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## ON TEACHING LAW AND MEDICINE

*Frederic K. Spies\**

It has been eighteen years since the Seminar in Law and Medicine was first offered at the University of Arkansas at Fayetteville School of Law, probably in advance of general acceptance of the course in the law school community. Over that period of time, its dimensions and content have been altered and rearranged yearly, reflecting changes in the medical industry and its relationship to the legal system.

One constant component of the seminar has been the requirement that each student, for his paper, make a study in depth of the medical and legal aspects of a particular injury or disease, whether recovery is sought in tort or under modern social legislation. Most of the research topics are drawn from recent cases and assigned by the instructor. A necessary by-product of this requirement is a working familiarity with a medical library, some of it gained in an early medical bibliography session and the rest while writing the paper. The law students soon learn that the usefulness of medical articles is not always reflected in their titles and that there are frequently more sources available on a given syndrome than even the most avid researcher is interested in or has time to read.<sup>1</sup>

At the outset of the course the research topics tended to be modest in scope. Some were of limited interest and even distasteful to the student authors although these, too, could point up liability factors and elements of damage which might be missed by the practicing bar; an example is *Medical Malpractice—The Medical and Legal Aspects of the Post-Prostatectomy Urinary Incontinence Suit*.<sup>2</sup> As time passed, the papers grew in length and sophistication, and some have become extremely complex.<sup>3</sup> Students frequently have corresponded with the lawyers who handled the cases and the physicians who participated and testified in them. In recent years a number of students have done field research by interviewing phy-

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1. Spies, *Research in the Medical Literature: Some Observations and Guidelines*, 32 J. Am. Trial Law. A. 86 (1968).

2. 17 Buffalo L. Rev. 471 (1968).

3. Perroni, *The Anatomy of a Medical Negligence Case Involving Venous Thromboses, Pulmonary Embolism and Legal Causation*, 22 Med. Trial Tech. Q. 8 (1975).

sicians in their offices, a technique which has proved valuable when the medical literature is suspiciously uncommunicative.

For years an intriguing question has been the physician's view of what would seem a perfectly straightforward legal relationship: the patient, his attending physician (the attending)—often a general practitioner, and a specialist whom the attending has called upon for consultation. The question would arise when the specialist disagreed with the attending's mode of treatment and later discovered that the attending ignored his suggested regimen. The legalities of the relationship are clear enough, but personal observation led to the conviction that the medical realities were something quite different. To whom does the specialist consider himself primarily responsible, the patient, whom he bills directly, or the attending who sent him the case?

A cynic might say that the economics of the situation must dictate the result, since many specialists are dependent on referrals for their entire practice. In fact, referrals from one physician to another permeate all of medical practice, but no institutional position could be found in the medical literature except the Principles of Medical Ethics of the American Medical Association.<sup>4</sup>

Armed with this background and a questionnaire which she had prepared, a law student in the summer of 1975 held a group of the Washington County, Arkansas, Medical Society enthralled and, it is said, *in terrorem*, when she sought answers to her questions. The pinnacle inquiry, paraphrased, was, "Would you, as a consulting specialist, inform the patient if you discovered that the attending physician had negligently and irreversibly injured him?" The results of her survey indicate that most physicians follow the Principles of Medical Ethics of the American Medical Association. The legal component of the paper suggests that those Principles are neither ethical nor lawful—nor in the best interests of the patient.<sup>5</sup>

At the time of assignment it is difficult to predict whether the topic will require a legal or a medical emphasis, or, indeed, whether the topic or the case which suggested it is worthy of further research

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4. See *Principles of Medical Ethics—Opinions and Reports of the Judicial Council*, 167 J.A.M.A. at 7 (Special ed. June 7, 1958):

A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

5. Pope, *The Medical-Ethical Responsibilities and Legal Duties of the Consulting Physician*, 31 Ark. L. Rev. 504, 506 (1977).

in either discipline.<sup>6</sup> Issues similar to the medical consultation problem just discussed can arise which are almost purely legal in nature. An example is one recently explored in another paper. A widely held assumption in the medical industry, particularly by hospitals, is that one spouse can freely give consent to medical or surgical treatment of the other spouse when the other is unable to respond for himself. The attitude that a spouse may do so appears in consent forms<sup>7</sup> as well as casual dictum in the case law.

In *Rogers v. Lumbermen's Mutual Casualty Co.*,<sup>8</sup> for example, the plaintiff was diagnosed as having appendicitis. She wanted children by her second husband. Her testimony was that she unequivocally limited her consent to an appendectomy and was ignorant of any possibility of surgery involving her reproductive system. Never-

6. Students are warned of this possibility when topics are assigned. The results of preliminary research may dictate abandonment of the original topic and selection of a new one. In the time constraints of a two-hour course, the beneficial effect is to spur the students to begin their investigations early in the semester. Less than ten percent of the originally assigned topics require an alternate selection.

