practice with, in one study (Persad *et al.*, 2008) 59% of US medical schools requiring course work in health law. A number of methods were recommended, including:

- Vignettes to gauge the effect of training (Shorr *et al.*, 1994);
- Unfolding case studies with short written answers (Johnston and Haughton, 2007);
- Standardised patient interactions, trigger video tapes, and modified essay questions (Weiss Roberts *et al.*, 2003);
- Questions on medico-legal principles (Gordon, 2003).

Some commentators have researched the utility of different assessment methods as students progress through their medical education. This mirrors a journey – know, can, do – with multiple choice questions to assess knowledge and open-ended case analyses, standardised patients or objective structured clinical examinations (OSCEs) to evaluate students' ability to apply what they have learned (Hayes *et al.*, 1999; Gordon, 2003). Campbell and colleagues (2007) envisage this student journey as one from knowledge, through habituation, to action. They recommend essays and multiple choice questions to assess knowledge and understanding; case reports and portfolios to evaluate awareness and critical thinking, and finally OSCEs to assess competence in actual practice. Although not necessarily expressed as such, what is being sought is an alignment (Braye *et al.*, 2005) between assessment methods and the tasks that students' will encounter in clinical training and post qualification.

What exercises some researchers is the anxiety that traditional education methods may be insufficiently strong determinants for students' or graduates' actual behaviour and performance in clinical settings (for example, Hope and Fulford, 1994; Gordon, 2003; Weiss Roberts *et al.*, 2003; Campbell *et al.*, 2007). How students analyse cases may not actually correlate with whether and how they act lawfully and ethically in practice. Hence, Hayes and colleagues (1999) rightly conclude that more research is needed on students' abilities to practise what might be termed legally literate medicine.

15. Hope (1998) argued for the need to develop assessment methods and to research which teaching methods appear effective in enabling learning. Assessment of different dimensions of learning is also discussed. For instance, McNamee and colleagues (2009) referred to assessing cognitive (knowledge), emotional (experience) and societal (external) dimensions. Mitchell and colleagues (1993) also captured the progression from knowledge (knowing what and how), through application (ability to select options), to actual performance in a clinical setting. Like others they proposed modified essay questions to assess a student's knowledge, and OSCEs to evaluate applied skills. They were concerned as to whether assessed performance translated into actual practice. Finally, Jenkins and Lemak (2007) report positive student evaluations for assessments orientated around practice simulations, echoing a theme in assessing law in social work education (Braye *et al.*, 2005), namely that assessment should align closely to the tasks that students encountered in practice once qualified.

2.9 Outcome evidence

Just how effective is teaching, learning and assessment of law in medical education? The evidence base is not extensive in relation to the quality, effectiveness or outcomes of different methods. The paucity of studies designed to measure what is known and practised has been highlighted by researchers in the field (Walrond *et al.*, 2006; Campbell *et al.*, 2007; Persad *et al.*, 2008) and was one motivation for this knowledge review and the practice survey that follows. There is certainly the need for more outcome research.

The studies that have been done are often not encouraging. One group of studies relates to practising physicians. An assessment of the legal knowledge of general practitioners, the impact of law on their practice, and their needs for information and training (Darvall *et al.*, 2001) found a very inadequate understanding of relevant law and, therefore, an enhanced risk of liability. Relevant statutory standards appeared to have little impact on actual practice and the researchers conclude that there is an urgent need to develop education programmes. This replays the emphasis given earlier in this knowledge review to the importance of continuing professional development. Stark Toller and Budge (2006) surveyed 56 doctors for their understanding of advance directives. Twenty-two out of 43 did not know the legal status of advance directives, and 44% did not find medical school education an important influence on their end-of-life decision-making. The researchers express concern about the advice that may be given to patients and their families, and concluded that improved training is needed.

Similarly, Ashtekar and colleagues (2007) found few junior staff with adequate knowledge of the basic principles for practice with children and young people. There were widespread deficiencies concerning understanding of the Children Act 1989 and child protection powers; 20% of junior doctors did not know the legal age for consent and hardly any junior doctors knew that unmarried fathers with parental responsibility could give consent for their child to be treated. Two-thirds of senior house officers and one-half of specialist registrars did not know that the police and social services have legal powers to protect children. No senior house officers and only 11% of specialist registrars appeared to understand the Bolam principle *(Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118) whilst just over half of senior house officers were aware of Gillick competence *(Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112). Those who had received more training performed better when tested about their knowledge.

Beninger and colleagues (1985) found that those with formal medical school education in law did not necessarily perform any better than those who had had no training. They were often unaware of specific statutes that would affect their practice. Moreover, experience did not necessarily mean that the accuracy of their knowledge improved, alongside which their access and exposure to relevant, accurate and up-to-date medico-legal information was poor, highlighting again points made about continuing professional development.

Hariharan and colleagues (2006), in a study of 159 health care professionals found that 52% of senior medics and 20% of senior nurses knew little of the law relating to their work and concluded that previous training had been inadequate or ineffective and that continuing professional development was required. Another account, of the ethical and legal knowledge of 50 house officers (Schildmann *et al.*, 2005), found a self-reported lack of knowledge alongside the absence of supervision when respondents were obtaining patients' consent to treatment. However, participants gave a high rate of correct answers to legal questions, suggesting a positive outcome of undergraduate teaching.

Knight and Thompson (1986) surveyed both students (see below) and newly qualified house officers. The majority of the latter (50 as against 26) were dissatisfied with the amount of instruction received, with implications for how ready they perceive themselves to be for practice. Amongst their criticisms were that law teaching was given too early, was insufficiently broad, and with an absence of practical instruction. There are clear parallels here with evidence presented earlier about the importance of timing some teaching and learning close to and within clinical placements, and that the practice curriculum itself should be developed. Students here were critical of the ad hoc approach to practice learning and supportive of supervision and continuing professional development. The study also found considerable variability amongst medical schools in terms of the emphasis given to medical law and the types of tuition available.

Finally, in a small scale study (with a response rate of 46% and a sample of 45) researchers wanted to know how much family medicine residents knew about medico-legal issues and what their attitudes were to their law training (Saltstone *et al.*, 1997). They found that knowledge was variable – excellent with respect to some issues but poor elswehere, for instance with respect to children and consent to treatment. The respondents saw legal knowledge as

important for good quality care and avoiding litigation but 69% felt inadequately trained, and 44% felt uncomfortable when dealing with medico-legal issues.

A second group of studies related to current students. An assessment of the effect of a class in medical ethics that contained tuition in legal issues, with a pre and post-test methodology amongst 110 students (Shorr *et al.*, 1994), found that the course had little influence, although the number of correct answers to factual knowledge questions increased. The researchers suggest that this finding could be attributed to students arriving with well-established ethical principles but it may be that the teaching provided was insufficiently followed through to enable learning to become embedded. More recently Johnson and Haughton (2007), in a sample of 238 medical students, found that 94% were interested in law and 87% perceived the subject to be (very) important. Some students described a learning journey from disliking the subject to understanding and appreciating its relevance, although a major barrier cited was that legal rules could be difficult to understand.

In a study to research whether students lacked knowledge regarding the law relating to confidentiality, Elger and Harding (2005) found trainees reporting insufficient knowledge and difficulty in understanding and following through on their obligations, in this case concerning patient confidentiality. Other students had also been found to be interested in but confused by legal rules (Saltstone *et al.*, 1997), presenting with variable knowledge and concerns about the inadequacy of training and the likelihood of having to respond to medico-legal issues. In a study of 55 medical students, high levels of inadequate legal knowledge were reported – 93% of students questioning their understanding, and 50% reported that they would seek advice from supervisors or senior colleagues, but the study also found that just over half of the consultants (14/27) also lacked legal knowledge relevant to their work.

Goldie and colleagues (2002; 2004) evaluated the impact of a three-year ethics programme. Some improvement was found to answers after the first year but none thereafter. They suggest that small group teaching can be effective providing that ethics and medico-legal education is integrated with the remainder of the curriculum and is assessed formally. In another study of 238 respondents (Goldie *et al.*, 2000), small group teaching was found to be highly acceptable to students and tutors. In a specific study on whistle blowing (Goldie *et al.*, 2003), involving 162 respondents, pre and post-test data in year one and post-test data in years three and five, little improvement was reported, for example in the legal implications of (not) reporting poor practice. Concern about the impact on careers and respect for the decisions of senior colleagues appear to off-set teaching about the importance of whistle blowing for patient well-being.

In an earlier study of one cohort of 75 students, (Knight and Thompson, 1986), 55 reported that teaching had been insufficient to allow them to cope with problems arising in practice. Only 25 were content with tuition, commenting particularly on the need for more time for the subject, for a broader scope to allow the inclusion of additional topics, such as alcohol and sexual offences, and for an emphasis in clinical training and practical experience alongside theoretical inputs. There have also been occasional reports that reading legal cases might actually increase students' anxieties (Mayeda and Takase, 2005). This highlights the importance of academic and clinical tutors being sensitive to what students may be taking from learning opportunities.

Perhaps more positively in respect of the impact of training, Gome and colleagues (2008) evaluated a ten-week rotation. They found that interns reported feeling better prepared by undergraduate legal teaching than they had appreciated prior to clinical education. Against nine of sixteen parameters they showed significantly increased scores for preparedness for practice. However, appreciation of and readiness for medico-legal issues remained at the bottom of the rankings of the sixteen parameters. Similarly, another study found that a formal session on informed consent in a paediatric residency education programme positively affected students' knowledge and attitudes about the topic (Sherman *et al.*, 2005). However, whilst the study draws on pre and post-test data, with an intervention and a control group wherein the former achieve better outcomes, there is no follow-up to ascertain whether the positive improvement in knowledge endures or impacts on subsequent practice. Moreover, on the legal rules sub-scale in this study, no significant differences emerged between the intervention and control groups, perhaps, the authors suggest, because of widespread familiarity about basic medico-legal issues within this sample. However, no data is offered by which this assertion can be interrogated. An alternative explanation was that a one-hour session proved insufficient to generate a marked improvement in the intervention as opposed to the control group.

Other studies of medico-legal education, involving pre and post-tests, have also reported increased student knowledge of legal issues and improved attitudes about the law as applied to medicine (Le Blang *et al.*, 1985; Liu *et al.*, 2005). However, these studies are limited because of the absence of further follow-up. In a study focusing on standardised patient interaction as a method of assessment, where ethical (and more implicitly legal) issues were

part of the text (Weiss Roberts *et al.*, 2003), students affirmed its value and relevance but also indicated the need for more training around confidentiality and consent to treatment. Another study concerns the usefulness of open-ended case analysis as a method of assessing the effect of an ethics course on students' decision-making skills, where they had also been taught about legal contextual matters (Hayes *et al.*, 1999). The researchers drew on pre and post-test data and focussed on informed consent, professional liability, resource allocation and physician assisted suicide. A high number of students cited legal precedents post-test but against other measures of legal rules low level scores were similar before and after the intervention. Students expressed uncertainty about the legal implications of certain decisions. Some students did identify the tensions involved in actions that could be morally right but unlawful and there did appear to be some change in how knowledge was used, rather than an increase in acquired understanding, between pre and post-test. The threat of litigation could be a greater influence on decision-making than the legal rules pertaining to a decision, suggesting that more emphasis should have been given in the course to legal precedents and rules.

Sometimes claims are made for which supporting evidence is unavailable. Thus, Ping Tsao and Layde (2009) suggested that training can lead to increased awareness of high risk situations and demystify the legal process, thereby reducing levels of anxiety and promoting a sense of control. However, this statement is not backed up with evidence. Olick (2001) suggests that taught inputs improve moral reasoning skills and ability to recognise ethical and legal issues but provided evidence only in respect of ethics rather than the law. Sometimes, the focus on ethics obscured attention to legally informed practice. A good example is the study by Cordingley and colleagues (2007) wherein there are only three references to law. It is therefore difficult to determine to what degree, when students report little confidence in their ability to address ethical challenges, or moral levelling and difficulty raising concerns with senior staff, they are also referring to their levels of legal knowledge and/or skills in its application. The evidence in the paper appeared to suggest that the problem lay less with their knowledge than with their confidence to challenge and deal confidently with challenging situations. What is certainly concerning, however, is the alarming rate of reporting practice experiences that appear to be both unethical and unlawful, such as misleading patients, failing to obtain consent, breaching confidentiality and bullying by senior staff. This finding reinforces the importance of points made earlier in respect of the practice curriculum and hidden curriculum. The authors also agree with the conclusion reached within this section, namely that more research is needed into the most effective methods of teaching.

2.10 Conclusion

This knowledge review has explored the evidence base within the published literature on law as it relates to medical education. As such it contributes to current debates and interest in aspects of professionalism and the development of professional identity. It is hard to escape the conclusion that more research is required into the most effective ways of teaching and assessing medico-legal knowledge and skills (Furman *et al.*, 2006) and that there is an urgent need to address the problems and potential for error in practice, whether in child protection (Ashtekar *et al.*, 2007) or elsewhere. It will also be important to consider what training on legal issues and competence follows initial medical education, given the rapidity with which legal rules change and expand.

In taking this agenda forward, some familiar barriers will have to be confronted, not least amongst which are financial constraints, staff disinterest, lack of expertise, and an already crowded curriculum (Knight and Thompson, 1986; Harry *et al.*, 1989; Williams and Winslade, 1995; Alpert *et al.*, 1998).

Evidence is available from other professions, such as social work education on how to equip students with the knowledge and skills for legally literate practice. Exploring this evidence base will enable parallels to be drawn with other available data so that patients and service users can benefit from improvements in the way in which health and social care professionals learn and apply the law in practice.

