Teaching medical ethics through medical law

Abstract (150 words)

Medical ethics is normally taught in a combination of three ways: through discussions of normative theories and principles; through for-and-against debating of topics; or through case studies (narrative ethics). I want to argue that a fourth approach might be better, and should be used more: teaching medical ethics through medical law. Medical law is already deeply imbued with ethical concepts, principles and reasons, and allows the discussion of ethics through the 'back door', as it were. The greatest two advantages of the law are (i) its familiar authority, especially among the disengaged medical students who have little interest or respect for the subject of ethics; and (ii) its focus on the reality of the people and the tragedies discussed (as opposed to the abstractness of a lot of ethical discussion). Finally, I argue that medical law, unlike ethics, allows more efficient and more detailed MCQ assessment.

4-6 Keywords: ethics education, medical law, medical ethics, ethical understanding.

No potential competing interest was reported by the author.

By Christopher Cowley. E-mail: Christopher.cowley@ucd.ie

Biographical note. Christopher Cowley works at University College Dublin, Ireland. His main areas of research interest are in ethical theory, applied ethics and the philosophy of criminal law.

***

I will start with three assumptions which readers of this journal will probably not find controversial. First, ethics needs to be taught to medical students, not only because of the very real ethical issues in medicine, but also because of the great risk of harm to vulnerable patients. Second, ethics is not (or at least not only) a body of information to be transmitted to students and memorised for a test; ethics is also about sound ethical reasoning and good ethical behaviour. Third, I'm going to assume that mainstream philosophical courses in meta-ethical theory or in the history of ethical thought are not appropriate for medical students, and that we should be focusing on something like 'applied' ethics. Given these assumptions, what's the best way to teach and assess medical students in a

crowded medical curriculum, in order to make them more ethically sensitive doctors, with better ethical reasoning, and better able to publicly justify their ethical decisions?

I want to argue that it is not enough to rely on an 'applied ethics' approach, and that the constrained medical ethics curriculum should be tilted significantly toward the use of medical law. This might not sound revolutionary, since medical ethics and law are often taught in a single course or curricular stream already. And obviously the medical students need to learn some medical law. But I argue that the ethics content should be reduced and the law content increased, precisely because teaching law is a more effective way of teaching ethics *indirectly*, within the particular context of a medical school. And teaching ethics indirectly greatly increases the chance of making a real difference to the students' ethical reasoning and ethical behaviour, I claim.

Now there is a long tradition of teaching ethics indirectly, starting with Biblical (and other) parables and proceeding through to case studies from literature or from history, with greater or lesser amounts of reality or detail. Some would describe this approach as 'inductive', using the detail of the cases to elicit and articulate and constructively challenge intuitions, perhaps leading to the formulation of ethical principles. It might seem that my conception of the law is no more than as a source of further case studies. So part of my task will be to explain why the legal case studies can be even more effective than the parable, literary or historical case studies.

Two caveats before I proceed. In many medical schools, medical law is taught by a law academic or by a practising solicitor. I am not suggesting that ethics should be delegated to a law academic, nor am I suggesting that the ethics teacher needs a degree in law. Instead, the ethics teacher needs to know enough about the law to use it for her teaching. Second, if my argument is successful, then it might be applicable to nursing students, engineering students, and business students. However, there may also be relevant differences between the disciplines. Since I do not have the space to explore them properly, I will focus only on the medical school context.

Medical students and philosophy students

Most ethics teachers who are asked to teach in medical schools have a background in philosophy. So there is an obvious temptation to teach in the way they have themselves been taught. But there are important differences between medical students and philosophy students. Most philosophy major students can be assumed to have some antecedent interest in philosophy. And even if they are not interested in ethics, they mostly acknowledge the rightful place of ethics in the philosophy curriculum, just as they acknowledge the overlap of ethical questions with questions from other parts of philosophy. If someone is more interested in, say, metaphysics, they can focus on the metaphysics of ethical value, for example; if they are more interested in the history of philosophy,

they can examine the relationship between Kant's metaphysics and Kant's ethics. What's more, philosophy major students have probably discovered an interest in the humanities and in discursive essay-writing already at secondary school. Once in university, their reading and writing skills can only improve.

