JOURNAL OF EDUCATIONAL AND INSTRUCTIONAL STUDIES
IN THE WORLD
June 2016, Volume: 6 Special Issue 1 Article: 19 ISSN: 2146-7463

LEGAL EDUCATION OF HEALTHCARE PROFESSIONALS

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Abstract

Emerging professional efforts focus on integration across healthcare and related professions. Medical schools are integrating legal concepts and skills, as well, using the lens of medical-legal partnership.

Cases of alleged medical negligence have brought need of changes related to professional exercising regulation and patient safety.

The need of educating healthcare professionals about legal issues is evident as the law defines what they can or cannot do in terms of medical practice, relationship with patients, etc.

Healthcare professionals need to be conversant with the law. At the Faculty of Public Health in Medical University – Sofia, as part of the main educational programme, a course of legal disciplines has been introduced. Students and healthcare professionals have been introduced to law of public health, health care generally, and medical care specifically.

The main advantage of practical education is that, compared to traditional teaching methods, it involves a different approach to the learning of law: it encompasses experiential learning.

Keywords: Legal education, medical care, professional.

INTRODUCTION

Legal education of healthcare professionals is closely related to the patient-centered care, which is a quality of personal, professional, and organizational relationships. The patient-centered medicine, which William Osler first wrote about, in 1875, recognized the importance of patients' perception of their illness, which led to a change in the culture of medical education. This educational shift was driven by one man's recognition of the importance of understanding the uniqueness of each individual, and by his devotion, dedication, and service to his patients.

Medicine and law have been related from the earliest times. The bonds that first united them were religion and superstition. In early civilizations, primitive legal codes, religious doctrines, and social precepts were often ill distinguished, and laws with a medical content were often found within their context. Ecclesiastical courts and canon law were concerned with much that related not only to religious matters but also to medicine. The oldest of these written records, the Code of Hammurabi, includes legislation pertaining to the practice of medicine, dating back to the year 2200 B.C. It covered the topic of medical malpractice and set out for the first time the concept of civil and criminal liability for improper and negligent medical care.

Historical approach

In ancient Egypt, the acts of the medical man were circumscribed by law. The Egyptians had a thorough knowledge of poisons. The Chinese published information about poisons, including arsenic and opium 3000 years B.C. In ancient Persia, wounds were put into one of seven classes, ranging from simple to mortal. In ancient Greece, there was knowledge of poisons and laws against abortions.

In Rome 600 years B.C., a law was passed requiring that a woman who died in confinement should be immediately "opened" to save the child. The investigators of murder were selected from the citizenry. When Julius Caesar was assassinated in 44 B.C., the physician Antistius examined his body and concluded that only one of the 23 stab wounds was mortal.

The legal code in ancient Greece (about 460 B.C.) was very elaborate. In addition, it was a time of great advances in medicine. Though there is no clear evidence that medical knowledge was officially made use of in establishing proof in courts of law, it is known that Hippocrates and others discussed many genuine medico-legal questions. These questions included the relative fatality of wounds in different parts of the body, the average duration of pregnancy, the viability of children born before full term, and other matters. Moving across the Mediterranean, there is in existence a papyrus, found in Egypt and dated from pre-Christian times, in which a medical officer in Alexandria submitted a report on a suicide about which there had been some suspicion of murder.

The Justinian Code, which made its appearance in Rome between 529 and 564 A.D., included within its provisions a precept that indicated that a medical expert would not be used to proper or greatest advantage if he were to be simply regarded as an ordinary witness, appearing for one side or the other. The Code, with much wisdom, stated that the function of such an expert was really to assist the judiciary by impartial interpretation and opinion, based on his specialized knowledge.

In 1553 the Germanic Emperor, Charles V, published and proclaimed the Caroline Code, which clearly stated in its pertinent sections that expert medical testimony must be obtained for the guidance of the judges in cases of murder, wounding, poisoning, hanging, drowning, infanticide, and abortion and in other circumstances involving injury to the person.

France also had an early start among European nations in the cultivation of a medico-legal system. From 1570 to 1692, France enacted laws that, like those of Germany, favored the development of legal medicine as an academic discipline. However, by 1690, medico-legal offices became corrupt, and progress in legal medicine actually regressed, not to start on a forward march again until after the French Revolution in the next century.