7. See Office of the General Counsel, American Medical Association, *Medicolegal Forms with Legal Analysis*, Forms P-17 & P-18 (1973). This is a very useful pamphlet, obtainable from the AMA, 535 North Dearborn Street, Chicago, Ill. 60610 for \$1.25. Caution should be exercised in using some of the forms. For example, Form P-1, "Consent to Operation, Anesthetics, and Other Medical Services," recites in paragraph 5 the old litany as follows: "I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained." This serves to reinforce the misconception held by many physicians that they are responsible for a result only if words of warranty are used; it does not rule out contractual commitment to achieve a result, often a danger in radiology, pathology, or plastic and reconstructive surgery. Likewise, in Form P-50, "Agreement with Blood Donor," paragraph 2, much is asked of the donor, who represents that

I am not now nor have I ever been afflicted with syphilis, tuberculosis, malaria, infectious hepatitis, brucellosis, infectious mononucleosis or any other infectious disease or blood impairment . . . [and] I am in good health and know no reason or condition which might impair or affect the suitability of my blood or create a danger in any way for the recipient of my blood. . . .

If a general criticism can be leveled at the forms, it is that they are unnecessarily protective of the hospital and physicians. For example, Form P-55, "Consent to Use of Prosthesis," authorizes the installation of a prosthesis within the patient's body and specifies the material of which it is made. It continues,

I know that there is no adequate substitute for normal bone and that there is a possibility of breakage or complications such as infection and pain. I understand, also, that the complications that may arise often require removal of the prosthesis and further surgery. No guarantee or assurance has been given as to the results that may be obtained.

Without compromising the position of the hospital and the physicians, it could be provided that a prosthesis which must be removed for breakage ought to be saved, in the event that it has been defectively manufactured, a possible cause of breakage which the form does not consider. See, e.g., Spies, *Liability for the Use of Surgical Materials that Fail: A Medicolegal Study in Liability*, 14 Ark. L. Rev. 1 (1959), reprinted in M. Belli, *Trial and Tort Trends* 94 (1960), and, as expanded, in 6 *Law. Med. Cyclopedia* 241 (1961). In addition, the form may waive too much; infection is often caused by insertion error.

8. 119 So. 2d 649 (La. Ct. App. 1960).

theless, in addition to her appendix, the defendant physician also removed her ovaries, ovarian tubes, and uterus for, he said, "the well-being, health and best interest of Mrs. Rogers." Although the plaintiff arguably had gotten more than she bargained for, she sued and recovered.

*Rogers* is instructive as a lesson for lawyers who advise physician-clients to keep sparse and incomplete records as a defense against malpractice and on the vulnerability of both the "emergency doctrine" and the overbroad consent form as defensive measures. Unfortunately, the Louisiana court felt constrained to point out by way of dictum that

Mrs. Rogers' husband, her married daughter and son-in-law were present in the hospital during the entire time of the operation, and during this period were either in Mrs. Rogers' room or the hallway immediately adjacent thereto on the floor below the operating room. Obviously at the time Dr. Mason opened Mrs. Rogers' abdomen by a midline incision, she was under anesthesia, and, therefore, could not possibly have given or refused consent to the action which the surgeons declared to be in accord with good operative procedure, but which extended far beyond the nature of the operation originally determined upon. However, it appears that under the circumstances it would have been entirely feasible and practicable to make immediate contact with the husband, Mr. Rogers, for the purpose of obtaining his consent. That no such action was taken is conclusively established by the record.<sup>9</sup>

No authority is cited for the proposition that the husband may consent for the wife.

Even in 1960, before the current emphasis on women's rights, it would have been difficult to accept the proposition that a husband could permit, in this setting, what his wife specifically had prohibited. In light of *Roe v. Wade*,<sup>10</sup> which held that a married woman may decide to abort a pregnancy without her husband's consent during the first trimester of pregnancy, the court's attitude needs re-examination.

Indeed, the 1973 Arkansas consent statute seems to cover, in nine separate categories, almost every conceivable situation in which one member of a family is called upon to consent to treatment for another, even a grandparent for a child in the absence of parents. Spousal consent is mentioned only peripherally.<sup>11</sup> Thus, in light of

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9. *Id.* at 652-53.

10. 410 U.S. 113 (1973).