In general, medical students are much more interested in medicine and science than in philosophy and the humanities. Most medical schools select applicants primarily on the basis of their achievements in scientific subjects: perhaps they were even exempt from literature and history and politics in the last years of secondary school curriculum, and therefore from all the rich ethical issues and discussions that arise in those subjects. Of course some medical students will be interested in philosophy and the humanities, but once in medical school they will simply not have the time to explore that interest, given the massive amount of medical science they need to master. And the disengaged medical students will not have been 'primed' into absorbing the humanities content and approach fast enough to make it interesting.

Second, there is a limit to how much an ethics teacher in a *philosophy* department can and should care about disengaged students. Obviously she should welcome all students to the class. But like all subjects, philosophy has a set of principles and standards; if a given student is unwilling or unable to respect those principles and standards, or unwilling to respect *her* as the expert on those standards, then there may come a point where the ethics teacher is entitled to turn her attention away from that disengaged students, in order to focus on the engaged ones. Obviously she needs to offer support to interested students who need it, obviously she needs to take into account extenuating circumstances, but eventually there will come a point where she can honestly say "I have done all I can. These are the standards of the discipline – and you have to fail." Perhaps the solution will be for the student to make up the failure in other areas of philosophy, or to abandon philosophy altogether. In contrast, the ethics teacher in the *medical school* cannot adopt this "limit of care" attitude, because the chances are that those who do badly on the ethics course (after repeated attempts) will *nevertheless* go on to become doctors and to treat patients. I hasten to add, of course, that they might turn out to be ethically good doctors, but the point is that the medical school should at least be concerned about any medical student who repeatedly does badly at ethics. In philosophy, the teacher can aim higher, to those with the basic ability and willingness to put in the work; in medicine, the ethics teacher has to make sure to get through to *all students*, including to the perhaps large group of disengaged students (except for those already failing in multiple medical subjects, and at risk of dropping out).

Third, medical students lack the curricular time to explore ethics properly, and many of them lack the interest and the aptitude to study discursive subjects. That means that the ethics teacher has to get through to them much sooner, and much more efficiently. What this means, for starters, is that there will probably be little room for meta-ethics, or the history of ethics. Instead, many medical ethics teachers will go straight to normative theory. With utilitarianism, one starts with a plausible definition of ethical behaviour as promoting the best consequences (defined in terms of patient welfare), and one then moves to ethically perplexing cases that can perhaps be solved by plugging the relevant case details into the formula to generate the right answer. One then introduces the familiar deontological limits (e.g. the need to respect patient autonomy even if this leads to a sub-optimal consequence for the patient's welfare) to show that ethics is complicated. But at least the students will have learned how to reason for themselves, and to better justify their decisions. Call this the 'normative-theoretical approach'.[1]

Does that approach work? Maybe it does. There is a problem here with evaluating the long-term success of any approach to teaching, let alone to ethics teaching. It might be a matter for empirical research, and therefore beyond the disagreements of philosophers in a journal like this. But even if one can find unambiguous examples of bad practice in doctors, it will be very hard to confirm (empirically) its causal origin in inadequate or negligent ethics teaching and assessment at medical school! So many factors contribute to a doctor's bad practice. And again, remember that the ethics teacher had relatively little curricular access to the former student, and that reduces the teacher's responsibility even further.[2]

Given the above limitation to empirically assessing effectiveness, one can still argue for different approaches to teaching ethics to medical students, but the arguments will necessarily be speculative and conceptual. I would argue against the normative-theoretical approach on the grounds that it is more likely to be misunderstood by medical students, given their lesser background in and opportunity for discursive thinking. As a result, they will tend to grasp the normative theory in the same way that they grasp scientific theories – after all, they have a lot of experience at applying the latter. But scientific theories are radically different, since they are fundamentally about third-personal explanation and prediction, and not about first-personal action-guidance. In science, if I get

[1] I'm taking this approach to be familiar enough to readers. There are many variations of it, for example the 'Four Principles' approach of Beauchamp, Tom L., and James F. Childress. *Principles of biomedical ethics*. Oxford University Press, USA, 2001. They would use the principles of "beneficence" and "non-maleficence" to describe utilitarianism.