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3 Appendix 1

3.1 Search strategy for medical education and law

3.1.1 Electronic databases

Sector specific databases

- Lawtel
- Westlaw
- Lexis-Nexis
- Legal Journals Index
- Kluwer
- SOSIG
- MEDLINE
- PUBMED
- Embase
- PsycINFO
- CINAHL
- Caredata
- Web of science

General databases

- SIGLE
- BIDS
- ASSIA
- EBSCO
- JSTOR
- ERIC
- Synergy
- Ingenta
- Metapress
- Science Direct
- Highwire
- Ovid: Bibliographic Records
- British National Bibliography for Report Literature
- British Library Catalogue

Search terms were used that combined law and medical ethics with medicine, and linked these discipline fields with literature relevant to teaching, learning and assessment. Other health professions were excluded as the focus of the knowledge review, and accompanying practice survey, was on medical education.

The search terms used can be found in Appendix Two.

3.1.2 Hand searching

Manual searching of selected law, medicine, and medical education journals and abstracts was undertaken to identify additional materials. Specific journals included:

- British Medical Journal (British Medical Journal);
- The Lancet;
- Hospital Doctor;
- Journal of Medical Ethics;
- Journal of Postgraduate Medicine;
- Medical Education;
- Academic Medicine;
- Medical Teacher;
- Journal of Interprofessional Care.

3.1.3 Other sources

References cited in selected papers were followed up. In addition, relevant websites were searched, such as the King's Fund, General Medical Council, Medical Royal Colleges (Psychiatrists, Paediatrics and Child health, General Practice, Obstetrics and Gynaecologists, Surgeons, Physicians, Anaesthetists, etc.), and the British Medical Association. Links with staff at the UKCLE and MEDEV proved helpful and suggestions were also made by participants in the practice survey.

3.2 Selection criteria

The initial search included ethics and professionalism and professional behaviour as well as law, as increasingly the development of professionalism is coming under scrutiny and the teaching of professional skills/attitudes and behaviours often includes ethics and law.

All titles and abstracts were selected for review that discussed medicine, medical education and law, *and* focused on teaching, learning and/or assessment of law and/or legal knowledge and skills. Throughout, a distinction was made between law in medical practice and law in medical education. Whilst both aspects were found during the preliminary search, the final selection from abstracts for more detailed review was shaped by the focus on teaching, learning and assessment of law in medical education. Thus, perspectives from inquiry reports, from service user organisations and from statutory and voluntary organisations were included where they referred to teaching, learning and assessment of law in medical education. Where their focus was upon how doctors are implementing or use the law in their medical practice, these sources were only included if the discussion was then extended to implications for undergraduate or postgraduate medical education.

Reference to teaching, learning and assessment of law in medical education formed the initial screening question for this research review. Using the framework proposed by the National Health Service Centre for Reviews and Dissemination (NHSCRD, 2001), the initial selection criteria were expressed as follows.

Selection criteria	Inclusion criteria	Exclusion criteria
Population	All students, trainees and practicing clinicians in medical education/medicine	Students in other related disciplines
Intervention	Teaching, learning or assessment of law, legal knowledge, legal/ethical knowledge or legal skills in undergraduate programmes Teaching, learning or assessment in postgraduate medical education, CPD and vocational training	Using law in medical practice without referring to medical education Teaching, learning or assessment of ethics or professionalism without reference to law, legal knowledge or legal skills
Outcome	Acquisition of knowledge, skills or attitudes Curriculum development Professional practice Outcomes	
Study design/type of paper	Empirical papers Conceptual papers Descriptive papers	Papers not in English
Time frame	All relevant papers since 1985	

The focus has been on the teaching, learning and assessment of law, legal knowledge and skills in medical education. This focus has been framed by debates surrounding the content of any law curriculum in medical education. Papers referring to curriculum development necessarily form the starting point for the knowledge review.

4 Appendix 2

4.1 Search strategies

All databases were searched from 1985-2009. The earlier date was chosen to reflect the run-up to the Children Act 1989 and to capture developments subsequent to the Mental Health Act 1983. The earlier date was also intended to capture debate prior to the major shift in UK undergraduate education stimulated in1993 with the publication of *Tomorrow's Doctors:* the GMC recommendations on undergraduate medical education.

4.1.1 Index to theses

#1 legal education
#2 law teaching
#3 law skills
#4 education and law
#5 law and medicine
#6 medical law and ethics

4.1.2 Legal journals index

#1 legal education
#2 vocational training
#3 practitioner
#4 vocational qualifications
#5 teaching legal skills
#6 academic skills
#7 study skills
#8 legal study skills
#9 legal profession
#10 legal skills
#11 legal theory
#12 undergraduate legal education
#13 university legal education
#14 vocational education
#15 law education
#16 legal skills training
#17 law and medical practice
#18 law and medicine
#19 law and medical education
#20 law and medical ethics
#21 medico-legal education

4.1.3 Westlaw

#1 medicine
#2 medicine and education
#3 medicine and training
#4 medicine and practice
#5 medicine and child abuse
#6 care proceedings
#7 medical practice
#8 law and medicine
#9 medical values
#10 law and medical practice
#11 Children Act and education
#12 Children Act and training
#13 medicine and children
#14 medicine and child care or childcare
#15 medicine and mental health law
#16 medical education and law
#17 undergraduate medical education and law
#18 medical ethics and law
#19 medico-legal education
#20 medical law and consent

4.1.4 Ebscohost research databases – academic search elite

#1 medicine
#2 law
#3 medicine and law
#4 medical practice
#5 communication skills and medicine
#6 medical practice and law
#7 medical ethics and law
#8 education and medicine
#9 legal education
#10 medical profession and law

4.1.5 SIGLE 1985-2007 (index to grey literature)

#1 medical education
#2 legal education
#3 law education and theory
#4 law and medical education
#5 child protection and law and educat*
#6 family and law and educat*
#7 family and law and train*
#8 adoption and law and train*
#9 adoption and law and educat*
#10 adoption and law
#11 disab* and law and educat*
#12 disab* and law and train*
#13 mental health and law and train*
#14 law and mental health and educat*
#15 nurs* and legal and educat*
#16 health service* and law and train*
#17 health service* and law and educat*
#18 communit* and law and educat*
#19 educat* and law and nurs*
#20 educat* and law
#21 law and nurs*
#22 law and medicine
#23 ethics and law and medicine
#24 medical ethics and educat*
#25 professional practice and law

4.1.6 ASSIA (applied social sciences index and abstracts)

#1 medicine/de and law/de
#2 medicine/de
#3 medicine/de and computer assisted instruction/de
#4 medicine/de and education/de

4.1.7 Social services abstracts

#1 law/de and medicine/de
#2 law and clinical medicine
#3 law and international medicine
#4 law and occupational medicine
#5 medical education research
#6 medicine theory

4.1.8 Ovid medicine/medical education abstracts

#1 disab* and law and educat*
#2 educational programs/de
#3 institutional ethnography/de
#4 disabilities/de
#5 colleges/de
#6 legislation/de
#7children/de
#8 civil rights/de
#9 special education/de
#10 medical education supervision and training/de
#11 medical education/de
#12 undergraduate education/de
#13 medical practice/de and education
#14 law and education and training/de
#15 medicine and educat* and law
#16 law/de and medicine/de
#17 interdisciplinary education/de
#18 interdisciplinary education/de and law
#19 ethical and legal issues/de
#20 medical students/de
#21 educational preparedness/de
#22 legal issues/de and medical education/de
#23 law and teaching
#24 undergraduate education/de and medical education
#25 medical students/de
#25 legal system and medicine
#26 doctors/de and lawyers/de
#27 medical ethics/de and law
#28 medical education and ethics and law
#29 professional medical practice and law
#30 medical profession and law
#31 professional values and law

4.1.9 JSTOR

1 legal education
2 legal and education
3 teaching law
4 health and teaching law

4.1.10 INGENTA

1 health and teaching law
2 health professional*
3 educ*

5 Appendix 3

5.1 Included papers

Authors	Focus	Date	Source	Country	Type
Alpert *et al.*	Family violence curricula	1998	Am J Prev Med	USA	Empirical
Ashtekar *et al.*	Knowledge in paediatrics	2007	Child: Care, Health & Development	UK	Empirical
Beninger *et al.*	Survey of knowledge	1985	Journal of Medical Education	USA	Empirical
Campbell *et al.*	Impact of ethics education on behaviour	2007	Medical Teacher	Singapore	Conceptual
Cordingley *et al.*	Clinical ethics & professional development	2007	Medical Education	UK	Empirical
Darvall *et al.*	GPs' medico-legal knowledge	2001	J Law Med Ethics	Australia	Empirical
Elger and Harding	Breaches of confidentiality	2005	Medical Education	Switzerland	Empirical
Felthous & Miller	Mental health law courses	1987	Bulletin Am Acad Psychiatry & Law	USA	Empirical
Furman *et al.*	Learning on advance directives	2006	J Paliative Medicine	USA	Empirical
Gilbert *et al.*	Mock trials as a teaching tool	2003	Obstetrics and Gynaecology	USA	Empirical
Goldie *et al.*	Medical ethics teaching	2000	Medical Education	UK	Empirical
Goldie *et al.*	Impact of teaching on behaviour	2002	Medical Education	UK	Empirical
Goldie *et al.*	Attitudes to whistle blowing	2003	Medical Education	UK/Canada	Empirical
Goldie *et al.*	Impact of teaching on behaviour	2004	Medical Education	UK	Empirical
Gome *et al.*	Preparedness of interns for practice	2008	Internal Medicine J	Australia	Empirical
Gordon	Personal & professional development	2003	Medical Education	Australia	Conceptual
Hariharan *et al.*	Knowledge, attitudes & practice	2006	BMC Medical Ethics	West Indies	Empirical
Harry *et al.*	Health law education	1989	New Dir Ment Health Ser	USA	Empirical
Hashman	Postgraduate training forensic psychiatry	1994	Med Law	Canada	Conceptual

Authors	Focus	Date	Source	Country	Type
Hayes *et al.*	Outcome assessment	1999	General Hospital Psychiatry	USA	Empirical
Hope & Fulford	Teaching ethics & law	1994	J Medical Ethics	UK	Conceptual
Johnston & Haughton	Students' perception of teaching	2007	J Medical Ethics	UK	Empirical
Knight & Thompson	Teaching of legal medicine	1986	Medical Education	UK	Empirical
Le Blang *et al.*	Impact of medico-legal education	1985	J Medical Education	USA	Empirical
Liu *et al.*	Outcome of teaching	2005	J Obstet Gynae Can	Canada	Empirical
Mayeda & Takase	Ethico-legal content in postgraduate clinical training	2005	BMC Medical Ethics	Japan	Empirical
McAbee *et al.*	Paediatric medico-legal education	2006	Pediatrics	USA	Empirical
Notzer *et al.*	Students' experiences	2005	Medical Education	Israel	Empirical
Olick	Teaching ethics and law	2001	Anat Rec	USA	Conceptual
Persad *et al.*	Review of health law education	2008	J Law, Medicine & Ethics	USA	Empirical
Ping Tsao & Layde	Psychiatric malpractice	2009	Academic Psychiatry	USA	Conceptual
Saltstone *et al.*	Knowledge of medical-legal issues	1997	Canadian Family Physician	Canada	Empirical
Schildmann *et al.*	Knowledge of informed consent	2005	Medical Teacher	Germany/UK	Empirical
Sherman *et al.*	Paediatric residents & informed consent	2005	Academic Medicine	USA	Empirical
Shorr *et al.*	Medical ethics teaching	1994	Academic Medicine	USA	Empirical
Simpson *et al.*	Learning outcomes	2002	Medical Teacher	UK	Conceptual
Stark Toller & Budge	Compliance with advance directives	2006	J Palliative Care	UK/Australia	Empirical
Walrond *et al.*	Students' knowledge, attitudes & practice	2006	West Indian Med J	West Indies	Empirical
Warren	Teaching health law	1988	J Health Adm Ed	USA	Conceptual
Weiss Roberts *et al.*	Students' skills & informed consent	2003	J Gen Intern Med	USA	Empirical
Williams & Winslade	Educating medical students on law	1995	Academic Medicine	USA	Conceptual
Wlasienko	Teaching ethics & law	2005	Science & Engineering Ethics	Poland	Conceptual

6 Appendix 4

6.1 Core curriculum materials

Authors	Date	Source	Country	Type
Ashcroft *et al.*	1998	J Medical Ethics	UK	Core curriculum
Bridgman *et al.*	1999	British Dental Journal	UK	Core curriculum
Doyal & Gillon	1998	British Medical Journal	UK	Editorial
	2009	Institute of Medical Ethics	UK	Draft revised core curriculum

7 Appendix 5

	Number	Multi-site	Control	Obj Out	Valid Out	Later Post	Repeated	Stat Pow
Alpert *et al.*	111	Yes	No	No	No	N/A	No	No
Ashtekar *et al.*	238	Yes	No	Yes	No	No	No	Yes
Beninger *et al.*	111	No	No	Yes	No	No	No	No
Campbell et al.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cordingley *et al.*	732	Yes	No	No	No	No	No	No
Darvall *et al.*	541	Yes	No	Yes	No	No	No	Yes
Elger and Harding	311	No	No	Yes	No	No	No	Yes
Felthous & Robert	127	Yes	No	No	No	N/A	No	Part
Furman *et al.*	8	No	No	Yes	No	No	No	Limited
Gilbert *et al.*	43	No	No	No	No	No	No	Yes
Goldie *et al.*	268	No	No	No	Yes	No	No	No
Goldie *et al.*	85	No	No	Yes	Yes	Yes	Yes	Yes
Goldie *et al.*	162	No	No	Yes	Yes	Yes	No	Yes
Goldie *et al.*	503	No	No	Yes	Yes	Yes	Yes	Yes
Gome *et al.*	25	No	No	No	Yes	No	No	Yes
Gordon	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hariharan *et al.*	159	No	No	Yes	No	No	No	Yes
Harry *et al.*	127	Yes	No	No	No	N/A	No	Yes
Hashman	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hayes *et al.*	94	No	No	Yes	No	No	No	No
Hope & Fulford	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Johnston & Haughton	238	No	No	No	No	No	No	No
Knight & Thompson	174	Yes	No	No	No	No	No	No
Le Blang *et al.*	80	No	No	No	No	No	No	Yes
Liu *et al.*	57	No	No	No	No	No	No	No
Mayeda & Takase	102	No	No	Yes	No	No	No	Yes
McAbee et al.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Notzer *et al.*	144	No	No	No	No	No	No	Yes