11. Ark. Stat. Ann. § 82-363 (Repl. 1976):

[I]n addition to such other persons as may be so authorized, . . . any . . . of the

the common assumption that one spouse can give consent for the other, a problem arises, well covered in a recent paper which was later published.<sup>12</sup>

One paper, appearing in this issue of the *UALR Law Journal*, has suggested that the medical profession is either inept at or disinterested in cleaning up after trauma has lodged foreign material—shards of glass, pieces of wood, or whatever—in the bodies of accident victims.<sup>13</sup> Research in the medical literature seems to reveal that only in time of war does there emerge a lively interest in wound debridement and management. Perhaps this is due to the fact that most surgical specialty training today stresses elective procedures rather than routine care.

In addition to the required research, the Law and Medicine course includes comparisons of the professions' national and local organizations, esprit de corps, and internal discipline. The course also calls attention to the difference in attitudes toward record-keeping between the two professions. Some lawyers do not understand why a treating physician, who has seen a patient from admission to the emergency room through the acute phase and regularly thereafter, is unwilling to testify on the issue of impairment or disability without a complete physical examination, or at least the record on which an entire case is based.<sup>14</sup> On the other hand, lawyers frequently complain about physicians' well known antipathy to paper work, so the students are taught the methods by which one can stimulate the production of a much-needed medical report.

Another point of emphasis is that lawyers and physicians do not share a common basis for evaluation of medical facts. While a law-

following persons is authorized and empowered to consent . . . to any surgical or medical treatment or procedures not prohibited by law which may be suggested, recommended, prescribed, or directed by a duly licensed physician:

(c) Any married person . . . for himself, and, where his joinder in the consent of his spouse may be desired or required, with his spouse.

The statute neglects to point out where spousal consent is desired or required.

12. 31 Ark. L. Rev. 493 (1977). On the matter of consent to medical or surgical treatment in Arkansas, see Ark. Stat. Ann §§ 82-363 to -364.1 (Repl. 1976 & Cum. Supp. 1977). See also Simpson & Armbrust, *A Critical Analysis of the Arkansas Death With Dignity Act*, 1 UALR L.J. 473, 479 (1978).

13. Webber, *Medicolegal Issues in Wound Management*, 1 UALR L.J. 455 (1978).

14. Patient records alone can make a case. I represented the parents of a four month old boy who was hospitalized with diarrhea. The pediatrician prescribed 500 cc. of 0.5% saline solution to bring up his fluids. The nurse selected and administered 500 cc. of 5.0% saline solution, and the patient died. The entire case was developed on the hospital patient record—specifically, the progress notes and orders, nurses' notes, and the incident report. The record did not disclose why 5.0% saline solution, used only occasionally for lost blood volume cases, was being stored in a pediatric ward medicine pantry.

yer considering the tale of a client's automobile accident can balance it with his own sense of credulity tempered by experience, a case involving the severing of a ureter during a hysterectomy presents a different problem altogether: the lawyer is unfamiliar with the environment, and evaluations are therefore difficult. The Law and Medicine seminar attempts to supply some of the missing links for the student lawyers' evaluation.

The course also explores the different problem-solving techniques of the two professions, the attitudes of the practitioners, and some of the underlying reasons for those attitudes.<sup>15</sup> The emphasis is to acquaint the students with medical people and medical methodology rather than with basic anatomy or pathology. The very term "scientific method" somehow sounds pure and shining when compared to the crass overtones of the "adversary method," which suggests a grubby wrestling match in the courtroom. The law students learn, if they do not know already, that the scientific method is really only a matter of trial and error which can be devoid of acute analytical content. In learning this, they also discover the basis of the physician's tedious reliance on statistics and his unwillingness to testify to a conclusion without the support of a hundred, or perhaps a thousand, other cases reporting the same phenomenon.<sup>16</sup>

Lawyers tend to become compromisers, negotiators, and bargainers, the extent in a given case depending on their assessment of how the facts will fall if the case should come to trial. Their case-method training fosters this attitude. The result of each studied case is stated in black and white terms, either for the plaintiff or for the defendant. There are no shades of gray. Only in practice, or in legal clinical programs or simulations, do law students learn that facts are feckless things—sometimes favoring one's position, sometimes not—and worse, that determinative facts are sometimes not available at all. When he learns these things, the lawyer's reliance upon clearly stated rules of law wavers.

The impact of the compromise and negotiation process is twofold. First, the traditional law school curriculum offers nothing whatever to assist the student in the difficult process of assessment of facts or in the art of negotiation which follows that assessment. Second, it is this very process of negotiation and compromise in the

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15. I use W. Curran & D. Shapiro, *Law, Medicine and Forensic Science* (2d ed. 1970) heavily augmented with mimeographed handouts.