[2] A far more reliable indicator of the future doctor's bad practice would be the student's present infringement of 'Fitness to Practice' guidelines, for example.

the wrong result, it might be because the theory or the data is incorrect; it might not be my fault. In ethics, I cannot 'hide' behind the theory in the same way. The temptation for the medical student, when she hears the word' theory' will be to think of ethics as 'merely another theory', and that 'applying ethical theory correctly' is all there is to ethics. Then she will get frustrated when the teacher reminds the student about some of the famous counter-examples against utilitarianism. And then there might not be enough curricular time to correct such a misunderstanding.

Many ethics teachers have recognised this risk, I am not yet claiming anything new here. Such teachers might prefer an 'applied ethics' approach. They go from one topic to another, they rehearse the arguments for and against a particular proposition, they help the students to articulate where they stand, and to anticipate and respond to their real or imagined opponents. This is fine as far as it goes, with a real potential for engaging entertainment, but the worry is that the medical students will take it more as an entertaining debating society than as a bona fide academic subject. On some issues they may have clarity, on others they may not, but I worry that the underlying message will be that ethics is not more than a theatrical game: "who wants to play the pro-euthanasia side?" Coupled with that message is the message that it doesn't even matter what side you take, since ethics is arbitrary and subjective; every argument has a counter-argument. Obviously not all applied ethics classes are like this, and a skilled philosophy teacher – with enough time and energy – could draw her applied ethics students toward greater depth, nuance and personal commitment, but that is less possible in the crowded medical curriculum.

A third kind of ethics teacher will recognise the risks of the 'normative-theoretical' and the 'applied ethics' approach, and cultivate an *indirect* approach through the use of case studies. Some case studies are schematic, such as the Trolley problem, but these are so outlandish that they are unlikely to generate any useful conclusions outside the philosophy seminar room, and are more likely to provoke indifference (bordering on resentment) among medical students: "*this* is ethics? We've got enough ethical issues in the hospital without any need to discuss runaway trolleys."[3] Better case studies would be from a medical context, with all the medical detail to make it real. Here the students will take the discussion seriously because they know they may well face such a scenario in their future work-lives. The problem with medical case studies is that they may seem *contrived* in just the right way to instantiate a particular ethical discussion: real medical cases are generally more

[3] This example is popular in ethics textbooks, but I have always resisted it in my own teaching because it is just too much of a contrivance. I am not sure whether it generates any useful ethical intuitions because it is so far from my and from students' ordinary experiences. (I haven't a clue what I would do in the trolley situation, and I resent the suggestion that I *ought* to know!). I would certainly resist the crass utilitarianism that would present itself as the only reasonable solution.

complicated by the messy human details of the patient's life and values. Because of this, some 'case studies' teachers prefer to draw from literature or history (both in medical and non-medical contexts) in order to capture the full rich detail. Literature also has the advantage here of making that subject compelling and vivid.

Again, all this might work with some medical students, but I am worried that it will not be taken seriously by the disengaged students – because it is 'merely' literature and therefore invented; because it is 'only one' case, and perhaps not typical; because it took place in a different culture and time, and is therefore less relevant to our own. The list of excuses for not taking case studies seriously is long. But the biggest excuse of all is for the student to hide behind a vague *non-ethical scientism*. Her future job, as a doctor, is merely to apply the science; her job is not to make ethical decisions beyond a simple common-sense duty of care and courtesy. If a patient presents with condition A, then you offer treatment X. If that doesn't work, you offer Y. Medicine is about problem-solving, and the doctor can leave the ethical decisions to their superiors, to the hospital executives, to the patient's family.

And again, to reiterate an important structural point in this discussion: it is the disengaged medical students I am worried about, the ones who think ethics is either obvious or irrelevant – the students who are just as likely to become doctors as the students who are keen about ethics.

My proposal: ethics through law

So where are we? I agree that ethics should not be taught to medical students through normative theory. (Or rather, normative theory can be brought in later, if time permits.) I agree that the 'applied ethics' approach is likely to be seen as too much of a relativistic game without a unifying theoretical discussion. I like the 'case study' approach, but I'm worried that the disengaged students will not take them seriously because they are 'merely' stories.