	Number	Multi-site	Control	Obj Out	Valid Out	Later Post	Repeated	Stat Pow
Olick	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Persad *et al.*	62	Yes	No	No	No	No	No	No
Ping Tsao & Layde	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Saltstone *et al.*	45	No	No	Yes	No	No	No	Yes
Schildmann *et al.*	50	No	No	Yes	No	No	No	No
Sherman *et al.*	27	No	Yes	Yes	No	No	No	Yes
Shorr *et al.*	110	No	No	Yes	Yes	No	No	Yes
Simpson et al.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stark Toller & Budge	43	No	No	Yes	No	No	No	Yes
Walrond *et al.*	55	No	No	Yes	No	No	No	No
Warren	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Weiss Roberts *et al.*	79	No	No	Yes	Yes	No	No	Yes
Williams & Winslade	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Wlasienko	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

1 Authors in italics denote conceptual rather than empirical paper

2 Quality criteria are taken from Baernstein et al., 2007.

Teaching, Learning and Assessment of Law in Medical Education

Practice survey

Michael Preston-Shoot
Professor of Social Work & Dean of Faculty of Health and Social Sciences
University of Bedfordshire

Judy McKimm
Visiting Professor of Leadership and Healthcare Education
University of Bedfordshire
Associate Professor and Pro-Dean
Health and Social Practice
Unitec
New Zealand

1 Table of contents

2 Introduction

2.1 Introduction to the practice survey

Between January and August 2009, Judy McKimm and Michael Preston-Shoot (University of Bedfordshire) carried out a UK *practice survey and systematic literature review of teaching, learning and assessment of law in undergraduate medical education* as a part of a mini-project funded jointly by the Higher Education Academy, UK Centre for Legal Education (UKCLE) and the Subject Centre for Medicine, Dentistry and Veterinary Medicine (MEDEV). The practice survey was accompanied by a systematic knowledge review of the literature on teaching, learning and assessment of law in medical education.

The practice survey utilised a survey questionnaire distributed to all UK medical schools which aimed to elicit information about where and how law was taught, learned and assessed throughout undergraduate medical programmes, and by whom. Alongside completion of the questionnaire, some schools provided examples of course documentation to illustrate or expand on questionnaire responses.

Following discussion of both this report and the knowledge review with the commissioning subject centres, further engagement with law teachers and others responsible for determining the content and assessment of the law teaching was planned, co-ordinated with the publication by the Institute of Medical Ethics of the 2010 Core Curriculum for Medical Ethics and Law in UK medical schools. Engagement focussing specifically on taking forward the work of the practice survey and knowledge review might include telephone interviews or meetings with law teachers or a subject centre national meeting. The latter would provide an opportunity to discuss the literature review and the findings from the practice survey and related research studies. It would also enable law teachers to participate in taking this work forward and to share practice.

When asked if they would be prepared to talk to us further about their responses to this questionnaire, 88% replied that they would be willing to engage further in the work of this project.

This report summarises the responses to the questionnaire survey with examples of curriculum information provided by medical schools where relevant.

2.2 The survey questionnaire

The questionnaire (see 6 Appendix 1: Survey questionnaire on page 34 below) was developed from an earlier questionnaire used in a practice survey of social work law teaching, learning and assessment (Braye *et al.*, 2005), modified to reflect the context of undergraduate medical education. The questionnaire and a request for provide general programme information was sent out via email to contacts responsible for law teaching in each medical school identified by the MEDEV nominated primary contacts (NPCs).[1]

Megan Quentin-Baxter (Director of MEDEV) contacted the NPCs in each of the medical schools in January 2009 to inform them of the practice survey and to say that the research team would be contacting ethics and law teachers from each of the schools. Elaine Paris and Carolyn Johnston (Kings College London), who were leading on a project funded by the Institute of Medical Ethics designed to update the *consensus statement on medical ethics and law teaching* (Ashcroft *et al.,* 1998), provided a list of ethics teachers (many of whom also teach law) from the UK medical schools. This was used as a basis for contacting the law/ethics teachers.

1. MEDEV has established a network of institutional NPCs across medical, dental and veterinary schools in the UK. These NPCs provide a valuable link between the subject centre and its constituents. Their role is to identify the needs of their schools and the constituency in relation to current learning and teaching support issues, and to help define the developing agenda for the subject centre. This network also helps to maintain links with the appropriate special interest groups and professional associations in medicine, dentistry and veterinary medicine. The subject centre keeps the NPCs informed of all contact that we had with programmes in their institution.

The questionnaire was designed to be completed electronically or by hand and emailed or posted back to the researchers. The questionnaire was sent out in February 2009 after some delay in identifying contacts. Respondents were initially asked to respond by 23rd March 2009. Four reminders and offers to assist by completing the survey form from curriculum documentation were sent out. Although this resulted in some project slippage, the final responses were very positive in that 22 full responses and three partial responses were received by 25 August 2009.

2.3 Anonymity

Other than producing a general list of schools responding and not responding to the survey, respondents were informed that information provided would be collated and anonymised for the report on findings. No individual or school would be named in publications available to the public unless permission was sought and received to do so (for instance we might ask if we could cite something as an example of good practice).

This report summarises responses in the order of the sections in the survey questionnaire. We have summarised the responses from all medical schools for some questions and included specific responses for each medical school (coded) where there were illuminating differences which need to be further explored or explained.

3 Results

3.1 Section 1: Background information

3.1.1 Survey respondents

These were included in the summary tables in the report. Responses from those who provided 'partial responses' were also included where relevant.

Responses were received from 25 of the 33 medical schools contacted via the NPCs, a 76% response rate and 24% of medical schools contacted did not submit a questionnaire or partial response. See 7 Appendix 2: Respondents on page 46 below. The responding schools included one from Northern Ireland, two from Wales, two from Scotland and 20 from England.

The majority of individual respondents (92%) were those responsible for some part of the law teaching, the remainder were responsible for wider aspects of the undergraduate programme.

The responses received from the 25 medical schools covered both 'traditional' five year programmes as well as four year graduate entry programmes. No significant differences in law teaching were noted between the graduate entry and the five year programmes and therefore results were presented in relation to medical programmes overall.

3.2 Section 2: Content, structure and location of law teaching and learning

This section is about the **academic** taught element of the programme, practice learning is summarised later in the report.

3.2.1 Law as a separately taught topic

We asked:

Do you have a discrete law module/course or modules/courses in your programme?

Here we mean a course where law is taught as a separate topic, not where it is taught alongside (for example) ethics or professionalism.

Yes	8% (2)	No	92% (23)

Ninety two percent of schools teach law as an integrated topic alongside ethics, professionalism or clinical topics (see below for further details). This immediately highlights an issue identified in the literature review, namely whether there is sufficient coverage to ensure adequate development of legal knowledge and skills alongside other topics.

3.2.2 Location of discrete law teaching

We asked:

Where in the programme is separate law teaching taught?

Both programmes that teach law as a separate module offer this as a student selected component (SSC). This is in addition to core law teaching which is integrated with ethics. One school offers this as a six week SSC in year 1 (R25) and the aim of this course is to give an overview of medical law.

The other school offers a 3 week SSC in year 3 and a 12 week (30 CATS point) intercalated BSc module (R1). The aim of the SSC Doctor Patients and the Law is to provide students with an understanding of the basic principles of medical law (R1).

This school offers an SSC for up to five fourth year students each year. The learning outcomes varied and in 2009 they included:

- Gain an understanding of the workings of the GMC;
- Appreciate medico-legal consequences of negligence;
- Appreciate the medico-legal responsibilities of junior doctors;
- Gain a basic understanding of the English legal system;
- Improve teamwork skills;
- Build on oral presentation skills;
- Reflect on ethical background to medical law;
- Three individual areas for learning outcomes (students make presentations on three topics in syndicate groups of three: thus the learning outcome might be "*develop an in-depth understanding of the law on confidentiality*");
- Appreciate the interface between doctors and other professionals involved in medico-legal issues;
- Become familiar with appropriate sources of information in medical law;
- Appreciate the risks of litigation in clinical practice;
- Develop an understanding of law-related career paths;
- Develop familiarity with the language and conventions of law.

In addition, four other schools identify that they offer a separate SSC in medical ethics and law. We believe that other schools offer a BSc or other award bearing programme in ethics and/or law (for instance as an intercalated degree option) but no information was provided via the survey.

These results also raise questions that were surveyed in the literature review. One relates to the balance between compulsory and optional modules of learning and whether medico-legal teaching should be left to any degree to student choice. Another question relates to the timing of learning, with the research evidence tending to support academic input close to and within clinical placements. A third question relates to the amount of curriculum space devoted to legal issues, with some research evidence in the literature review suggesting that, for learning to be retained, particular levels of teaching and learning were required.

3.2.3 Reasons for teaching law separately

We asked:

What is your rationale for locating some or all of your law teaching/learning in a discrete module/course?

Respondents cite the reasons for teaching law as a separate topic through an SSC as being a lack of curricular time on offer for law (R1, R25). This requires "*that an SSC be developed. The new MSc Interprofessional Health & Social Studies was deemed an appropriate place for a discrete module*" (R1).

3.2.4 Law teaching outside the medical school

We asked all schools:

Is legal content taught/learned on any university based module/course other than a law module/course?

In terms of the core curriculum, *no* programmes include law teaching offered by any other university based modules or courses, but see Section 3.2.1 above regarding an optional programme including law for some students.

3.2.5 Law as an integrated topic

We asked:

Where in the academic programmes does law teaching/learning appear?

Responses indicated that many courses include law as an integrated topic within themes including ethics, professional development or professionalism, patient care, research or medicine in society or as integrated within academic teaching related to clinical specialities, for example psychiatry.

Not all schools responded in detail to this question, however of the 60% that did respond, the majority of programmes offer academic courses in the earlier years. This highlights again the question of timing raised above and in the literature survey. A summary of academic teaching across years of the programme and range of hours of teaching is tabled below. Of schools that offered academic programmes including law teaching, 93% offer this in years 1 and 2, 86% in year 3, 77% in year 4 and 65% in year 5. The number of hours taught varied widely between schools. The amount of teaching varies from an average of 11.5 hours in year 1 to an average of 4.6 hours in year 5.

Year 1	Year 2	Year 3	Year 4	Year 5
Contact hours relating to law	Contact hours relating to law	Contact hours relating to law	Contact hours relating to law	Contact hours relating to law
93% of programmes Range 9–40 hrs, average 11.5 hrs	93% of programmes Range 1–40 hrs, average 9.4 hrs	86% of programmes Range 3–40 hrs, average 9.6 hours	77% of programmes Range 0.5–20 hrs, average 6.1 hrs	64% of programmes Range 3–20 hrs, average 4.6 hrs

3.2.6 Aims and learning outcomes

We asked:

What are the aims of the law teaching/learning in these modules/courses? And what are the learning outcomes relating to law learning in these modules/courses?

A wide range of responses were received to this question (see 8 Appendix 3: Learning outcomes on page 48 below for an example curriculum). An overarching theme was that law and ethics were taught as integrated topics throughout the curriculum, including in the academic courses/modules. As reported below, many schools did not have specific learning outcomes for clinical placement law learning except for specific pieces of legislation which underpin practice, such as the Mental Health Act 1983 and Mental Capacity Act 2005, often covered in psychiatry attachments (for instance R29).

The broad aims cited by 60% of respondents included familiarising students with law in relation to ethical situations and clinical cases/settings. For example R23 noted that their aims were to:

- Provide an understanding of medical law and professional standards;
- Develop an understanding of the legal and ethical challenges encountered in clinical settings and how to deal with them;

- Encourage students to develop the skills and attitudes needed for good clinical decision-making and respectful, professional practice.

And the aims of R29's programme were to:

- Encourage students to explore the philosophical, professional and practical aspects of ethics and law in relation to medicine;
- Provide real case examples of legal and ethical dilemmas;
- Provide opportunities for students to reflect on these issues through reflective practice.

Many respondents noted the difficulty in identifying the specific learning outcomes related to law as these were integrated with ethics and clinical cases. Indeed the questionnaire itself generated some confusion with three respondents, one noting "*this questionnaire sometimes seems to incorporate ethical issues as part of the legal framework, while they may overlap – they are different disciplines and in the main our students get more general education in terms of ethics*" (R15).

A typical approach to the relationship between medical ethics and law was summarised by R22:

- "*If medical ethics is the entire body of norms of the medical profession, then medical law is an integral part of medical ethics. In the assumption that medical students should be aware of the ethics of their profession, they should also be aware of medical law. There is no essential difference then between medical law and, say, the guidelines of the GMC, the Royal Colleges, the particular NHS Trust's policy, etc.*"
- "*Philosophical ethics, that part of philosophy that deals with justifications for normative assertions, should not be confused with medical ethics. At any rate, to the degree that it should be taught at all, it applies to non-legal norms as much as to legal ones. The major focus of teaching in our school is on medical ethics. Philosophical ethics is supportive only.*"

Once again there were parallels with findings in the literature survey. One relates to the interface between law and ethics and the relatively unproblematic way in which the literature describes this relationship. Another relates to the focus of teaching law, specifically the degree to which the purpose is the transmission of essential knowledge and/or the development of a more critical understanding and skills set (Twining, 1967).