Meanwhile, in Italy, a physician named Fortunato Fedele published in 1602 a fairly comprehensive volume on forensic medicine entitled, De Relationes Medicorum. Another Italian, Paola Zacchia, a papal physician, published the huge Questiones Medicina-Legales, which quickly overshadowed Fedele's work. Zacchia's book discussed in detail questions of age, legitimacy, pregnancy, death during delivery, resemblance of children to their parents, dementia, poisoning, impotence, feigned diseases, miracles, rape, mutilation, and the matters concerning public health. The work has deficiencies that can easily be explained by the era in which it was written; for instance, the knowledge of anatomy and physiology was sketchy and erroneous. The book also contains sections on the different methods of torture then in existence, and it has a section that deals with miracles. Despite these shortcomings, it was a worthwhile and influential volume.

Legal medicine was not treated as being just a theoretical pursuit. It was eventually brought into the courtroom. For example, in 1667 Schwammerdamm, in Germany, claimed that the lungs of a newborn baby would float in water if the baby had actually breathed. That is, if it was not stillborn and had lived and subsequently died, either by natural causes or by homicide. In 1681, the German physician Schreger used this test forensically, and secured the acquittal of a girl who had been accused of murdering her illegitimate child.

Legal medicine began to be promoted within formal educational circles. In 1650, Michiaelis, in Germany,

delivered lectures on legal medicine. By 1720, professorships concerning the subject were founded by the state. Germany, in fact, established the first known medico-legal clinic in Vienna in about 1830 and a second one in Berlin in 1833. France established its first clinic in 1840. France has also provided, since 1803, that judges appoint medical experts who must be graduates in medicine and must have attended a course (in earlier days this requirement was fulfilled by going to one or more lectures) and have passed an examination in legal medicine. France established its first professional Chair in Legal Medicine in 1794. Great Britain, in 1803, established its first Chair of Forensic Medicine at the University of Edinburgh. By 1876, there were chairs in all of its medical schools.

The first book on legal medicine written in English was authored by Samuel Farr in 1788 and was entitled Elements of Medical Jurisprudence, a succinct and compendious description of findings in the human body that were required for judgment by coroners and courts of law in cases of divorce, rape, and murder, among others. The first British teacher of legal medicine was Andrew Duncan, a professor of physiology, who gave a course of lectures on legal medicine and public health, beginning in 1789. His son, Andrew Duncan, Jr., became the first professor on this subject at the University of Edinburgh, where the first Chair in Legal Medicine in the English-speaking world was established. Alfred Taylor (1806 –1880), Professor of Medical Jurisprudence at Guy's Hospital Medical School, wrote Principles and Practice of Medical Jurisprudence. The British Association in Forensic Medicine was established in 1950, and later the British Academy of Forensic Sciences was created in 1960.

From World War II until the late 1960s, the field of legal medicine was defined by law school courses that were almost exclusively concerned with forensic psychiatry and pathology and were properly considered advanced courses in criminal law. In the late 1960s, some law and medicine courses began concentrating on broader medico-legal questions faced in the courtroom, including disability evaluation and medical malpractice. These courses were properly considered either advanced tort or trial practice courses.

In the 1970s the concerns of at least some law and medicine courses expanded to include public policy, including access to health care and the quality of that care. At the same time, advances in medical technology created new legal areas to explore—from brain death and organ donation to abortion and in vitro fertilization. These topics were increasingly incorporated into law and medicine courses, which were themselves becoming known by the broader term of "health law."

Teachers of health law in law schools and medical schools, together with health law teachers in schools of public health and schools of management, began meeting on a regular basis in 1976, when the first national health law teachers' meeting took place at Boston University under the auspices of the law school's Center of Law and Health Sciences (the successor organization to the Law-Medicine Institute). The purpose was to help define the expanding field and develop necessary teaching materials.

In 1987, the American Association of Law Schools sponsored its first teaching workshop on health law. Although this narrower group only recently convened, its program and proceedings offer useful insight into the current state of health law in law schools. As the organizers of the workshop saw it, law and medicine (fields primarily concerned with medical malpractice, forensic medicine, and psychiatric commitment) had become subdivisions of the new field of health law. Health law itself has three additional subdivisions: economics of health care delivery, public policy and health care regulation, and bioethics. These three subdivisions are actually three different approaches to the same subject matter—the health care industry. Health law is applied law, much the way medical ethics is applied ethics.