So my solution is to take cases, but from medical law. This offers all the advantages of a case-based approach, but backed up by the ethical and prudential *authority* of the law, together with a nuanced discussion of the ethically-relevant facts of the case. The ethics teaching is then indirect in two ways: first, it comes out in the discussion of the case; second, it comes out in the discussion of the law.

What do I mean by the authority of law? This is key. Even if the disengaged 'scientistic' students are not interested in 'ethics', they *have to* be interested in law. At the very least, they understand law as a system of threats, backed up by very real force. They understand that doctors sign employment contracts and thereby make binding promises; they understand that doctors can get in trouble for negligence, and occasionally go to jail. That means that the disengaged student cannot, in the end,

see herself as a mere scientist applying impersonal solutions to problems; she has to keep an eye out for legal norms and risks.

Some parts of the law are arbitrary: tax law and traffic law, for example. But much of the law also expresses familiar ethical principles. So in complying with the law, and in worrying about compliance, the disengaged medical student is forced to think and to worry about those ethical principles, regardless of her attitude (indifference, resentment) to those principles. This might strike some readers as a low bar; but I think it is more than can be hoped for from traditional approaches to ethics teaching.

I have stressed the *prudential* authority of the law for these disengaged students. But law also has *ethical* authority in so far as it articulates the familiar ethical principles. The laws against assault and murder are hardly arbitrary, after all. But the ethical authority means more than this: we should not be expecting unthinking compliance from the more engaged medical students, we should be expecting them to understand why the law is the way it is, and to understand something of the language of the law; we should even expect them to invoke ethical principles in articulating the occasional criticism of the law. There may come a time in their professional lives when they want to lobby to change hospital rules, professional guidelines, or parliamentary statutes. Spending more time on medical law – and less on direct ethical teaching – means that the medical student will be a bit more sophisticated in their thoughts about the law: not only the law governing their own behaviour, but also the laws governing their society. Again, the widespread temptation is for doctors to focus on their local problem-solving, and to withdraw from political discussions; whereas doctors are much better placed than many citizens to articulate and fight for political concerns because of their contact with a wide variety of the most vulnerable members of society.

This two-fold authority commands the attention and respect of both disengaged and engaged students in a way that ordinary case studies do not. The law's institutional framework adds a seriousness to the case studies. It also offers an 'official' language in which to articulate and recognise the harm done to victims, to describe the causal origins of that harm (i.e. what the doctor did and did not do), and to capture something of the 'spirit' in which the doctor did it (i.e. whether it was reckless, negligent, or within the scope of justified risk). The law's language has an objective currency, even among fools and knaves. How many lazy undergraduates – including philosophy undergraduates – confidently declare that ethics is "all subjective"? It's much more difficult to say that, or to say it so dismissively, about the law. Even when such lazy undergraduates are inclined to dismiss the law as no more than a system to enforce capitalist interests, such a dismissal marks the beginning of an ethical criticism.

Teaching a legal case

How would my proposal work in practice? Consider one of the main topics of medical ethics, which is also one of the main topics of medical law: patient autonomy and patient consent. Usually this is a fairly easy principle for a medical student to understand and for a doctor to practice. One *offers* the competent patient a treatment, together with an explanation of what the treatment is supposed to do, together with the possible side-effects and risks. If the patient refuses the treatment, even at the risk of death, that's the end of the matter; the doctor can only offer alternative treatments, and explain the risks arising from non-treatment. The basic idea is no different from any other kind of customer service and respect, really – it doesn't actually need much normative-theoretical underpinning. And that's the problem. It's so familiar that there might not seem to be any point to talking about it. Already the disengaged students are drifting away, thinking about their upcoming anatomy test.

Now as a mantra, it's probably worth reciting the 'principle of autonomy', over and over again, just to counteract any temptation toward invidious paternalism. "Even if," the ethics teacher can say, "you actually *do* know what is in the patient's best medical interest better than she does, you simply can't use force or duplicity to override their competent refusal."