Topics covered by schools vary but commonly included fields were autonomy, informed consent, confidentiality, abortion, duties of a doctor and GMC guidance, duty of care, clinical negligence, standard of care, patient records, legal system, statute and common law, criminal and civil law, mental health, competence and capacity, detention, Human Rights, law relating to children, end of life care, resuscitation, death certification, women's health, Gillick, diversity and multi-culturalism, assisted conception, medical error, risk and doctor patient relationships. Relevant pieces of legislation were also covered.

3.2.7 Rationale for integrated teaching

We asked:

Why do you believe it is important to teach law only within other modules and not as a separate topic?

The reasons cited for teaching law **within** other modules (i.e. integrated) and not as a separate topic were primarily concerned with encouraging students to think about law in all areas of the programme, including clinical practice. Many schools incorporated law and ethics teaching as a vertical theme (as part of a spiral curriculum) throughout the course, although the more formal teaching tended to occur in the early parts of the curriculum. For example, "*ethics and law form a 'theme' within the Bachelors in Medicine programmes (graduate entry, traditional entry and widening access entry) and teaching and learning takes place across all years, but builds towards a finals essay question in ethics and law. There are no discrete modules and medical law is not taught separately*" (R30).

Some schools integrated law with other topics in the same way that all topics were integrated in their choice of overarching curricular structure, for example in a PBL curriculum or curriculum structured around 'learning weeks' or 'cases of the week' (often led by clinicians) where no topics were taught separately (R13, R21, R32). For example:

- "*We believe that ethics and law are part of clinical practice. As such, we adopt a spiral and integrated approach from the outset. All material is related to the clinical context of the learning week, whether in the classroom or on the wards. We cover all the topics in the core curriculum on ethics and law in medical education, but go well beyond the consensus statement to include areas of practice that are triggered by the rest of the curriculum and the student experience"* (R21).

R27 described their approach integrating law and ethics as follows:

- "*the aim of our course is to help students make judgements about what is the ethically right thing to do working within the legal guidance and constraints. A course purely in ethics would leave open the questions about how can/should doctors behave given the law. It would we think seem incomplete to say to students after a discussion of ethics: this has been about ethics, you will have to discuss in a separate course how your conclusions relate to what the law says. Similarly, a course purely on law would seem incomplete if students were not able to critique the law ethically. One further value of the combined course is that there are students who want 'facts' and the legal aspects can often satisfy such wishes. Indeed many students like the combination. Mixing law and ethics can provide a good balance between these different wishes. Legal judgements and concepts are often good pieces of ethical reasoning. Legal statements and guidelines should be subject to ethical analysis. The two disciplines complement each other nicely. Having said all this, we do not necessarily believe that it is important to teach law only within other modules. This is how we do it and we come from a primary background in ethics and philosophy. As always in education, there are many ways of approaching things and we are not dogmatic on the issue*".

Some respondents deemed it important to teach law viewed as part of everyday clinical practice so that junior doctors have a grasp of the law in relation to their practical duties (R7). "*Law and ethics are integrally related to the practice of medicine on a day to day basis. By integrating the teaching of ethics and law in to the practice of medicine, it is hoped that their relevance will be better related to the 'patients bedside'. To teach it separately would potentially run the risk of students thinking law is something distinct, separate and removed*" (R28).

Others commented that law should be seen more widely, for example "*in the context of the relationship of law, the doctor, the patient and society*" (R9).

Some schools saw that law teaching should be located primarily within clinical practice and that this ensures timeliness: "*The Children Act is relevant when you encounter a child protection issue, the Mental Health Act is relevant when you see a detained patient, the Abortion Act is relevant in O & G etc.*" (R25). Another explanation offered was that ensuring *"how the law relates to appropriate treatment and is a component in decisions about such treatment. Hence it should be integrated with clinical and ethical considerations to foster a holistic approach to clinical decisions. If taught in relation to clinical contexts where it applies, the students were more likely to understand why and remember that a given legal consideration applies, and be able to apply it appropriately. Use of MHA and MCA is an integral part of psychiatric practice, such that the issues around their use were better learnt as part of clinical practice, rather than as formal teaching sessions, with real patients as the case for discussion"* (R16).

R29 noted that "*we don't teach medical law per se to any extent. The law that is immediately relevant is taught as part of clinical placement and pedagogical activities. Also, it contextualises learning and ensures that it is directly relevant to future clinical practice. Integrating law teaching with relevant subjects in the curriculum rather than teaching it as a discrete topic is more likely to ensure student engagement*".

The emphasis given by some respondents to learning law within clinical placements draws attention to research findings in the literature survey concerning the breadth, depth and accuracy of medico-legal knowledge held by clinical tutors, and the availability of continuing professional development opportunities.

3.2.8 Content of law teaching and learning

We asked:

Regardless of whether law teaching is in discrete or integrated courses, please indicate the core curriculum content covered and indicate whether/where in the undergraduate or postgraduate courses.

It should be noted that we called 'university based' teaching (lectures, tutorials, PBL etc.) 'classroom' teaching to differentiate this from learning primarily on clinical attachments. Also, in responding to this question, one respondent reminds us that *there are different jurisdictions north and south of the border, plus associated statutes* (R12). R11 noted that they *"bear in mind that our students are medical students and not law students",* hence limiting the amount of law that is taught.

The topics most commonly taught in the 'classroom' (over 40% respondents) were:

- Principles of consent (68%);
- Confidentiality (68%);
- Assessing mental capacity (64%);
- Mental Capacity Act 2005 (64%);
- Mental health legislation (60%);
- Data Protection Act 1998 (60%);
- Principles of negligence (60%);
- Human Rights Act 1998 (52%);
- Abortion Act 1967 (52%);
- Bolam principle (52%);
- Working together with other agencies to safeguard children (48%);
- Suicide Act 1961 (48%);
- Statutory notification duties (44%);
- Childcare law (40%);
- NHS complaints procedure (40%);
- Bolitho principle (40%).

Topics most commonly taught in the clinical environment (over 40% respondents) were:

- Mental health legislation (48%);
- Assessing mental capacity (44%);
- Mental Capacity Act 2005 (40%).

Figure 1. Summary of responses received re core law curriculum content covered and where

Knowledge of legal powers, duties and case law	Yes class-room	Yes clinical	Don't know	Taught at PG level
Structure of UK and European legal system	32%	4%	8%	16%
Sources of UK and European legislation	32%	4%	8%	16%
Human Rights Act 1998	52%	12%		16%
Data Protection Act 1998	60%	16%		12%
Childcare law	44%	28%		12%
Adoption law	16%	8%	12%	
Working together with other agencies to safeguard children	48%	20%		12%
Framework for assessment of children in need and their families	24%	24%	8%	4%
Mental health legislation	60%	48%		12%
Mental Capacity Act 2005	64%	40%		8%
Housing (homelessness) law	12%	8%	8%	4%
Equalities legislation	36%	8%	12%	8%
Community Care legislation	20%	12%	8%	4%
National Health Service (Primary Care) Act 1997	8%	12%	12%	4%
Homicide Act 1957	12%	4%	16%	4%
Suicide Act 1961	48%	12%	12%	8%
Abortion Act 1967	52%	28%		
Medical Act 1983	20%	4%	8%	4%
Medical Act (Professional Performance) Act 1995	8%		16%	4%
Human Fertilisation and Embryology Act 1990 and 2008	56%	24%	8%	8%
The Coroner's Act 1988	24%	8%	8%	4%
NHS complaints procedure	40%	8%		8%
Civil procedure rules	8%	4%	20%	8%
Principles of consent	68%	36%		12%
Assessing mental capacity	64%	44%	4%	8%
Principles of negligence	60%	28%		8%
Bolam principle	52%	16%	4%	8%
Bolitho principle	40%	8%	4%	8%
Law on domestic violence	20%	20%	16%	4%
Confidentiality	68%	28%		20%
Statutory notification duties	44%	24%		16%
The Medicines for Human Use (Clinical Trials) Regulations 2004	20%	8%	4%	4%

Additional topic areas (not necessarily recognised as included in the list above) identified by respondents as included in their programmes were:

- Euthanasia/advance decisions/HTA:
  - limited coverage of homicide in relation to euthanasia (R16);
  - MCA – advance decisions, in classroom and clinical settings (R16);
  - euthanasia – Diane Pretty, Anthony Bland (R28);
  - HTA and organ donation/BSD (R28, R32);
  - Human Tissue Act 2004 (R7);
  - euthanasia (R32);
  - end of life law, withholding and withdrawing treatment (R27).
- Competence and capacity:
  - Gillick/Fraser competence – classroom and clinical settings (R16);
  - parallel Scottish legislation, e.g. Adults with Incapacity (Scotland) Act 2000 and Scottish legislation in similar areas to Gillick (R11);
  - GMC and fitness to practice:
  - status of GMC in regards to fitness to practice (R21);
- GMC fitness to practice (R28);
  - GMC guidelines were taken so seriously in the courts that I think these should be seen as part of the law – anyway we cover quite a lot of these guidelines.
- National Assistance:
  - National Assistance Act 1947 – use for detention of patients without mental disorder;
  - National Assistance Act provisions (R21).
- Resource allocation, research ethics (R1);
- Law regarding withdrawal of treatment and communicable diseases (R3);
- Asylum – for some second years depending on the tutorials they take (R16);
- Domestic violence – for some second years depending on the tutorials they take (R16);
- DDE – in classroom setting (R16);
- Infanticide Act – perinatal psychiatry (R16);
- Issues surrounding mentally ill offenders (diminished responsibility, McNaughton rules) though specific acts not discussed (R16);
- Gender and the law (R21);
- Whistle blowing and public interest disclosure (R21);
- Patient safety (R21);
- Occupational health law (R21);
- Wrongful birth (R21);
- Statute of limitations (R21);

- Comparative law (R21);
- Law relating to pharmaceutical companies (R21);
- Basic rules of evidence and role of the court expert (R21);
- Negligence and knowledge of risk (R32);
- Sexual offences act insofar as it relates to issues like how clinicians should respond to patients who have had underage sex; or sexual activity and people who lack capacity to consent (e.g. people with dementia) (R27).

With reference back to the findings in the literature survey about topic areas covered, the question to be asked in relation to classroom teaching, but especially in relation to clinical tuition, is whether coverage is adequate, for instance in relation to data protection and information sharing, human rights and equality.

3.2.9 Law topics excluded from the curriculum

We asked:

Are there any specific areas of relevant law that you have chosen to exclude? If so, please tell us what they are and the reasons for exclusion.

Selection of which law topics should be included in the curriculum is made on the grounds of clinical relevance (in terms of relevance to future practice); curriculum space and staff expertise to teach the topic.

Three respondents cited specific areas of law that they excluded:

- Reproductive law (due to lack of expertise), this is offered within an SSC only (R1);
- Medical research (due to lack of curriculum space) (R23);
- Human Tissue Act and Gillick competence (R25) – no reason cited.

One respondent also noted that "*exclusions are due to a limited amount of time available to law and ethics on the main undergraduate course*" (R3).

Another respondent commented that they were "*not aware that the formal curriculum has chosen to exclude areas of law. The problem is that we have no law lecturer and the curriculum has limited space for teaching additional to that included in the current programme even if we had the expertise available to teach it. This will be rectified to some extent in the new curriculum planned for 2010. We aim to have a more systematic and comprehensive law curriculum. This is being devised by doctors with medical law degrees to make it relevant to the training necessary to prepare for foundation training*" (R16).

The point about how 'relevance' was decided on the grounds of relevance to future clinical practice was also made by R13 who noted:

- *"There are no specific areas of 'relevant' law that we have excluded but it might be worth saying something about how we interpret 'relevance'. The curriculum is organised so that all content is clinically relevant. So in deciding which elements of medical law are 'relevant' we have taken into account what it is that they need to know from a clinical point of view and when they need to know this. There are some fundamental legal points that need to be made early in the course. In the final year we check that they have the appropriate clinical legal knowledge for progression to F1".*

Respondents have drawn attention here to two questions also identified by research reported in the literature review, namely the challenge of finding curriculum space and the availability of staff with either interest and/or expertise in medical law.

3.2.10 Additional comments about content, structure and location of law teaching

We asked:

Please add any comments you wish to make about the choice of content, structure and location of law teaching within the university based programme.

Responses to this question also supported comments made above in that *"content is dictated by requirement to prepare students for [foundation year] FY practice, to give them adequate understanding to protect themselves from prosecution or disciplinary action, and to protect patients. Law teaching is integrated into clinical programmes to ensure relevance, and integrated with ethics to enhance understanding ... In psychiatry (due to time constraints) the main areas of the MHA/MCA are covered that are likely to affect the students as practitioners, especially as FY doctors are covered. Most psychiatry law will be covered on placements"* (R16).

Another respondent referred to the curriculum trend towards increasing integration *"until three years ago law and ethics was taught as a separate module – then all of "medicine in society' was integrated in the first two years and now the law and ethics teaching takes place within these integrated MIS modules"* (R3).

3.3 Section 3: Teaching and learning processes

This section is about teaching and learning, we will come to assessment later.

3.3.1 Who teaches law?

We asked:

Is all the formally identified law (i.e. listed in learning outcomes) on your programme taught by one person?

Across all responding schools 88% of law teaching was taught by more than one person, however in three schools, law teaching was the teaching responsibility of just one person.

Most schools had between two – four leaders of the law (and usually also the ethics) teaching. The curriculum leads tended to be non clinical or clinical medical ethicists, philosophers or lawyers, for example:

"There are two of us principally involved across most of the course. One of us is a philosopher and one a clinician by background but both of us have considerable expertise in ethics and some amateur expertise in law. One of us has co-written a book on medical ethics and law. We are joined for some sessions by an experienced barrister who specialises in medical law and some clinicians. In clinical attachments, some topics are taught by clinical experts in the specialty e.g. child psychiatry, child care and protection" (R27).