16. The seminal article pointing up the differences in the lawyer's and the physician's viewpoint is Small, *Gaffing at a Thing Called Cause: Medico-Legal Conflicts in the Concept of Causation*, 31 *Tex. L. Rev.* 630 (1953).

legal system which physicians find anathema to their own problem solving and value system.

Consider, for example, the doctor who becomes a defendant in a medical malpractice action. He is usually hurt and angry, and often he takes refuge in the notion that what he did conformed to what his colleagues around town have been doing. His lawyer, however, is apt to conclude that the facts are presently unknown, and possibly unknowable, and that his client would make the worst possible witness in his own behalf. As a matter of reason and expedience, the lawyer suggests settlement. His client explodes in anger. According to the physician's value system, settlement would amount to proof of his misdoing. The scientific method does not recognize negotiation and compromise; to the physician, a settlement under these circumstances is nothing less than retreat from principle.

A popular theme these days is that law students emerge from law schools unable to practice law, although law schools are striving mightily to correct this deficiency with their clinical programs. Recognition of practical needs has become an integral part of Law and Medicine. Little stress had been placed on clinical training in the seminar prior to the mid-1960's, and soon the abstract nature of the course became all too evident. It was decided that the students should acquire some background in the workings of a hospital—not from a medical point of view, of course, but from a sociological point of view—for the purpose of addressing certain questions: what is the authority pattern, the sociology of the operating theatre? More importantly, is what the lawyer is told by his client, be he patient or physician, likely to be true? To answer these and other questions, a tentative visitation program was arranged with the University of Arkansas for Medical Sciences campus and the Veterans Administration Hospital in Fayetteville, Arkansas.

To gain the necessary background, the entire Law and Medicine group began spending a day at the University Hospital. After viewing induction of anesthesia and post-operative recovery therefrom, the two most critical periods, the students spend an hour with an anesthesiologist, who explains risks of the procedure, which vary according to age, weight, general health, and other factors. Later the students are divided into manageable teams (eight or less persons) for alternate tours of the surgical suite, the obstetrical suite, and various special care units, which are staffed with specially trained personnel and include the recovery room, the coronary care unit, and the adult and infant intensive care units. The physicians and interns meeting the students reflect the spectrum of medical atti-



tudes about law and lawyers: some are hostile; some are interested and friendly; some are unconcerned and indifferent. Most of them can pose good questions. For example, the pediatrician in charge of the infant intensive care unit recently commented to my students, "Ten years ago we lost 80% of these kids and saved 20%. Today we lose 20% and save 80%. What are you lawyers going to do about that?" Obviously, he is aware of that thin line between what was considered experimental and extraordinary a few years ago and what is now considered conventional, accepted therapy well within the locality standard.<sup>17</sup>

During the afternoon, the Law and Medicine students meet all too briefly with the hospital administrator.<sup>18</sup> Unfortunately, a survey course can only touch basic problems of hospital liability, not health care delivery under federal and state funding programs.<sup>19</sup>

In three particulars the visitation experience has always proved to be useful. First, students absorb the atmosphere of the operating room.<sup>20</sup> That atmosphere cannot be conveyed on television, even when a serious effort is made to do so, and television dramas are usually not serious efforts. Second, students learn that the greatest risk lies not in the surgery itself, but in the anesthesia which accompanies it. After all, anesthesia is a controlled form of poisoning conducted with a variety of agents whose effects on the central nervous system are not understood. Additionally, if the surgery is orthopaedic (that is, involves the musculoskeletal system) it be-

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17. This distinction is applied in other areas. For example, in *In re Quinlan*, 137 N.J. Super. 227, 248, 267, 348 A.2d 801, 813, 823 (1975), reference is made to a declaration of Pope Pius XII, November 24, 1957, in which the position of the Roman Catholic Church is that "ordinary" rather than "extraordinary" efforts only are required to sustain a person in a persistent vegetative state. Here, too, as in the legal distinction between experimental and accepted procedures, the blending of one into the other is difficult to delineate. See also Simpson & Armbrust, *A Critical Analysis of the Arkansas Death With Dignity Act*, 1 UALR L.J. 473, 475-76 n.22 (1978).

18. Some hospital administrators, though not legally trained, are quite familiar with cases and statutes which pertain to the hospital industry, but their comprehension is strangely one-dimensional—*i.e.*, that of an intelligent layman who perhaps understands the implication of a particular decision or statute without being able to project it into the emerging legal pattern perceived by the law students. Clearly, an understanding of the legal system is becoming more necessary to the successful operation of hospitals, and lawyers no doubt will fill a larger role on the administrative side in the future.

19. The University of Arkansas at Little Rock School of Law plans to offer a master's degree in health care law in the near future.