DISCUSSION

The health care delivery system has begun to turn a corner, heading away from a system focused on the expensive and inefficient treatment of individuals at their sickest to one that emphasizes prevention, integration, interprofessional collaboration, and the health of populations. For quite some time, society has ignored the extent to which social determinants of health - the conditions, in which people live, learn, work, and play - are inextricably woven into and affect individual and population health. In 1993 the model of medical

- legal partnership (MLP) was first introduced. The tradition in the medical profession was, for much of the last two hundred years, that the patient was passive recipient of medical care and doctors took it upon themselves to decide what treatment and information should be provided. Principles of autonomy and empowerment of the individual have been brought to medical practice with far-reaching consequences for the relationship between medicine and law.

Patient-centred care improves patient care experience and creates public value for services. When healthcare administrators, providers, patients and families work in partnership, the quality and safety of health care rise, costs decrease, and provider satisfaction increases and patient care experience improves.

Efforts to promote patient-centered care should consider patient-centeredness of patients (and their families), clinicians, and health systems. Helping patients to be more active in consultations changes centuries of physician-dominated dialogues to those that engage patients as active participants. Training physicians to be more mindful, informative, and empathic transforms their role from one characterized by authority to one that has the goals of partnership, solidarity, empathy, and collaboration. Systems changes that unburden primary care physicians from the drudgery of productivity-driven assembly-line medicine can diminish the cognitive overload and exhaustion that makes medical care anything but caring or patient-centered.

Healthcare professionals education should standardize learning outcomes and general competencies and then provide options for individualizing the learning process for students and residents, such as offering the possibility of fast tracking within and across levels or providing opportunities for experiences in research, policy, education, etc., reflecting the broad role played by specialists providing healthcare.

Emerging interprofessional and team-based efforts tend to focus on integration across healthcare and related professions (e.g. nursing, pharmacy, and public health). But, increasingly, medical schools and residency programs are integrating legal concepts and skills, as well, using the lens of medical-legal partnership. Medical-legal partnership education refers to the integration into the curriculum of content, skills, and an interprofessional, team-based orientation to healthcare. The trends in medical education that are synergistic with MLP education include the focus on: health disparities, social and behavioral health with an emphasis on the social determinants of health; the integration of primary care and population health; health law and policy; and interprofessional, team-based learning.

This type of education closely considers the fact that medical intervention is often characterized by legal principles. There are strict legal duties, which healthcare professionals have towards their patients. The particular duties arising: at common law; civil law; and pursuant to other legislation governing particular dimensions of the physician–patient relationship, namely consent and capacity, advance directives, privacy, public health, and professional conduct.

Teaching assignments in most healthcare programs are based on a faculty member's experience, because faculty are preparing students to enter the world of healthcare practice. The faculty practice usually includes all aspects of delivery of healthcare services.

When in comes to legal education of healthcare professionals, if faculties do not have legally trained members, they often collaborate with professionals from legal departments to perform the education.

Main curriculum often includes medical law issues as well as ethics of healthcare delivery. Knowledge of medical law and ethics can help healthcare professionals to gain perspective in the following areas:

- The rights, responsibilities, and concerns of health-care consumers. Not only do healthcare professionals need to be concerned about how law and ethics impact their respective professions, they must also understand how legal and ethical issues affect patients. As medical technology advances and the use of computers increases, patients want to know more about their options and rights as well as more about the responsibilities of health-care practitioners. Patients want to know who and how their information is used and the options they have regarding health-care treatments. Patients have come to expect favorable outcomes from medical treatment, and when these expectations are not met, lawsuits may result.

- The legal and ethical issues facing society, patients, and health-care professionals as the world changes. Every day new technologies emerge with solutions to biological and medical issues. These solutions often involve social issues, and we are faced with decisions, for example, regarding reproductive rights, fetal stem cell research, and confidentiality with sensitive medical records.
- The impact of rising costs on the laws and ethics of healthcare delivery. Rising costs, both of healthcare insurance and of medical treatment in general, can lead to questions concerning access to healthcare services and the allocation of medical treatment. For example, should everyone, regardless of age or lifestyle, have the same access to scarce medical commodities such as transplant organs or highly expensive drugs?