These curriculum leads usually ran the 'academic 'programme, often supported by academic lawyers, retired medico-legal lawyers, guest lecturers, other academics and clinicians, some of whom had medical law and/or ethics qualifications. In programmes that offered problem based learning, small group teaching or case based scenarios, many people were involved (some schools cite up to 20 people), not all who had a specific interest or expertise in law. The majority of law teaching occurring in the clinical attachments was facilitated by clinicians in the relevant speciality, for example: *every paediatrician, psychiatrist, gynaecologist and their trainees in the region – as well as other specialists* (R25). For this reason, many schools found it impossible to answer this question accurately.

3.3.2 The teaching team

For each person who teaches law, please identify their location within and outside the teaching team and use the codes below to indicate their professional background.

Figure 2.

Member of core medical programme team	Clinical academic (52%) Non clinical academic (44%) Practising lawyer (28%) Clinician (20%) Academic lawyer (16%)
Member of different team in same institution	Clinical academic (64%) Academic lawyer (20%) Non clinical academic (8%) Clinician (4%) Patient/service user (4%)
Lecturer from another institution	Practising lawyer (16%)
Other	Clinician (64%) Social worker; judge; PG tutors, barrister (56%) Practising lawyer (16%)

3.3.3 Patients' and carers' involvement

If patients and carers are involved in teaching law, please tell us more about what they contribute.

Examples of contributions from patients and carers included:

- *AVMA* (Action Against Media Accidents – the Charity for Patient Safety and Justice) run a session on medical accidents and negligence. Someone from *Witness* leads a session on boundaries and abuse by healthcare professionals. Another person contributes to a session on public inquiries and patient safety – she is a patient whose daughter died at the Bristol Royal Infirmary (R21);
- Some patients come to tutorials and lectures to facilitate dialogue (R28).

As in teaching law to social workers (Braye *et al.*, 2005), the involvement of service users and carers is under-developed.

3.3.4 Clinicians' involvement

If clinicians are involved in teaching law, please tell us more about what they contribute.

Clinicians contributed towards law teaching in all schools, taking a variety of roles. *"Their experience and insight about applying the law in clinical practice is invaluable"* (R23). Some schools (e.g. R11, R13, R21, R27) involved clinicians who were specialists in medical ethics and/or law, for example they may have a law degree, have formal ethico-legal training or qualifications, or have a specialist clinico-legal role (such as the State Pathologist, R1). Such clinicians may be guest lecturers on a specific topic (for instance medical error, death certification, critical incident reporting and complaints), lead a module or course, manage theoretical sessions and case studies or may be regular tutors and facilitators on the core teaching team (R9, R11, R13, R21).

Other schools involve clinicians in law teaching based on their speciality. This was the most common model and such clinicians typically taught students on clinical attachments, in bedside and other teaching or in 'classroom' sessions in their speciality. Typical specialities cited include paediatrics (children's law, consent), mental health (Mental Capacity

Act), obstetrics and gynaecology, palliative care or general practice (death and dying). These clinicians taught within the area they work and were asked to teach about law based on *reality* and their *"knowledge about how the law applies to their particular speciality and so how to apply the law in relation to specific cases. They bring a practical as well as a theoretical expertise"* (R16). One school noted that *"from the third year onwards ethics and law is during clinical placements and only what is directly relevant to clinical practice is covered"* (R29).

Given that the literature review reported studies that questioned the legal knowledge held and used by clinicians, a question arises of how medical schools ensure that students receive up-to-date tuition in the clinical application of legal rules.

3.3.5 NHS managers' involvement

If NHS managers are involved in teaching law, please tell us more about what they contribute.

Contributions from NHS managers included:

- The complaints manager talks about duties of a doctor in years 3 and 5, and complaints procedures and relation to GMC (R4);
- All four managers were practicing lawyers at the NHS trust attached to this university and have honorary lectureships with the University. We use practicing lawyers in the same way that cardiology is taught by cardiologists, paediatrics by paediatricians and ethics by an ethicist (R10);
- Session on patient safety and complaints (R21).

3.3.6 Teaching and learning methods

We asked:

What teaching and learning methods do you use for law teaching/learning?

A wide range of teaching and learning methods were used. The most common methods were case scenarios (used in 80% of schools), tutor led seminars (used in 72% of schools), clinical placement teaching and lectures (both used in 48% of schools).

Some methods, such as e-learning or simulation exercises, were little used.

Figure 3. Breakdown of teaching and learning methods.

Lectures	48%	Lectures with small group exercises	32%
Seminars – tutor led	72%	Seminars – student led	32%
Case scenarios	80%	Problem based learning	24%
Video material	20%	Simulation exercises using case scenarios	16%
Independent individual study	40%	Independent group study	16%
Visits/observations	20%	Individual tutorials	12%
e-learning (university network)	20%	e-learning (web based)	16%
Distance learning	4%	Clinical placement teaching	48%
Other: We also have a SSC in medical ethics for @6 students each year, some students incorporate law into their assignments. Assignments were student led and much of the learning is through individual tutorials (R27).			

3.3.7 Rationale for choice of teaching and learning methods

We asked:

What is the rationale behind your choice of teaching and learning methods for law?

As reported earlier, the choice of teaching and learning methods related closely to the overall curriculum structure and approach. It also corresponded to the emphasis found in the literature review.

For example, some schools took a problem based learning approach (e.g. R 12, R15), and commented that this is the underpinning curriculum philosophy not just a teaching method. R12 reported that they use *"androgogical principles (PBL course design) linked with an emphasis on medical professionalism as an explicit curriculum theme in the MBChB".* R 13 had a spiral, integrated curriculum: they move back through the same blocks at different levels so that *"basic elements of medical law are introduced in the first two years via lectures. In years three to five some new material is added but the later sessions tend to involve the application of this knowledge to their clinical practice. For example the Mental Capacity Act is introduced in year two but is revisited during year three when the students have a clerk in mental health. This re-emerges in year five when we have whole group case discussions."*

Most schools used different methods to teach law (e.g. lectures, case studies, PBL and seminars), most commonly in an applied context to clinical situations. Respondents stressed the importance of enabling contextualisation. For example R 21 noted that:

- "*diverse methods are used depending on the aims and purpose of the session e.g. lectures for efficiently communicating factual information, student-led 'road shows' for discussing the clinical experiences of students in a safe environment etc. All teaching is applied and no session, whatever the method and place in the curriculum, occurs without real clinical examples and discussion of the application of material to clinical practice".* R11 cites a common model of learning with *"basic introductory interactive lectures followed by iteration of examples in clinical context; (this) demonstrates practical relevance and importance of understanding legal aspects of medical practice".* R9 comments on how law is introduced in their programme: *"Law is introduced within the context of other PPD/MiC learning. The idea of law is to guide clinicians to aid in resolution of potential conflict between doctor/patient and society, is introduced within the curriculum in areas such as professionalism, ethics, disability, end of life. Specific legislation is not taught and will be introduced in phase 2 within the clinical placements".*

Citing an example of an SSC and MSc options programme for medical students, R1 explained their rationale for selecting teaching and learning methods. *"With the SSC it is important for the students to understand the theory and practice of law as it relates to medicine. With this in mind, lectures are used for conveying the theory in addition to cases and videos which illustrate the theory in practice. Students also utilise e-learning tutorials for content. Students visit the Royal Courts of Justice within the SSC and the MSc course twice and are addressed by the high court judges".*

R27 noted the *"central importance for students of articulating ideas and challenging them".* Active learning is deemed essential within *"a practical approach that allows learning in context and in relation to real/simulated cases. Also an approach that fosters interaction and debate rather than didactic. Also learning from reflection via portfolio and clinical practice"* (R4). The theme of practical relevance is also highlighted by R16 who commented that this will enhance student learning:

- *"Students should understand how the law relates to appropriate treatment and is a component in decisions about such treatment. Hence it should be integrated with clinical and ethical considerations to foster a holistic approach to clinical decisions. If taught in relation to clinical contexts where it applies, the students are more likely to understand why and remember that a given legal consideration applies, and be able to apply it appropriately".*

Three respondents (R22, R23 and R25) noted that although small group learning is one of the preferred methods they need to be pragmatic, citing for example that *"the rationale is almost entirely resource based. I run as many small groups as resources and curriculum space allow'* (R23). R22 and R25 suggested that direct teacher student contact and interactive methods were appropriate but limited by resources, R25 added that *"otherwise it is important to choose the method most likely to embed the subject matter".*

3.3.8 Learning and teaching materials

We asked:

What materials do you expect students to use in learning about the law?

Respondents reported requiring students to use a range of materials in learning about the law. The most common were class handouts (64%); law textbooks written for doctors (56%), policy statements (44%) and websites (40%). Very few expect students to use inquiry reports (12%) or critical legal texts/journals (8%).

Figure 4. Breakdown of materials.

Law textbooks written for doctors	56%	36%	Law textbooks written for medical students
Critical medicine texts/journals	32%	8%	Critical legal texts/journals
Class handouts	64%	28%	Electronic databases
Online journals	32%	40%	Websites
Policy statements	44%	12%	Inquiry reports
Other materials: Case reports (R7) Codes of practice (e.g. Mental Capacity Act) (R25)			

3.3.9 Sources of law

We asked:

What sources of law do you expect students to become familiar with in their studies across the curriculum as a whole, recognising that the sources may vary depending on the area of law under consideration.

Respondents reported requiring students to become familiar with a range of sources of law. The most common were codes of practice (64%); guidance (60%) and case law (56%).

Figure 5. Breakdown of statutes.

Statutes	44%	44%	Regulations
Guidance	60%	56%	Case law
Codes of practice	64%	28%	NHS circulars
Local authority circulars	8%		

Given that the legal rules comprise a body, beginning with statute or primary legislation, and fleshed out through regulations, guidance and case law (Braye and Preston-Shoot, 2009), the reported percentages raise an interesting question as to whether medical students might fully appreciate the full extent and complexity.

3.4 Section 4: Clinical placement learning

3.4.1 Timing and duration of clinical placements

We asked:

Where and how long are the clinical placements/attachments located in your programme that are the subject of your answers in this section relating to law teaching?

Respondents reported that law teaching/learning took place across the range of clinical attachments with varying amounts of time being allocated. The responses do not provide a useful picture of the length of clinical attachments as these were so variable. However, law teaching is reported to occur at various times in the following attachments:

- General medicine – years 1, 2, 3, 4 and 5;
- General surgery – years 2, 3, 4 and 5;
- General practice – years 1, 2, 3, 4 and 5;
- Public health/community medicine – years 1, 2, 3, 4 and 5;
- Paediatrics/child health – years 3, 4 and 5;
- Psychiatry – years 3, 4 and 5;
- Obstetrics and gynaecology – years 3, 4 and 5;
- Anaesthetics – years 3, 4 and 5;
- Intensive care – years 3, 4 and 5;
- Emergency medicine – years 3, 4 and 5;
- Orthopaedics/rheumatology – years 2 and 4;
- Geriatrics – years 3, 4 and 5;
- Genito-urinary medicine – year 3;
- Pharmacology – year 3;
- Infectious diseases – year 3;
- Chronic disease and rehabilitation – year 3;
- Palliative care – year 4.

3.4.2 Learning objectives on clinical placements

We asked:

Do you have specific learning objectives relating to law on clinical placements?

Seventy six percent of schools **did not** have specific learning objectives for clinical placement teaching relating to law. This finding suggests that, as with teaching law to social workers (Braye and Preston-Shoot *et al.*, 2005), the practice curriculum is under-developed.

For the 24% (six respondents) that did have specific learning objectives, some were integrated with ethics, but those relating specifically to law include Mental Health law (three respondents) or Obstetrics and Gynaecology (two respondents).

One example of specific learning outcomes spanning clinical placements was provided by R25:

Students must:

- Behave within an appropriate legal framework with respect to:
    - human rights;
    - drug prescribing;
    - physical and sexual abuse of children and adults;
    - death certification;
    - codes of conduct;
    - reporting of adverse medical care / standards involving other practitioners.
- Demonstrate an understanding of legal responsibilities, with respect to:
    - a basic knowledge of responsibilities relating to women who may have been abused physically or sexually;
    - an understanding of a newly qualified doctor's responsibility in dealing with these issues;
    - an understanding of legal issues relation to contraception for teenagers, termination of pregnancy, assisted fertility techniques and violence against women;
    - indicating the requirements to achieve informed consent before prostate surgery or male sterilisation;
    - an understanding of the assessment of the competence of the patient to make management decisions, and the making of "best interest" decisions where the patient is not competent.

3.4.3 Incorporating law learning into clinical placements

We asked:

How is the teaching and learning of law incorporated into students' clinical placement learning?

- 28% incorporatde law into students' clinical placements through legal components in clinical cases;
- 16% incorporated law into students' clinical placements through overt inclusion in clinical placement learning objectives/contracts;
- 8% incorporated law into students' clinical placements through specific tasks built into placement learning;
- 4% incorporated law into students' clinical placements through a specified element of written work produced during placements.

Other examples include:

- Students have to complete SSM7: ethics and law. Choose two cases from their clinical placements in years 4 & 5 and evaluate them from an ethical and legal perspective (R3);
- Ethics and law 'road shows' (R21);
- Clinical placement related teaching of medical ethics (R22).

3.4.4 Guidance or development on the law for clinical teachers

We asked:

Do you undertake any specific activities or provide any guidance to clinical teachers to support their role in students' learning of law?

80% of respondents **did not** currently provide any specific activities or guidance to clinical teachers to support their role in students' learning of law. Once again, this invites questions about the continuing professional development available to clinical teachers in respect of legal knowledge.