20. Unless one has telescopic vision, nothing of the operative field can be seen from the traditional surgical amphitheatre or viewing area (in fact, the viewing area was eliminated during a recent renovation of the operating suite at the University of Arkansas Health Sciences campus). Law students in surgical attire therefore began attending procedures at the operating table and have done so ever since. The success of this endeavor depends on the willingness of the operating surgeon to explain his problems as the operation progresses.

comes obvious to any student that the human body is tough, resilient, and resistive of encroachment. Third, students learn that trauma, or underlying disease by way of hemorrhage, edema, infections, or general mutilation, can make anatomical identification and surgical repair very difficult, a factor which must be considered if a malpractice claim should later arise.

Although a day at the hospital and the exposure to the various departments proves helpful in these particulars, it is entirely too brief to permit the law students to absorb the folkways and sociology of medicine or the hospital. In the summer of 1973, at the University of Oklahoma, a new approach was attempted at the suggestion of Dr. Thomas A. Bruce,<sup>21</sup> then chairman of cardiology. Three important services were selected: medicine, surgery, and obstetrics-gynecology. One or two law students were teamed with the chief resident in each service for an entire evening shift, which, depending on the hospital, might last as long as fourteen hours—*e.g.*, from 6 p.m. until 8 a.m. the next day. If the young physicians managed to get some sleep in the residents' quarters, so did the students; residents who were called up in the middle of the night were overjoyed at the prospect of rousting a lawyer to accompany them.

After a few weeks, however, the program seemed a dismal failure. The law students involved reported that the residents ignored them or did not take them to the coffee klatches in which difficult cases were discussed with colleagues or simply left them sitting in an anteroom. Residencies and internships change in hospitals on June 30 of each year, and when this happenstance occurred, Dr. Bruce found that a number of white clinical coats had been left behind. At his suggestion, they were supplied to the law students. The effect was immediate. The students were accepted at once by the young physicians, itself an interesting commentary on the psychology of the medical profession, and the program continued successfully. Since it was last described in writing,<sup>22</sup> a number of changes have taken place.

The night shift was selected at the outset because it provided the students an opportunity to see emergency admissions, especially during the weekends. This has proved illuminating to the students, who, in fact, are often drafted into service when the hospital is shorthanded. It is perhaps true that night activity in a hospital

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21. Dr. Bruce now is Dean, College of Medicine, University of Arkansas for Medical Sciences.

22. Spies, Weiss, & Campbell, *Teaching Law Students in the Medical Schools*, 77 *Surgery* 793 (1975).

alternates between periods of urgency and utter boredom. The residents themselves, in the past several years, have indicated their preference for the law students' accompanying them during their regular daytime duties on the wards, such as rounding, conferences, and surgery. The students are free to visit the hospital as often as they wish, within reason, and most try to spend at least one day and one night with the surgery residents.

While at the hospital, students are alert to liability factors, and hospitals are not infertile places to find them. Clinical coats, for example, were found to be unnecessary. Any hospital garment, even a scrub shirt over one's street attire, is enough to gain access to any part of most hospitals. Almost without exception, law students have commented on the appalling lack of security in the various hospitals which have participated in the program. In addition, after seeing residents asleep on their feet in the emergency room or at the operating table, the students have reservations about the seemingly over-long hours which go into creation of the medical mystique.

Not infrequently students have encountered abrasion at the administrative level, as was demonstrated when students attempted to investigate the rate of nosocomial (hospital-generated) infections at several institutions. Sometimes the impression is gained that large hospitals are essentially unmanageable, simply because of the numbers and diversity of the personnel, which supports the further impression that the people who work there are the ones who must be dragged, kicking and screaming, to the hospital as patients.<sup>23</sup>

Once law students become used to the hospital, it becomes evident that many of them, even those soon to be deputy prosecutors or public defenders, have never seen a human cadaver, except as prepared for burial and the "beautiful memory picture" described by Jessica Mitford in her classic, *The American Way of Death*.<sup>24</sup> The role of the pathologist thus becomes important in Law

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23. See R. Cook, *Coma* (1977), for a fictional but true-to-life account of how patients are likely to encounter this less-than-confidence-inspiring phenomenon. For example, in one passage a patient named Berman, while being taken to surgery, engages an orderly in conversation:

"Have you ever had surgery here?" asked Berman, enjoying a sensation of calmness and detachment spreading through his limbs.

"Nope. I'd never have an operation here," said the orderly, looking up at the floor indicator as the [elevator] car eased to a stop on two.

"Why not?" asked Berman.

"I've seen too much, I guess," said the orderly, pushing Berman into the hall.

*Id.* at 69.