Autonomy becomes interesting as an issue when the doctor suspects that the patient is not fully autonomous – perhaps the patient is denying the seriousness of her medical condition, perhaps she is under the influence of a strong-minded relative who is recommending homeopathic remedies. One can imagine the ethics teacher writing out a case study with plenty of detail. And yes, such a case study could form the basis for a lively discussion about what the doctor should do when she has such suspicions. Perhaps the case study is even based on a real anonymised patient. But I'm still worried about the disengaged student: she might dismiss the case study as a 'mere' story, dismiss the discussion as a 'mere' discussion. The teacher presented certain details about the story, but those details could easily have been different. There is thus a lightweight contingency about the story that is in marked contrast to the heavy necessities of the science that makes up the bulk of the medical curriculum. The disengaged student may even deny that there are any *general* points to take away from the discussion, especially when there is any disagreement among the class participants about what ought to be done.

Contrast this with a discussion of a legal case, such as the 1993 English case of Re: C.[4] The patient suffered from paranoid schizophrenia, which normally entails a compromised autonomy. The patient

[4] Re C (adult: refusal of medical treatment) [1994] 1 All ER 819 (QBD). There is another advantage of using legal cases: it teaches the students the importance of good referencing. The case is mentioned on a useful

was not allowed to handle money, sign contracts etc. The patient developed gangrene in his leg. Doctors believed that without amputation, there was only a 15% chance of him living, and they explained this to the patient. The patient vehemently and persistently refused. The doctors believed that the patient did not really understand the risks he was facing, and that he was therefore not in a position to understand his best medical interests. They petitioned the courts for permission to conduct the amputation by force. The court rejected the request.

So here we have a real case with a real patient. But in addition, the description is an official description, it's not an informal description of "a case I bumped into down at the hospital last weekend." The language of the judgement is the official language, and that guides the reader in what sorts of things are legally important. For example, the court approaches the situation with the important *presumption* in favour of self-determination, founded on the presumption that the patient understands enough of the nature, purpose and effects of the proposed treatment to reject it, regardless of the risks to C's health. The burden is on the petitioning hospital to demonstrate that C did not in fact have sufficient understanding – regardless of his accepted incompetence in other contexts.

Consider the 2002 English case of Ms. B.[5] The patient was paralysed from the neck down, and dependent on a ventilator to breathe. She repeatedly asked her doctors to remove the ventilator, even though this would inevitably lead to her death. The doctors refused, partly in the belief that she was depressed, and that she would eventually learn to live with her condition. The court declared that Ms. B was fully competent, and therefore in a position to demand (not just request) the removal of life-saving treatment.

'factsheet' from the General Medical Council (GMC) called 'Key legislation and case law relating to Decision making and consent':

https://www.gmc-uk.org/-/media/documents/factsheet---key-legislation-and-case-law-relating-to-decision-making-and-consent-84176182.pdf

[5] Ms B v An NHS Hospital Trust [2002] EWHC 429 (Fam). The case is also mentioned on the above GMC factsheet. This case even has a Wikipedia page, although it is not detailed enough.

https://en.wikipedia.org/wiki/Ms_B_v_An_NHS_Hospital_Trust

The best account is the official one, available at:

https://www.bailii.org/ew/cases/EWHC/Fam/2002/429.html

There is a concern that the Bailii website might be too technical for medical students to understand correctly and to be interested in. I am therefore assuming that the ethics-through-law teacher can use an appropriate medical law textbook designed for medical students.

Importantly, I have not done justice to the detail of the case, but it is all accessible on the Bailii website. Who was Ms. B? How did she get in this position? Why exactly did she want to die? Why did the doctors refuse? What was the nature of the conversation? This is the stuff of a fascinating discussion – a discussion about the law, about medicine, about people, and ultimately about ethics. This particular case also brings in a number of secondary issues that will be relevant to the legal and ethical discussion. What is the nature of depression, and in what ways might it undermine competence? (After all, one could say that it is quite rational for Ms B to be depressed about her paraplegia.) Why can a patient request the removal of medical treatment with the certainty of death, and not request an injection of poison with the same certainty of death?