Examples of guidance or support for clinical teachers included:

- "*We wrote a programme of distance learning for the psychiatry block – but other specialities were less welcoming*" (R3);
- "*Guidance for assessing the MELPR (theme that includes medical ethics and law) theme issues in student portfolios*" (R11);
- "*Staff development sessions over two days for all clinical tutors, including a general practice/primary care specific day. Regular contribution to grand rounds*" (R21).

And R23 noted that, although they do not currently offer support, from next year the Division of Medical Education will be running an MSc in Medical Education including a module on '*teaching ethics and law*'. A TIPS style one-day course will also be offered on '*teaching ethics and law*' for clinicians.

3.4.5 Additional comments

Additional comments about law within the clinical placement aspects within programmes highlighted an increasing awareness that this area has possibly been less formally planned and co-ordinated than the 'academic' sessions and also under-monitored. Comments included:

- *"I am sure there are aspects of law covered within clinical placements by the clinical tutors at our University, but there is not appropriate time or resources to audit this. It is anticipated through the recent restructure that an audit of this nature will take place in due course once a lead is appointed for ethics and law within the curriculum"* (R1);
- *"It should probably be increased"* (R4);
- *"This is largely an informal curriculum. With the new curriculum that is being developed, the particular aspects of the law to be taught in each placement will be specified and its delivery monitored"* (R16);
- *"It would be good to have better integration between clinical placement and the teaching of medical ethics and law. I am beginning to work on this"* (R29);
- *"It looks like this is an important area to develop, I will bring it to the attention of the clinical placement team"* (R32).

3.5 Section 5: Assessment

3.5.1 Summative assessment of law

We asked:

How is student law learning summatively assessed, i.e. included in assessments that contribute to a formal grade?

Two schools reported a summative assessment specifically relating to law, one in relation to the undergraduate programme (R10) and one in relation to an optional MSC course (R1); 48% of assessments were 'unseen' (i.e. questions were not given to students in advance); 8% were 'seen' (i.e. students know questions in advance); 40% were 'closed book' (i.e. students cannot use textbooks or other materials) and 16% were 'open book'.

Ninety two percent of schools reported that summative assessment of law took place alongside or is integrated within assessment of other topics.

Reflecting the teaching and learning approach, the main single topic assessed alongside law was ethics, cited by 24% of respondents (R7, R11, R22, R23, R27, R30).

- Examples of ethics and law integrated assessments included:
- "*All students complete at least one in course longitudinal assessment in ethics and law, plus there is an ethico-legal component to their portfolio assessment which runs throughout the entire course*" (R21);
- "*Extra-legal medical ethics (politics, declarations, regulations, philosophical ethics, sociology of medical ethics*" (R22);
- "*An essay around a particular clinical experience which the student chooses – the essay to be an ethical and legal argument around what is the right way to respond to the clinical situation. In first clinical year. A structured question in ethics and law in final exam*" (R27).

Other schools integrated law within a broader range of topics and assessments throughout the programme, for example included within integrated papers, either as extended matching item questions or short answer questions (R15). Other examples included:

- "*Clinical, social services, anatomy, physiology. EMQ and SAQ written exams in years 1–4*" (R10);
- "*Other material from the patient centred care theme*" (R13);
- "*All year 4 (phase II) topics – psychiatry, primary care, paediatrics, obstetrics and gynaecology, anaesthetics, emergency medicine, critical care, dermatology, orthopaedics*" (R16);
- "*Assessment is integrated, to reflect the educational approach, and in both written and practical examinations (e.g. OSCEs, debates and presentations) using a range of question styles and techniques*" (R21).

3.5.2 Practical assessment of law

Fourty four percent of respondents assessed law in OSCEs; 12% in workbased clinical assessments and 4% use an OSLER. Other practical assessments of law included:

- Moot – students prepare in teams of two a moot case which is heard within the Royal Courts of Justice and graded by the High Court Judge, another colleague and myself (R1);
- OSCAs – objective structured clinical assessment (R11);
- Presentations and debates (R21);

- In each clinical attachment, student behaviour is assessed in relation to that expected by GMC guidelines on code of practice (R28).

Topics assessed alongside law in practical assessments include ethics (three respondents); communications skills (three respondents) and clinical skills (one respondent).

3.5.3 Coursework

Law is included in a range of coursework assessments, including assessed presentations (20%); case study (24%); essays, assignments on clinical attachment or other projects (all 16%) and assessed seminars. Five examples of coursework which integrates law within other assignments were provided:

- SSM7 – year 5. Students choose two case studies and reflect upon them in 2000 words total (R3);
- Cases in depth submissions (R4);
- Year 1 – assessed presentation from provided list of topics; year 2 – Assessed presentation topic of student's choice; year 3 – Essay; year 4 – Poster presentation (R10);
- Year 1 assignment on ethics and year 3 assignment on **a)** lifecycle which includes assessment on law and **b)** essay and presentation on a topic in medical ethics which could include law (R16);
- Student selected component (SSC, option) (R22);
- An element in the final year ethics essay (R25);
- May be included in project assignments where topics were student selected (R32).

Other topics assessed alongside law in coursework include clinical specialities and therapeutics (R4) and ethics/clinical skills/communication (R11).

3.5.4 Written assessment methods

We asked:

If you use written examinations to assess law, do your methods include?

Ninety two percent of schools assessed law using written assessments. The methods cited by these schools were:

- Multiple choice (44%);
- Short answer questions (36%);
- Essays (28%);
- Case scenarios/case studies (24%);
- Extended matching, best answer etc. (16%).

3.5.5 Assessment of law on clinical placements

We asked:

Is law assessed formally on clinical placement?

Eighty four percent of schools **did not** assess law formally on clinical placements. Of the remainder, 8% did assess law formally (e.g. "*as part of integrated firm assessment*", R21) and 8% were unsure.

We asked respondents who answered '**no**' to comment on the rationale for not assessing law in clinical attachments. Of the five respondents, reasons cited included that it is *"not practical, other than formatively as part of placement, due to distribution and number of placements. Students also have high levels of assessments already and not felt necessary to increase this"* (R16) and that law is assessed formally outside clinical placements (e.g. through portfolios or end of year examinations, R11, R13). R32 noted that law assessment has never been part of the clinical curriculum and R28 noted that *"this has a part political, part practical, part substantive answer that would take a very long time to answer"*.

Respondents' answers here again raise the issues, also identified in the literature review, of the under-emphasis given to the practice curriculum and of how to embed learning from classroom teaching in clinical practice.

3.5.6 Purpose of assessment

We asked:

What are you looking for in assessing students' learning?

Seventy two percent of respondents were looking for students to apply ethical principles to professional medical practice and 68% were looking for students to apply the law to professional medical practice. In addition, schools were assessing that students could demonstrate:

- Application of human rights to professional medical practice (48%);
- Accurate knowledge of content of legal frameworks (32%);
- Use of varied sources of law (i.e. statute, case law etc.) (28%);
- Critical analysis of legal frameworks (20%);
- Knowledge of historical development of legal frameworks (12%).

3.5.7 Rationale for assessment strategy

We asked:

What is your rationale for assessing law in the way you do?

Seven respondents noted that their integrated assessment rationale was consistent with the integrated approach to course design and teaching and learning and had *"practical relevance to clinical practice"* (R19). For example, R16 noted that it is *"to ensure it is integrated with clinical and ethical issues and that students can apply knowledge to clinical cases"* and R21 commented that they use *"multiple methods, where possible mirroring clinical practice, to enhance reliability and validity"*.

The issue of choice of specific assessments to assess law was also commented on by two other respondents. *"For the SSC and the MSc module, the moot court is used for many reasons to include developing skills in presenting arguments, applying the law, reasoning and research skills. An essay is used to develop research and writing skills and to familiarise the students with legal databases and publications (texts and journals"* (R1). R3 uses *"MCQs – test range of topics and doesn't discriminate against those whose written English isn't great"*.

R30 noted that they have *"a range of assessments on ethics and law so students take an integrated approach"*. Two respondents noted that assessment design is to fit with university or medical school requirements (R10, R23) and two respondents commented that their choice of assessment was practical (R7) or was due to resourcing (R22).

3.6 Section 6: Evaluation of teaching, learning and assessment of law

3.6.1 Evaluation of law teaching, learning and assessment

We asked:

How do you evaluate the teaching, learning and assessment of law?

Evaluation of teaching, learning and assessment of law was carried out through feedback from:

- Students (68%), some of this is as part of a wider programme and not just relating to law teaching;
- External examiners (48%);
- Teaching staff (48%);
- GMC (44%);
- Clinical teachers (36%);
- Institutional quality monitoring (32%);
- The QAA (28%);
- Other clinicians (12%).

No schools reported gathering feedback from patients/carers or employers.

3.6.2 Messages from evaluation

We asked:

Please summarise the key messages from any evaluation undertaken in relation to students' learning of law.

Forty percent of schools responded to this question with examples of positive messages from evaluations from students, external examiners and the GMC. Feedback from students indicated that many aspects of law teaching were well received, including the quality of the teaching. They valued teaching that is relevant to their future practice as doctors (for example, R3, R25); they *"appreciate what they NEED to know"* (R11); *"what which law is and how it applies"* (R16). A specific example is cited by R1 in relation to the Moot assessment and noted that feedback from the external examiners was positive in relation to providing students with the legal and courtroom experience.

Two schools reported on feedback that is still to be implemented. R4 noted that the teaching *"needs to be more focussed on real clinical practice rather than learning in the abstract to engage students and help them to retain information"*. And R23 commented that although their students had *"an impressive knowledge of medical law, they need more practice in applying this knowledge in clinical encounters"*. These comments parallel findings in the literature review, to the effect that what is unclear from assessments and course evaluations is the degree to which increased legal knowledge, and skills in its application, actually impacts directly on patient experience.

One school (R13) reported that they had not undertaken any evaluations of law teaching.

3.7 Section 7: General comments

3.7.1 Factors influencing approach to teaching, learning and assessment of law

We asked:

Have there been any factors that have particularly influenced your approach to the teaching, learning and assessment of law?

Respondents cited a range of different factors that had influenced their approach to teaching, learning and assessment of law. These included:

- External guidance (40%), including:
  - discussion with other schools (R4);
  - GMC *Tomorrow's Doctors* (R10, R13, R21);
  - the philosopher whose post I took over in 2007 (R23).
- Research (20%), including:
  - research on teaching ethics and law guides all of my teaching and learning activities. Topical research in specific areas provides up to date cases and law for each course (R1);
  - research on ethico-legal issues leading to publications (R22).
- Literature (32%) including:
  - textbooks:
    Hope T, Savulescu J, Hendrick J. Medical ethics and law: the core curriculum. Churchill Livingstone. 2008. (Cited by four respondents);
    Brazier M, Cave E. Medicine, patients and the law. 4th edition; Penguin. 2007. (Cited by three respondents);
    Mason K, Laurie G. Mason & McCall Smith's law and medical ethics. 7th edition; Oxford University Press. 2005. (Cited by two respondents);
    Jackson E. Medical law: text, cases and materials. Oxford University Press. 2006. (Cited by one respondent).
  - journals:
    J of Medical Ethics, Medical Law Review, BMJ, American Journal of Bioethics;
    BMA Ethics;
    Medical education literature.
- Landmark/high profile cases involving doctors (28%) including:
  - Bolam, Bolitho, Sidaway, Wilsher, Adomoko etc. for negligence (R1);
  - Bristol, Alderhay, Shipman, Gillick (R4);
  - these were often used to illustrate ethical points e.g. Bland, re A (case of conjoined twins), Cox etc. (R13);
  - Bournewood case, refusal of treatment (adult) – re C (adult refusal of treatment) (R16).
- Landmark/high profile cases involving health and social care professionals (25%) including:
  - baby P, Climbié (R4);
  - recent cases relating to Human Rights Act 1998; Gillick (R29).

Other factors included obtaining feedback from "*postgraduate education activities where participants have said what they wished they had learned in medical school*" (R21) and *"feedback from FY1, SpR, consultant, GP, and other healthcare professional postgraduate courses taught & also postgraduate collaboration with law school colleagues"* (R11). R10 commented that *"as practicing lawyers working within the NHS (having previously made a living suing the NHS) we have some experience of 'when things go wrong' and of circumstances that cause difficulty. This underpins all our teaching"*.

3.7.2 Outcome studies of students' law learning

We asked:

Have you undertaken in the past, or are you undertaking, any outcome study of students' law learning?

84% of schools had not undertaken any outcome study of students' law learning. Of the four schools that had undertaken an outcome study, one noted that this forms part of regular feedback from foundation doctors (R11). Another school plans to look at law teaching as part of the University periodic review in 2010 (R4). No reports or publications were provided. The literature review commented on the quality of available research on teaching, learning and assessment of law in medical education and on the need for more research in this field.

3.7.3 Planned changes and developments

We asked:

Can you summarise any changes and developments in your approach in the last few years, ... especially any changes that you have made or anticipate making in response to the Tomorrow's Doctors 2009, to the changes in foundation or specialty curricula or to high profile cases relating to legal issues?

Respondents cited a number of planned general developments in law teaching. Some of these were noted as in response to Tomorrow's Doctors 2009, although respondents noted that they were waiting for the final version to be produced before making adjustments if required (R4, R15, R18, R29). Other external drivers cited include changes in foundation and speciality curricula (R4) and changes in educational guidance and policy developments. R4 commented that their *"aim is to avoid scaring students with the concept of "the law" and to see how it can help shape their professional practice"*. Responding to curricular changes at foundation level and beyond could help to locate law in the clinical practice of a junior doctor.