24. J. Mitford, *The American Way of Death* 19 (1963).

and Medicine, and, as pathologists are fond of pointing out, the greatest instrument of medical learning is the autopsy, which is conducted for the benefit of the living.<sup>25</sup>

It is important for lawyers to distinguish between clinical pathologists and forensic pathologists. The former analyze tissue specimens in the hospital and become known to the patient as only an adjunct of the hospital laboratory work. The latter undergo an additional residency program in which they are trained to determine the cause of death in criminal cases. They are experienced witnesses, frequently members of the bar, and not at all "shy and timorous folk."<sup>26</sup>

Initially, participation by the Medical Examiner in the seminar was limited to discussions involving the functions of his office, accompanied by the usual police-academy presentation: slides illustrating the grotesque manner in which some citizens elect to end their own lives and the lives of others. The Arkansas system is a dual one, with the authority of the State Medical Examiner<sup>27</sup> superimposed over a still extant local coroner system.<sup>28</sup>

Some time ago it became apparent that some additional teaching input from the medical examiner would be helpful. The first experience occurred about ten years ago when the pathology resident presented the class a tray with the brain of a man who had died of a berry aneurysm<sup>29</sup> a week earlier. When he touched it with a probe, the brain suddenly collapsed, dividing itself into a number

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25. In some cases, as with the private medical autopsy, a family benefits, directly or indirectly, by the proof of a compensable injury or death. When the medical autopsy rate in cases in which death is unexpected or unexplained drops to a very low level, under 10% to 15%, one must question the integrity of the hospital staff. A low autopsy rate may mean that attending physicians have not asked the family for autopsy consent because they do not want to know the cause of death—*i.e.*, knowledge may reflect on their management of the case. See Reynolds, *Autopsies—Benefits to the Family*, 69 Am. J. Clinical Pathology 220, 222 (1978). This article is part of a symposium issue entitled *The Autopsy: A Beginning, Not an End*, 69 Am. J. Clinical Pathology 215 (1978), and contains over a dozen separate articles covering the contribution of autopsies to clinicians, research, hospitals, the law, and society and several others dealing with the financial aspects of the autopsy.

26. McCormick's Handbook of the Law of Evidence § 111 (2d ed. 1972) (describing informers).

27. Ark. Stat. Ann. § 42-611 (Repl. 1977).

28. Ark. Stat. Ann. § 42-301 (Repl. 1977). Coroners need not be medically trained. There remains the possibility that deliberate homicide in the boondocks might be concealed unless the authority of the Medical Examiner is invoked by one of four enumerated persons: prosecutors, circuit judges, sheriffs, and chiefs of police. Ark. Stat. Ann. § 42-616 (Repl. 1977).

29. Dorland's Illustrated Medical Dictionary 88 (25th ed. 1974). An aneurysm is "a sac formed by the dilatation of the wall of an artery, a vein, or the heart." A berry aneurysm is "a small saccular aneurysm of a cerebral artery, usually at the junction of vessels in the circle of Willis [at the base of the brain], having a narrow opening into the artery; such aneurysms frequently rupture, causing subarachnoid hemorrhage." *Id.*

of neat triangular segments, as might a peeled orange similarly touched after having its connective fibers removed. The effect on the class was electric, to say the least.

Experiences such as the foregoing suggest guidelines for law teachers who are contemplating some experience in the medical examiner's office and the morgue as part of Law and Medicine. It is probably fair to say that while only a few students in a decade have cherished such exposure, none have forgotten it, and the great majority later find it valuable. Suggested considerations include the following:

1. Surprises, like the collapsible brain, may occasionally be anticipated.

2. Medical examiners and their associates, including toxicologists, criminologists, and other scientists, as well as investigators and dieners (morgue workers), tend to characterize crimes in a casual way which is disconcerting to law students. For example, in one case in which a young woman had been killed by two .22 calibre bullets into the head, the Medical Examiner, after completing the autopsy of the brain, indicated that he did not intend to autopsy the visceral cavity. Asked whether this might not render him vulnerable to defense counsel on cross-examination, since the death might have occurred in some manner other than the shooting, he replied, "No, this is a misdemeanor case." I pointed out that in the law schools we were accustomed to the notion, however quaint, that deliberately shooting people through the head was to be regarded as a felony. The examiner explained that the victim had been shot by a younger sister, clearly a psychotic, who claimed that the act was accomplished on orders from God. In his opinion, therefore, the case would never go to trial. Thus, it was a "misdemeanor."

3. Each medical examiner has his favorite mode of death. To one, it is the berry aneurysm; to another, unusual modes of hanging; and to still another, the inadvertent death that is sometimes confused with suicide. At times it is necessary to prod the examiner into cases of more general interest to lawyers.