At one point in the Bailii discussion, we have Dr. C's testimony:

> [Dr. C] had studied and spent her professional life trying to do her best to improve and preserve life. She did not feel able to agree with simply switching off Ms B's ventilation. She would not be able to do it. She felt she was being asked to kill Ms B. […] They knew her well and respected and liked her. They considered her to be competent to make decisions about her medical treatment.

This statement is enough to generate further discussion. How can the doctor, on the one hand, consider the patient competent, and 'like' and 'respect' her; and on the other hand refuse her autonomous wish? Is this a matter of conscientious objection? Is it a matter of cruelty? In declaring that she had spent her professional life trying to "improve and preserve life" – does that mean: at all cost to the patient? The point here is not to take the law as *given*, but to discuss it, criticise it, explore possible contradictions, questionable assumptions, the risks of unjust consequences.

Again, a lot of these issues can certainly be discussed within the context of a normative-theoretical discussion about utilitarianism and deontology; within the context of an 'applied ethics' debate with arguments for and against; and within a 'case study' approach separate from the law. But I claim that the legal document, with the judges' names at the top, about a real person, facing real doctors, carries a pedagogical heft that will allow it to get through to the disengaged medical students, and get them to think indirectly about ethics – while also learning important things about the law, about legal processes and legal language.

Assessment

There has been plenty of discussion about the best way to assess ethics, both in and out of philosophy departments. If traditional philosophy essays are not appropriate for medical students, then perhaps a short essay, a presentation, a debate. Some teachers have had good experience with

multiple-choice questions. The big advantage of the latter is that the grading process can be automated. Without automation of some kind, then the ethics teacher will probably be alone in grading all the short essays of a cohort of 200 students. The worry is then that the short essay topics will have to be so brief and simple – in order to be manageable by a single grader – as to lose all the detail and nuance that makes ethics real rather than schematic.

How useful are multiple-choice questions in ethics? If one were testing the students' understanding of a historical account, we might ask something like: "Which of the following pleasures would Mill consider to be 'higher'?" The problem here is that we are asking what *Mill* thinks, rather than asking what the *student* thinks. Second, we might ask "What might be a good reason for overriding autonomy?" and then provide a list of possible reasons. But it would be hard to formulate the possible answers with enough precision to allow only one unambiguous correct answer, without making the whole thing trivial. The most correct answer would be "it depends…"! Third, we might follow the Society of Professional Journalists (SPJ) and ask the following:

> SPJ's Code of Ethics includes all but which one of the following?
>
> > a. Seek truth and report it.
> >
> > b. Be honest, fair, and courageous in gathering, reporting, and interpreting information.
> >
> > c. Never distort the content of news, photos, or video.
> >
> > d. Bounce ideas off sources or potential sources before launching into a story.
> >
> > e. Support the open exchange of views.[6]

But all the correct answers to that question use ethical concepts whose meaning *already* invokes something that should be sought, not just by a journalist, but by everyone. Who would *deny* that truth should be sought? The virtues of honesty, fairness and courage are supposed to be attractive by definition, surely? When it comes to distortion, the more interesting question is not whether it should "never" be done, but whether it might sometimes be justified by a higher ethical or political goal; but that is a tricky and dangerous balance to strike, even without the simplistic structures of the MCQ.

Ethics MCQs will have their defenders, and I cannot persuade them with the modest (and perhaps unfair) selection above. But my point is this. The law is much more suitable for MCQs. We can ask

[6] https://global.oup.com/us/companion.websites/9780199342303/stud/ch10/test/mcq/

about the content of certain legislation. We can ask about official definitions of key concepts (like consent). We can ask about the precise locus of the illegality in a particular case. We can ask for the reasons supporting a particular judgement. In parallel to the complex question of when distortion might be justified, we could focus on the complex question of when breaking medical confidentiality might be justified, and to do so we could refer to the details of the 2017 English case of ABC v St George's Healthcare NHS Trust, concerning the right of a close relative to know about a patient's genetic condition. "Which of the following reasons did the court use to support its judgement?"[7]

Using the law to write MCQs for efficient assessment will force the students to study and understand the particularities of the cases and of the background legal principles, and this will lead to a greater appreciation not only of medical law – which they will have to learn about anyway – but also of ethics. MCQs can be formative as well as summative, and used at any stage in the course. The law is infused with ethical concepts, principles, and reasoning. But unlike the discussion of Mill, above, or the abstract discussion of relevant reasons for overriding autonomy, or the trivial test of the SPJ Code of Ethics, Law-based MCQs have the authority of the law to back them up. The underlying message is that the content is important, even if only for prudential reasons among the disengaged students.