R21 noted specifically the influence of the Kerr and Haslam inquiries. R16 noted their response to changes in legislation such as the Mental Capacity Act and Mental Health Act. R16 noted also that the revised consensus statement being developed by the Institute of Medical Ethics (Insitute of Medical Ethics, 2009), due for publication in 2010 will have *"some influence"*.

Some specific changes cited were: a general curriculum review of which law teaching is a part (R3); *"we are considering presently introducing three new tutorials for law within 2nd year"* (R1), some joint preparation of case scenarios used in ethics teaching (R10) and a presentation from the Medical Defence Union during the programme.

3.7.4 Preparedness for Foundation training

We asked:

How prepared do you think your students are in relation to the law for the next stage of their training?

- 76% of schools responded to this question (19 schools). Of these respondents:
  - 26% said they thought students were very prepared or well prepared;
  - 47% said they thought students were adequately, reasonably or satisfactorily prepared;
  - 16% said they thought there was room for improvement or they were not very prepared;
  - 11% were unsure or said their law teaching was about to change.

3.7.5 Satisfaction with law teaching, learning and assessment

We asked:

How satisfied are you with your current approach to the teaching, learning and assessment of law?

Sixty six percent of respondents were 'very satisfied' or 'reasonably satisfied' whereas 44% were 'a little dissatisfied' or 'very dissatisfied'.

Very satisfied	12%	Reasonably satisfied	44%
A little dissatisfied	40%	Very dissatisfied	4%

The two main reasons for dissatisfaction were a lack of curriculum and teacher time to support law teaching and an unsystematic approach to law teaching which lacks specific learning outcomes.

For example, in terms of time R1 noted that "*there are too few students who are able to take the SSC and only approximately half of the 5th year students attended the law 1-hour lecture which occurred this year for the first time. I do think that students will benefit from additional time for law related tutorials within the curriculum which is currently being discussed. This would mean that basic clinical negligence, human rights and healthcare and the law relating to abortion and end of life can be covered with the students".* And R3 noted "*dissatisfaction regarding time and amount of marking".*

That a more systematic approach would be beneficial was cited by R4 who said that law teaching needed "*more flagging in all parts of the curriculum. To aim to help students appreciate its importance from year 1, not just as they are about to qualify".*

Other comments included "*perhaps need to review objectives to be more specific regarding which areas of 'law' need to be covered within the first two years of medical curriculum"* (R9); "*we don't have a systematic approach to law teaching. We aim to testify this in our new 2010 curriculum"* (R16) and "*it is not a distinct strand, and would benefit from an overview"* (R25).

3.7.6 Examples of good practice

We asked respondents to describe or provide details of any specific examples of good practice in teaching, learning and assessment of law. Five respondents replied:

- The module 'doctors, patients and the law' has been commended for its innovative subject area and assessment (R1);
- We use a mock trial which works well for one of the special study modules. Also case studies work well especially if structured questions were given alongside the case (R3);
- The use of a wide teaching team comprising clinical and non-clinical teachers, ethicists, lawyers, Trust staff etc. (R4);
- Mock Fatal Accident Inquiry, with the participation of practising lawyers (including former deputy Procurator Fiscal) (R12);
- Integrating the teaching of law with clinical and ethical understanding of cases, and assessing understanding of law through application to clinical cases (R16).

4 Conclusion

The practice survey has provided data with which comparisons have been made with the literature review. The survey also highlighted many areas of good practice and a high level of concern, development and engagement from teachers in ensuring students learn about the law in relation to future medical practice. Many examples were provided that indicate a responsive approach to new legislation or case law in curriculum renewal. The survey confirmed that law teaching, learning and assessment is predominantly carried out with ethics teaching or learned in clinical attachments rather than being taught separately. Within this highly integrated approach to law teaching, there were variations between schools into which 'themed' law teaching is allocated. Much of the formal law teaching is in the early years with a typical model being devolvement of teaching to clinicians to teach the law in relation to their speciality in clinical attachments. Strong endorsements for this integrated approach were provided based around the need for students to learn the law in a clinical context and that understanding of medical law is best acquired in relation to medical ethics so that issues could be debated and discussed from different viewpoints. Law teaching is typically led by academics in medical ethics, law or philosophy supported by clinicians and others, some of whom also have qualifications in ethics and/or law.

The data does however raise some questions in particular relating to adequate coverage of legal knowledge, the involvement of patients and carers in teaching and assessment of legal knowledge and application skills, and the presence within the practice curriculum of law teaching and assessment. For example, although there is evidence that learning outcomes for law learning were available throughout many programmes, formal and systematic teaching and assessment of law tends to be less in evidence in the latter, more clinically oriented stages of the programmes. The shift towards a final year 'apprenticeship' model suggested by the GMC (2009) may require more curriculum attention be paid to ensuring that law is taught, learned and (more importantly) assessed appropriately in the later stages of medical programmes and that all students have equal opportunity to debate and discuss law and practice implications prior to the Foundation programme. Many respondents do not appear entirely satisifed with how law is taught and assessed in their programmes, nor convinced that medical students are as prepared for legally literate practice as they might be. Some respondents raised concerns about the adequacy of resourcing, particularly given the need for interactive, small group teaching to stimulate discussion and learning about challenging, or complex situations where the 'answers' may not be clear.

As in social work education (Braye *et al.*, 2005), it is possible to discern several different emphases when teaching law to medical students, namely an approach that focuses on legal knowledge, one that emanates from an ethics perspective and one that prioritises patients' rights. The close relationship between law and ethics in medical education suggests that this is a particularly dominant orientation. The recent consultation on the draft *Core Curriculum for Medical Ethics and Law* (Institute of Medical Ethics, 2009) places new emphasis on the development of professionalism, the ability to reflect and reason critically from an informed knowledge and practice base and the ability to benefit patient's health. In reporting recently on our ongoing National Teaching Fellowship funded research into law and social work education (McKimm and Preston-Shoot, 2009), we highlighted curriculum development implications in ensuring that students develop a professional identity that incorporates a real understanding of the law (legal rules and principles) as distinct from personal values, attitudes, morals and belies and professional ethics and codes of practice (see Figure 6 below).

Figure 6. A model of professional identity formation.

The survey indicated that although medical schools appear to be addressing the need for students to learn legal and ethical principles and factual information and apply this to clinical scenarios, it is unclear as to how this teaching and assessment incorporates or relates to the development of professional identity and demonstration of professional behaviours. This is an area for further exploration given the current policy emphases on patient safety, error reduction and professionalism.

The educational and practice landscape is changing and therefore medical curricula, teaching and learning approaches and assessment strategies need to respond in order to prepare medical students for the practice of tomorrow. Further research is needed as to whether a particular approach, or combination of approaches, is particularly effective in enabling students to embed and then apply skillfully their legal knowledge in a way that positively impacts on the experiences of patients and carers.

5 References

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Consensus Group of Teachers of Medical Ethics and Law in UK Medical Schools. Teaching medical ethics and law within medical education: a model for the UK core curriculum. J Med Ethics. 1998;24:188-92.

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Institute of Medical Ethics. Draft revised core curriculum for medical ethics and law in UK medical schools; 2009 [cited 2009 July 26]. Institute of Medical Ethics. Available from http://www.instituteofmedicalethics.org/edu_consult.html

McKimm J, Preston-Shoot M. Miniproject report: teaching, learning and assessment of law in undergraduate medical education. The Higher Education Academy Subject Centre for Medicine, Dental and Veterinary Medicine. 2009 Summer;01(19);23-5.

Twining W. Pericles and the plumber. Law Quarterly Review. 1967;83:396-426.

6 Appendix 1: Survey questionnaire

6.1 Section 1: Background information

1.1 Name of institution

1.2 Contact details of person completing this form

Name

Telephone

Email

Role/title (e.g. law module leader, programme head)

1.3 Programme information (complete all that applies).

Type of programme	Date of last major review/first intake (most recent)	Date of planned programme review (if relevant)	Annual intake numbers
Five-year programme			
Graduate entry programme			
Joint programme with other HEI *(please specify below)*			

Additional information

1.4 Can you please provide us with a copy of the latest programme specification for the MBBS/MBChB programme?

6.2 Section 2: Content, structure and location of law teaching and learning

This section is about the **academic** taught element of the programme. We will ask about practice learning later.

2.1 Do you have a discrete law module/course or modules/courses in your programme? Here we mean a course where law is taught as a separate topic, not where it is taught alongside (for example) ethics or professionalism, if you teach law integrated with another topic, please go to Q2.7

Yes No

If yes, please continue with Q2.2, if not please go to Q2.7.

2.2 If yes, where in your programme(s) do the discrete modules/courses appear (please enter all that apply – if you have more than one discrete module, use columns 2 and 3 to give us information about each one separately)?

Stage of learning	Discrete module 1		Discrete module 2		Discrete module 3	
	Contact hours	Length	Contact hours	Length	Contact hours	Length
Year 1						
Year 2						
Year 3						
Year 4						
Year 5						
Other (e.g. BSc)						

Here, you can either complete Q2.3 and Q2.4 or send us your module documentation and we will complete it for you.

2.3 What are the aims of the discrete law module/course? (Please list aims separately for each module/course if you have identified more than one module in Q2.2 above. Please also attach module/course outlines if available).

2.4 What are the learning outcomes (please list outcomes separately for each module if you have identified more than one module/course in Q2.2 above; also attach module/course outlines if available)?

2.5 What is your rationale for locating some or all of your law teaching/learning in a discrete module/course?

2.6 Is legal content taught/learned on any university based module/course other than a law module/course?

Yes No

If yes, please specify the modules/courses and levels/years

Module/Course	Year/Level	Contact hours relating to law

Now please go onto Q2.11.

If there is no discrete law module/course on your programme.

2.7 Where in your academic programme does law teaching/learning appear?

Module/course	Year 1	Year 2	Year 3	Year 4	Year 5
Please indicate subject area and length of course	Contact hours relating to law	Contact hours relating to law	Contact hours relating to law	Contact hours relating to law	Contact hours relating to law

Here, you can either complete Q2.8 and Q2.9 or send us your module documentation and we will complete it for you.

2.8 What are the aims of the law teaching/learning in these modules/courses (please list aims separately for each module/course if you have identified more than one module in Q2.7 above; also attach module/course outlines if available)?

2.9 What are the learning outcomes relating to law learning in these modules/courses (please list outcomes separately for each module if you have identified more than one module/course in Q2.7 above; also attach module/course outlines if available)?

2.10 Why do you believe it is important to teach law only within other modules and not as a separate topic?

Regardless of whether law teaching is in discrete or integrated courses....

Please tick to indicate the core law curriculum content covered and indicate whether/where in the UG or in PG courses. *Note that we have called 'university based' teaching (lectures, tutorials, PBL etc.) 'classroom' teaching to differentiate this from learning primarily on clinical attachments*

Knowledge of legal powers, duties and case law	Yes class-room	Yes clinical	Don't know	Taught at PG level
Structure of UK and European legal system				
Sources of UK and European legislation				
Human Rights Act 1998				
Data Protection Act 1998				
Childcare law				
Adoption law				
Working together with other agencies to safeguard children				
Framework for assessment of children in need and their families				
Mental health legislation				
Mental Capacity Act 2005				
Housing (homelessness) law				
Equalities legislation				
Community Care legislation				
National Health Service (Primary Care) Act 1997				
Homicide Act 1957				
Suicide Act 1961				
Abortion Act 1967				
Medical Act 1983				
Medical (Professional Performance) Act 1995				
Human Fertilisation and Embryology Act 1990 and 2008				
The Coroner's Act 1988				
NHS complaints procedure				
Civil procedure rules				
Principles of consent				
Assessing mental capacity				
Principles of negligence				
Bolam principle				
Bolitho principle				
Law on domestic violence				
Confidentiality				
Statutory notification duties				
The Medicines for Human Use (Clinical Trials) Regulations 2004				

2.11 Please list additional areas (not included in the list above) that you include in your programme

2.12 Are there any specific areas of relevant law that you have chosen to exclude? If so, please tell us what they are and why you have excluded them.

2.13 Please add any comments you wish to make about the choice of content, structure and location of law teaching within the university based programme.

6.3 Section 3: Teaching and learning processes

This section is about teaching and learning, we will come to assessment later.

3.1 Is all the formally identified law (i.e. listed in learning outcomes) on your programme taught by one person?

Yes No

If no, how many people are involved?

3.2 For each person who teaches law, please identify their location within and outside the teaching team and use the codes below to indicate their professional background.

	Member of core medical programme team	Member of different team in same institution	Lecturer from another institution	Someone else (please specify)
Person 1				
Person 2				
Person 3				
Person 4				
Person 5				
Person 6				
Person 7				
Person 8				
Add more if needed...				

Background (if an individual falls into more than one category, please enter all that apply).

1 = academic lawyer	2 = practising lawyer	3 = non-clinical academic
4 = clinical academic	5 = clinician	6 = patient/service user
7 = carer	8 = NHS manager	9 = other (please specify)

3.3 If patients and carers are involved in teaching law, please tell us more about what they contribute.

3.4 If clinicians are involved in teaching law, please tell us more about what they contribute.

3.5 If NHS managers are involved in teaching law, please tell us more about what they contribute.

3.6 What teaching and learning methods do you use for law teaching/learning (tick all that apply)?

Lectures		Lectures with small group exercises	
Seminars - tutor led		Seminars - student led	
Case scenarios		Problem based learning	
Video material		Simulation exercises	
Independent individual study		Independent group study	
Visits/observations		Individual tutorials	
e-learning (university network)		e-learning (web based)	
Distance learning		Clinical placement teaching	
Other *(please specify)*			

3.7 What is the rationale behind your choice of teaching and learning methods for law (we are interested in any philosophy of teaching and learning/pedagogy that underpins your approach)?