4. Morgues are notoriously underventilated. At the University of Arkansas Medical Sciences campus, for example, the exhaust fan blades do not revolve rapidly enough to lose their discrete visibility. The condition has persisted for years. The personnel who work there seem unaware of it. Little can be offered by way of advice in such a situation, except to suggest mirroring the unconcern of the personnel.

5. Some students, more squeamish than others, are seemingly

reluctant to enter the morgue. The remedy turned out to be a film.<sup>30</sup> Prepared for physicians who have not recently performed a medical autopsy, this film is brief, comprehensive (the head and spine are included), and it lacks the histological (tissue study) emphasis that is characteristic of other films. Students unanimously agree that it is an excellent precursor of the autopsy to come.

In addition to practical experiences, the course content of Law and Medicine should include consideration of philosophical and moral questions. Probably there is no real situation in the legal world or hypothetical construct in the law school which can duplicate the closely parallel nature of ethical and legal principles which arise in the modern hospital. Vexing questions about abortion, sterilization, human transplants, when life begins and ends, and who has the right to die all were confronted by physicians as matters of ethics before they metamorphosed into questions of law.<sup>31</sup> A lawyer in the hospital finds them in bewildering profusion and can only advise that legal consequences are certain to follow.

Such mixed issues of ethics and law can be seen in the odd coalition of *Roe v. Wade*,<sup>32</sup> absolutely permitting abortion during the first trimester of pregnancy (and thereafter only under certain conditions), and the now accepted medical procedure of amniocenteses, in which analysis of amniotic fluid drawn from the mother's womb can reveal genetic defects of the zygote or early fetus. If transmissible genetic disorders can be detected in the first three months of pregnancy, what new duties, ethical and legal, are imposed on the attending physician?<sup>33</sup> If a parent's physical appearance or family history suggests a possible genetic defect, what is the doctor to do? Is mere failure to offer a test for genetic disorder negligence? Does a child have a right to be born free of preventable birth defects? If defects are detected and the fetus is permitted to mature and be born with them, would the child have a cause of

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30. Basic Autopsy Procedure, PMF 5339, obtainable from the Director, Audio-Visual Support Center, U.S. Army Artillery & Missile Center, Fort Sill, Okla. 73503. Application should be made in triplicate on Form DA 4124, obtainable from the same source. The film is a demonstration of the Rokitsky technique—*i.e.*, removal of organ systems *en masse*. The narrator's voice is reminiscent of the announcer in some contemporary cereal advertisements, and the film opens and closes with bits of martial music. Thus, the experience lacks the sounds and effluvia one sometimes encounters in the real live autopsy.

31. S. Reiser, A. Dyck, & W. Curran, *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* (1977).

32. 410 U.S. 113 (1973).

33. The adviser might be the attending obstetrician, a pediatrician, or a nonmedically trained person who works as a genetic counsellor. See Reilly, *Genetic Counselling and the Law*, 12 Hous. L. Rev. 640 (1975).

action against his parents?<sup>34</sup>

Population screening for carriers of genetic disease also raises obvious social and legal difficulties. One article states it as follows:

Among the many complex issues that can arise from major population screening programs is the question of true paternity. In screening for an autosomal recessive disease (such as sickle cell anemia or Tay-Sachs disease), both parents of an affected child would be expected to be carriers. Testing of the parents may reveal that the father is not a carrier. A possible inference of adultery is inescapable. Facing this problem, how should the physician weigh that possibility against the very remote chance of a *de novo* mutation? Is the physician liable to the husband if he fails to discuss with him what the facts infer? Should he be?<sup>35</sup>

Law students learn that physicians expect responses from the legal community to these inquiries—if not categorical answers, at least guidelines on how they should proceed. Having confronted an ethical dilemma and made a good faith decision, a physician is embittered to be judged legally deficient by hindsight. And a further pedagogical point is that, like so many other medico-legal areas, Law and Genetics of itself has the makings of an acceptable course, even without consideration of what might be called the “policy areas” of genetic manipulation.<sup>36</sup>

Another ethical problem with implications for the Law and Medicine program is that of transgression of patients' rights.<sup>37</sup> The student participants have commented from time to time on what

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34. See *Park v. Chessin*, 60 App. Div. 2d 80, 400 N.Y.S.2d 110 (1977), which held that a physician who is consulted by prospective parents to determine whether they are at risk for genetic disease must observe the usual malpractice standard. The parents had lost a five year old infant to polycystic kidney disease, a fatal hereditary condition almost certain to be passed on to any offspring. Defendant physicians, whose advice the parents had sought, negligently informed them that the risk of subsequent children's inheriting the disease was “practically nil.” Relying on the advice, the parents had another child who succumbed to the same disease at age two and a half. The court held that the parents could recover for their economic loss during the child's lifetime and for loss of the wife's services, but not for emotional distress because of the difficulty of proving damages. More significantly, the court held that an action in the child's name for wrongful life could be maintained under these circumstances. *Id.* at 84, 400 N.Y.S.2d at 114.