The negative impact of a lawsuit can be overwhelming for the practitioner, the patient, the patient's family, and potentially the local and national communities. Consequences include increased implementation of defensive practices by physicians, increased cost of care (through unnecessary tests, legal fees, and rising insurance premiums), decreased physician confidence in the medical and legal systems, and physician burnout and attrition in high-risk specialties and/ or regions. These effects may stem in part from unfamiliarity with the legal system and its inherent culture and rules.

Negative consequences can be overcome by introducing interdisciplinary training. Currently interdisciplinary education programs have been introduces where law students learn side-by-side with medical students, residents, attending physicians, and other health care providers, as well as social work and public health students. The interdisciplinary training is usually part of a medical-legal partnership. This unique educational collaboration helps students understand that health disparities experienced by minorities, individuals and families with low economic status, and those with low educational attainment contribute to poorer health outcomes. Law students and students from the health professions learn first-hand the effect that socioeconomic determinants have on health and how to better address issues that can affect the health and well-being of families. The curriculum provides a multi-faceted interdisciplinary learning experience for students of multiple disciplines including, law, medicine, social work, public health, pediatric residents and other professionals.

Interdisciplinary learning can help improve the problem-solving abilities of all of the professions. The interdisciplinary approach also forces students from both the health and legal professions to consider their patient/client in the context of the client's life. For lawyers, this can mean understanding that the client has a medical condition that impacts the nature and purpose of the representation. For physicians, it can mean understanding that there may be legal remedies or legal issues intertwined with the client's illness.

At the Faculty of Public Health in Medical University – Sofia, as part of the main educational programme, a course of legal disciplines has been introduced. Students and healthcare professionals have been introduced to law of public health, health care generally, and medical care specifically. This has been directly connected with the claim that modern health care is patient centered, but there has also been noted the fact that in many nations around the world the consumer's voice in health care is not only being heard but is being recognized by government, the professions and health-care providers.

Any healthcare intervention has an element of uncertainty as to whether it will improve the health of the patient. Every consumer has the right to know what it means being a patient, and to receive helpful information about the quality of the care they will receive especially if they are to have any type of medical or surgical intervention.

Another general issues, included in the educational curriculum, have been influenced by the growing public concern regarding the ethical conduct of healthcare professionals.

The main goals of the introduced educational programme is to:

- support the realization of the right to the highest attainable standard of health of every human being;
- illustrate the basic elements of human rights and, in particular, the right to the highest attainable standard of health, and their meaning in the context of health practice;

- facilitate human rights education processes and awareness-building of human rights issues in the daily practice of healthcare professionals;
- be a point of reference for and articulate quality human rights education to those who develop educational programmes;
- articulate human rights education learner outcomes (specifically in the categories of knowledge and understanding, values and attitudes, and skills);
- assist in the elaboration of effective programmes for training educators to deliver human rights education for health workers;
- become a point of reference for assessing progress in promoting and adhering to human rights; and
- promote ongoing improvements in the quality of human rights education for healthcare professionals.

CONCLUSION

Legal education of healthcare professionals can help understand the ways in which patients and carers can be involved as partners in healthcare, both in preventing harm and learning and healing from an adverse event. Students' knowledge requirements include: basic communication techniques; informed consent procedures; and the basics of open disclosure. On the other hand, students performance requirements include: actively encourage patients and carers to share information; show empathy, honesty and respect for patients and carers; communicate effectively; obtain informed consent; show respect for each patient's differences; describe and understand the basic steps in an open disclosure process; apply patient engagement thinking in all clinical activities; and demonstrate ability to recognize the place of patient and carer engagement in good clinical management.

While most healthcare interventions have good results or at least do no harm, poor outcomes do happen that can include errors, both random and systemic. The quality of legal education in a healthcare system can improve the way of handling those errors. When healthcare organizations fail to integrate consumer involvement in managing systemic risk, they lose access to important knowledge that cannot be gained from any other source.

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