3.8 What materials do you expect students to use in learning about the law (tick all that apply)?

Law textbooks written for doctors		Law textbooks written for medical students	
Critical medicine texts/journals		Critical legal texts/journals	
Class handouts		Electronic databases	
Online journals		Websites	
Policy statements		Inquiry reports	
Other *(please specify)*			

3.9 What sources of law do you expect students to become familiar with in their studies (please tick all that apply across the curriculum as a whole, recognising that the sources may vary depending on the area of law under consideration)?

Statutes		Regulations	
Guidance		Case law	
Codes of practice		NHS circulars	
Local authority circulars			
Other *(please specify)*			

3.10 Please add any comments you wish to make about the process of teaching and learning of law within your programme.

6.4 Section 4: Clinical placement learning

4.1 Where and how long are the clinical placements/attachments located in your programme that are the subject of your answers in this section relating to law teaching? Please tick relevant areas and include number of weeks.

Clinical speciality	Year 1	Year 2	Year 3	Year 4	Year 5
General medicine					
General surgery					
General practice					
Public health/community medicine					
Paediatrics/child health					
Psychiatry					
Obstetrics and gynaecology					
Anaesthetics					
Intensive care					
Emergency medicine					
Orthopaedics/rheumatology					
Geriatrics					
Other *(please specify)*					

4.2 Do you have specific learning objectives relating to law on clinical placements?

Yes No

If yes, please tell us what they are (in relation to specialty areas as appropriate).

4.3 How is the teaching and learning of law incorporated into students' clinical placement learning (tick all that apply)?

Overt inclusion in clinical placement learning objectives/contracts	
Legal components in clinical cases	
Specific tasks built into placement learning	
Specified element of written work produced during placements	
Other *(please specify)*	

4.4 Do you undertake any specific activities or provide any guidance to clinical teachers to support their role in students' learning of law?

Yes No

If yes, please tell us what you do

4.5 Please add any comments you wish to make about law within the clinical placement aspects within your programme?

6.5 Section 5: Assessment

5.1 How is student law learning summatively assessed, i.e. included in assessments that contribute to a formal grade (tick all that apply)?

Written examinations		
Discrete law examination	Open book **	Closed book **
Seen *		
Unseen *		
Other examination		
Seen *		
Unseen *		
Please specify what other topics are assessed alongside law in written examinations		

* seen/unseen relates to whether questions are given to students in advance

** open/closed book relates to whether students my use textbooks during the exam

Practical examinations		
OSCEs		
OSLERs		
Workbased clinical assessments		
Other *(please specify)*		
Please specify what other topics are assessed alongside law in practical examinations		

Coursework	
Case study	
Essay	
Assignments on clinical attachment	
Assessed seminar	
Assessed presentation	
Other project	
Integrated in other assignments *(please specify which)*	
Other *(please specify)*	
Please specify what other topics are assessed alongside law in writted examinations	

5.2 Please send us examples of assessments that your students undertake that assess law learning.

5.3 If you use written examinations to assess law, do your methods include... Please tick all that apply.

Multiple choice	
Case scenarios/case studies	
Short answer questions	
Essays	
Other *(please specify)*	

5.4 Is law assessed formally on clinical placement?

Yes No

If yes, please list where law is assessed and in which clinical attachments

If no, please comment on the rationale for not assessing law in clinical attachments

5.5 What are you looking for in assessing students' learning (tick all that apply, including your assessment criteria, if available)?

Accurate knowledge of content of legal frameworks	
Use of varied sources of law (i.e. statute, case law etc)	
Knowledge of historical development of legal frameworks	
Critical analysis of legal frameworks	
Application of law to professional medical practice	
Application of ethical principles to professional medical practice	
Application of human rights to professional medical practice	
Other criteria *(please specify)*	

5.6 What is your rationale for assessing law in the way you do?

5.6 Please add any comments you wish to make about the assessment of law within your programme.

6.6 Section 6: Evaluation of teaching, learning and assessment of law

6.1 How do you evaluate the teaching, learning and assessment of law (tick all that apply)?

Feedback from:

Students		Teaching staff	
Clinical teachers		Patients/carers	
Other clinicians		Employers	
Eternal examiners		Institutional quality monitoring	
GMC		QAA	
Other *(please specify)*			

6.2 Please summarise the key messages from any evaluation undertaken in relation to students' learning of law.

6.7 Section 7: General comments

7.1 Have there been any factors that have particularly influenced your approach to the teaching, learning and assessment of law?

External guidance if so, which	
Research if so, which	
Literature if so, which	
Landmark/high profile cases involving doctors if so, which	
Landmark/high profile cases involving health and social care professionals if so, which	
Other *(please specify)*	

7.2 Have you undertaken in the past, or are you undertaking, any outcome study of students' law learning?

Yes No

If yes, please give us details

If a report or publication is available, please send us a copy or the reference

7.3 Can you summarise any changes and developments in your approach in the last few years? We are particularly interested to know of any changes that you have made or anticipate making in response to the Tomorrow's Doctors 2009, to the changes in Foundation or Specialty curricula or to high profile cases relating to legal issues.

7.4 How prepared do you think your students are in relation to the law for the next stage of their training?

7.5 How satisfied are you with your current approach to the teaching, learning and assessment of law?

Very satisfied		Reasonably satisfied	
A little dissatisfied		Very dissatisfied	

Please indicate in the box below any particular areas of satisfaction or dissatisfaction.

7.6 Please describe or provide details of any specific examples of good practice in teaching, learning and assessment of law.

7.7 Would you be prepared to talk to us further about your responses to this questionnaire? If yes, we might contact you by phone. If there is someone else we should speak to, please provide their contact details.

Yes No

7.8 Thank you very much for your co-operation and for taking the time to complete this questionnaire. If our questions have omitted to ask about important aspects of law in medical education, please continue your comments below.

Please return the completed questionnaire together with any supporting documentation by Monday 23rd March 2009.

If returning via **email**, please send to: Judy McKimm j.mckimm1@btinternet.com **or**
if returning by **post**, to Professor Michael-Preston Shoot, Dean, Room C221, Faculty of Health and Social Sciences, University of Bedfordshire, Park Square, Luton, LU1 3JU

7 Appendix 2: Respondents

Figure 7. Details of survey respondents.

Medical school	Role/title of person responding
Queen's University, Belfast	Lecturer, Centre for Medical Education [Directs ethics and law components throughout the undergraduate curriculum and MSc module in ethics and law within school of medicine]
Birmingham	Lecturer in Medical Law and Ethics
Brighton Sussex (BSMS)	Director of undergraduate education
Bristol	Senior Lecturer in Biomedical Ethics
Cardiff	Senior Lecturer in Forensic Pathology
Durham	Teaching fellow PPD Year 1
University of East Anglia (UEA)	Law module leader
Edinburgh	Professor of Medical Ethics/Theme Head for Medical Ethics, Legal and Professional Responsibilities
Glasgow	Senior University Teacher in Medical Ethics and Law
Hull York (HYMS)	Senior Lecturer in Medical Ethics
Keele	Partial response. Fully integrated course re medical ethics and law and clinical material and therefore unable to complete questionnaire
Lancaster (has the same curriculum as Liverpool)	Ethics and law module lead
Leeds	Medical Ethics Lecturer and Co-ordinator
Liverpool	Senior Lecturer Public Health Medicine and Deputy Director of Medical Studies (Admissions, Curriculum, & Student Support)
Imperial College London	Head of assessment
Kings College London	Partial response. Fully integrated course re medical ethics and law and clinical material and therefore unable to complete questionnaire
St Georges, London (SGUL)	Senior Lecturer in Medical Ethics and Law, Associate Dean
Barts and The Royal London	Law and ethics programme Head
University College London (UCL)	Medical Ethics and Law Unit Lead
Newcastle	Lecturer in Healthcare Ethics
Oxford	Professor of Medical Ethics and Ethics/Law Module joint Head
Peninsula College of Medicine and Dentistry	Clinical Academic Lead for Medical Ethics and Law
Sheffield	MLE champion and Lecturer in Medical Education
Southampton	Partial response. Fully integrated course re medical ethics and law and clinical material and therefore unable to complete questionnaire
Swansea	Law tutor and law strand leader

Figure 8. Non-respondents.

Medical school	Reason for not responding (if any)
Aberdeen	No response to emails
Cambridge	No response to emails
Dundee	No response to emails
Leicester	Initial response to email but questionnaire not submitted
Manchester	Initial response to email but questionnaire not submitted
Nottingham	Initial response to email but questionnaire not submitted
St Andrews	No response to emails
Warwick	Initial response to email but questionnaire not submitted

8 Appendix 3: Learning outcomes

An example of law curriculum provided by one medical school (R23). NB ethics-related learning outcomes are not included.

8.1.1 Year 1 (ethics and) law curriculum

Introduction to ethics and law.

- Explain why an understanding of ethics and law is fundamental to medical practice;
- Introduction to the law and professional guidelines;
- Outline the structure of the law in England and Wales;
- Explain the difference between statute and common law;
- Explain the difference between criminal and civil law.

Confidentiality and rights.

- Outline the law on patient confidentiality, distinguishing between statute and common law requirements;
- Explain the circumstances in which the law and GMC guidelines demand or permit the overriding of patient confidentiality;

Duty of care and clinical negligence.

- Explain the circumstances under which a doctor-patient relationship exists;
- Describe the requirements of a successful suit for clinical negligence;
- Outline the legal requirements for standard of care;
- Explain what is meant by the Bolam test.

Autonomy and consent.

- Explain the legal and professional requirements for valid patient consent.

Revision lecture.

- Explain the difference between statute and common law and between criminal and civil law;
- Outline the law and professional guidelines on patient confidentiality, distinguishing between statute and common law requirements;
- Describe the requirements of a successful suit for medical negligence;
- Outline the legal requirements for standard of care;
- Explain the legal and professional requirements for valid patient consent;
- Identify the main statutes and common law referred to this year.

8.1.2 Year 2 (ethics and) law curriculum

Equitable health care: human rights, personal beliefs and professional values.

- Outline the significance of the Human Rights Act and the European Court of Human Rights for medical practice;
- Outline the principles of a human rights based approach to health care;
- Outline patients' legal rights in terms of non-discriminatory health care;
- Outline legal and GMC guidelines on personal beliefs and medical practice.

The patient who lacks capacity.

- Outline the main provisions of the Mental Capacity Act (2005);
- Describe the criteria for recognising non-competence in adults;
- Describe the requirements for clinical decision making involving non-competent patients.

Legal and moral issues surrounding abortion.

- Describe the recent history of abortion law;
- Describe the doctor's legal and professional duties to a pregnant woman and the developing fetus.

Revision lecture.

- Outline the principles of a human rights based approach to health care;
- Outline legal and GMC guidelines on personal beliefs and medical practice;
- Outline the main provisions of the Mental Capacity Act (2005);
- Describe the requirements for clinical decision making involving non-competent patients;
- Describe the recent history of abortion law;
- Describe the doctor's legal and professional duties to a pregnant woman and the developing fetus.

Session on justice and resources to be added 2009/10.

8.1.3 Year 3 (ethics and) law curriculum

The doctor-patient relationship: the competent patient.

- Outline current law and professional standards that apply to the treatment of competent patients.

The doctor-patient relationship: the patient who lacks capacity.

- State the provisions of the Mental Capacity Act 2005.

Withholding and withdrawing treatment.

- Describe the BMA and UK Resuscitation Council guidelines for DNAR orders.

Block 3 – end of life.

- State current legal and professional principles for treatment at the end of life;
- State and evaluate the current law on euthanasia, suicide and physician-assisted suicide.

The Coroner's Act 1988 will be included in 2009/10.

Outline the requirements for death certification.

8.1.4 Year 4 (ethics and) law curriculum

Psychiatry

Introduction to the Mental Health Act.

- Outline the history, principles and rationale underpinning Mental Health Legislation in England and Wales;
- Describe the most commonly used MHA sections – civil sections 2, 3 and 5(2);
- Describe the circumstances in which these sections are used and how they are applied;
- Describe the people involved in the application of these sections and their duration of holding power;
- Outline the safeguarding procedures in place for appeal against these sections.

Introduction to the Mental Capacity Act Deprivation of Liberty safeguards.

- Describe the MCA deprivation of liberty safeguards (DoLS).

The Mental Health Act: practical and ethical issues.

- Differentiate between the appropriate application of the MHA verses the MCA;
- Understand doctors' duty to protect vulnerable patients and how this manifests itself in clinical practice.

Women's health

Legal and ethical issues at the beginning of life.

- Describe the doctor's legal and professional duties to the pregnant woman and the fetus;
- State the provisions of the Abortion Act 1967, as modified by the Human Fertilization and Embryology Act 1990;
- Outline the legal and professional guidelines relevant to doctors' conscientious objection to participating in abortion care;
- Discuss the ethical and legal status of the fetus;
- State the implications of Gillick for providing contraceptive advice and treatment to young people under 16;
- Outline Fraser guidelines;
- Outline the ethical issues involved in prenatal screening and testing.

Assisted Reproduction: legal and ethical issues.

- Describe the main provisions of the Human Fertilisation and Embryology Act 1990.

Child health

Describe the legal and professional guidelines for the medical treatment of minors under 16 and minors between 16 and 18.

The Higher Education Academy
Subject Centre for Medicine, Dentistry and Veterinary Medicine

School of Medical Sciences Education Development
Faculty of Medical Sciences
Newcastle University
Newcastle upon Tyne
NE2 4HH
United Kingdom

T: +44 (0)191 2225888
F: +44 (0)191 2225016

enquiries@medev.ac.uk
www.medev.ac.uk

The Higher Education Academy
UK Centre for Legal Education

University of Warwick
Coventry
CV4 7AL
United Kingdom

T: +44 (0)24 76523117
F: +44 (0)24 76523290

ukcle@warwick.ac.uk
www.ukcle.ac.uk

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