35. Milunsky & Reilly, *The “New” Genetics: Emerging Medicolegal Issues in the Prenatal Diagnosis of Hereditary Disorders*, 1 Am J.L. & Med. 71, 78-79 (1975).

36. Balmer, *Recombinant DNA: Legal Responses to a New Biohazard*, 7 Env'l L. 293 (1977); Comment, *Genetic Manipulation: Research Regulation and Legal Liability Under International Law*, 7 Cal. W. Int'l L.J. 203 (1977).

37. This is an amorphous concept which has received a good deal of attention in recent years. See, e.g., Minn. Stat. Ann. § 144.651 (West Cum. Supp. 1978); Annas, *The Hospital: A Human Rights Wasteland*, 1 Civ. Lib. Rev. 9 (1974); Curran, *The Patients' Bill of Rights Becomes Law*, 290 New England J. Med. 32 (1974).

appears to be disregard of a patient's right of privacy during rounds: a patient, partially disrobed and often in a double room, is descended upon by a group of doctors making rounds. The patient's condition may be discussed within his hearing, "as if he were a piece of meat," as one student put it.

The other side of the coin is, of course, that the law students themselves could be regarded as primary invaders of the patient's right of privacy, especially if their garb suggests that they are hospital personnel. The usual practice for medical students is not a useful pattern for law students. Medical students wear name tags with no professional identification. If inquiry is made about their status by patients, they are instructed to reply that they are "student doctors." Third and fourth year medical students in training hospitals regularly are called "doctor" by physicians and other hospital personnel, although they are not treated with the deference the title normally warrants. These practices as to medical students probably fall within the terms of the Arkansas licensing law,<sup>38</sup> although they raise the specter of a claim of a holding-out for vicarious liability purposes and of a requirement that the students adhere to the physicians' standard of care.<sup>39</sup> It should be emphasized, however, that medical students are supervised extremely closely after their extensive preliminary training. Further, they generally are much too in awe of their patients to deviate from accepted procedures.

Since no help could be gained from the medical student model, it was decided that the best way to handle the law students' intrusion would be to permit the chief resident to determine the capacity in which the law students should appear around the hospital. At this juncture the students themselves supplied the solution. Since their training also is fairly extensive and includes the precepts of the constitutional integrity of the person and the tort of invasion of privacy, most of them prefer simply to inform the patient who they are and why they are present in the hospital. The patients rarely object, and, as physicians like to put it, no complications have arisen.

Perhaps this is because teaching hospitals' consent forms ordinarily are broadly stated to include visitation for educational purposes.<sup>40</sup> At any rate the patients seem accustomed to intrusions by

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38. Ark. Stat. Ann. § 72-604(2)(j) (Cum. Supp. 1977) excludes medical students, interns, and residents from the licensing requirements of the Arkansas Medical Practices Act.

39. Note, *Physicians and Surgeons: Sanctions and Liabilities Arising from Medical Student's Clinical Education*, 27 Okla. L. Rev. 95 (1974). The genesis of this note was a Law and Medicine paper.

40. The Consent for Operation form used by University Hospital in Little Rock, Arkan-



a broad spectrum of personnel, including psychology, social welfare, and theology students, in addition to technician-trainees in the allied health sciences.

### *Conclusion*

Law school training traditionally has taken place in the classroom, and much of it no doubt will remain there. Clinical education in the law schools today augments classroom learning and introduces students to the real world in which they must function as professionals. For many legal practitioners a measurable part of that real world includes participation with members of the medical profession. It seems evident that lawyers will occupy an expanding role in the health care industry. Case studies and other written materials, augmented with lectures by physicians and hospital administrators in the law school classroom, cannot possibly convey the many facets of the health industry or the problems and attitudes of its practitioners. I think the perspective of the law students is broadened by their clinical experience in the hospitals<sup>41</sup> and that the hospital personnel learn something from law students as well.

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sas, states, "He [the operating surgeon] may use his discretion as to whom, if anyone, he will have present to witness the operation."

41. In the teaching of Law and Medicine courses, there are many roads to heaven. See, e.g., Wadlington, *Teaching Law and Medicine in the United States*, 14 J. Soc. Pub. T.L. 96 (1977); Linzer, *Law for Them and Medicine for Us—A "Counterdisciplinary" Approach to Learning*, 55 U. Det. J. Urb. L. 113 (1977).