In addition, the law has a clear 'hinterland' – by which I mean: a legally-ignorant student can sample the law through the law teaching and the preparation for the law MCQ, and she will have a clear sense of the vast legal world behind the small sample, a legal world with institutions and procedures and language, as well as with genuine experts and meaningful disagreements. She may not be interested in further investigation into that legal world, but she knows it's there. This will add to the respect (however grudging) in which she will hold the law, even after she completes the compulsory medical law course. In contrast, since ethics is not 'anchored' by the same kind of formal and institutional hinterland, or anchored in clearly identifiable experts, it is easier for a student to complete the ethics course and feel that she has "done ethics," and need not worry about it further as she gets back to the proper medical subjects of anatomy and physiology.

Another advantage of the detailed particularity of the legal case is the element of *human tragedy*. Unlike the generic ethics examples, these are real cases about real people. Many of the legal cases will have been accompanied by easily searchable newspaper articles with images of the main protagonists. This is tremendously important for medical students to understand the perspective of

[7] ABC v St George's Healthcare NHS Trust and Others [2017] EWCA Civ 336. See also the discussion at the UK Human Rights Blog: https://ukhumanrightsblog.com/2017/05/17/will-genetically-informed-medicine-upend-medical-confidentiality/

the patient and her family, and how it might differ from the doctor's – or the ethics teacher's – perspectives. These are real cases about real people who have suffered. Such stories of real people are the best antidote to the lazy student's conclusion that "ethics is just a matter of opinion".

Here is one final point in favour of using the law. I spoke earlier of the normative-theoretical approach, and the fact that many medical ethics textbooks use it. But not only are the words 'utilitarianism' and 'deontology' not used in ordinary life, by ordinary people trying to solve ordinary ethical dilemmas; they are not normally used by lawyers either. While the law has its own jargon, of course, it tends to use ordinary ethical concepts (such as 'consent') to make sense of a legally and ethically problematic situation. This is revealing: it points at one of the central features of the legal system, that it has to be relatively accessible to the general public if it is to command their democratic respect as something more than a system of arbitrary rules and threats. And in the end this is what we want from our future doctors as well: for them to be able to articulate and defend their ethical views and decisions in their 'own' language, rather than to hide behind philosophical jargon. Jargon is useful shorthand for philosophers in the philosophical seminar room, but it confuses more than clarifies when used by non-philosophers in ordinary situations or in the medical contexts.

Conclusion

An objection might run as follows: my approach seems to run the risk of *reducing* ethics to the law, thereby leaving out all the ways that we can have ethical disagreements and dilemmas within the limits of the law. Famously, adultery is unethical but not illegal – so how are we supposed to talk about it? This is a valid concern. A similar objection to my approach would be that it risks *conflating* law and ethics, diverting the medical student and later doctor toward a concern with appearances, with rule-worship, with legalisms, with defensive medicine *rather than* with ethics.

The important thing is to show that the law is not the *end* of the ethical discussion but the *beginning*. The law is designed to 'hook' the students into a socially legitimate, quasi-ethical way of thinking and discussing; once they are hooked, then they can 'break away' from the legal constructs by asking, for example, whether a particular statute or case judgement is intuitively fair, and why. Once they are engaged in questions of fairness, they are into the realm of ethics – and they can be *told* that they are in the realm of ethics. They might argue, for example, that a particular law might benefit one group of citizens while severely disadvantaging another, and thereby make a utilitarian argument against the law. Similarly, if two options are equally permissible legally, the student can be invited to argue whether one option is more *cruel* than the other, and why, and therefore ethically

worse. This claim could be supported with further empirical data. This opens up all sorts of possibilities for the ethics teacher.