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Case method

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Author's abstract

Teaching medical ethics by the case method may be enriched by adding to the principles-and-rules approach to practical reasoning modes of inquiry and interpretation that engage the moral imagination.

Cases are occasions for teaching. They are well suited to provoke discussion, to highlight issues and stimulate awareness of problems, and to simulate real clinical encounters. They are not the be-all and end-all of the teaching of medical ethics. Teachers are well advised to use them discriminatingly.

'It is the case,' we say, referring to a state of affairs, to factual matters. A case in law is a statement of the facts of a matter under consideration or in dispute, as in Hamlet: 'Why might not that be the skull of a lawyer? Where are his Quiddits now? His Quillets? His cases?' In 'making a case' we attempt to persuade by laying out the grounds, the evidence on which we rest a claim. In 'putting a case' or 'setting a case' we propound a hypothetical instance, or we suppose for purposes of illustration. A case in medicine is not merely an instance of disease or other condition requiring medical treatment but an account of illness in a person.

The reasons for using cases in medical ethics teaching are fundamentally two: to convey to students an appreciation of the drama of interactions between patients and practitioners, and to coax students to do a thing (make a judgement, a decision, take a stand) and to reflect in an orderly fashion on how they did it and why. Ways of arriving at these ends are various, the purpose itself unvarying.

In the introduction to perhaps the most widely used collection of case studies in medical ethics, Robert Veatch writes of the tension between the general and the particular, the abstract and the concrete, characteristic of such case studies. 'It is real-life, flesh-and-blood cases which raise the fundamental [ethical] questions. But a general framework is also needed from which to resolve the dilemmas of life' (1). The method preferred by many bioethics scholars (2) is a deductive method according to which general moral principles generate rules of action which, in turn, define practices. The idea is to illuminate problematic cases by the application of principles and rules. But circumstances alter cases, a fact not readily accommodated by this method. Whereas circumstances are richly variable, principles and rules draw their strength from their capacity for universal application.

Cases are useful in teaching precisely because of their particularity. To smooth out the unevenness and sheer off the rough edges of a case history is to defeat the purpose of teaching by the case method. As one literary historian has remarked 'Every time a patient enters a practitioner's office a literary experience is about to occur: replete with characters, setting, time, place, language, and a scenario that can end in a number of predictable ways. Literature enriches this sense of this daily drama' (3). To begin with experience that invites moral discernment is the inductive approach most compatible with the case method.

In order to analyse a situation adequately, one must first be engaged by it. To communicate the quality and texture of experience, narrative is needed, not a freeze-frame vignette. Narratives are evocative. They lay claim to the reader's imagination before inviting rational mastery. This is not to say that they cannot be analysed, but only that analysis must be preceded and sustained by appreciation.

My remarks thus far fall roughly within the context of the tradition of casuistry, that mode of practical moral reasoning by which specific rules derived from broad principles are applied to concrete situations. Casuistry, even in a descriptive (non-pejorative) sense of the term implying discerning judgement, does not however hold a monopoly on the case approach (4).

There is another tradition, not as old as that of casuistry but no less pertinent to medicine's use of case history, in which cases figured prominently. I refer to the literary-theological tradition of spiritual autobiography associated in particular with English puritanism and characterised by sustained reflection on what were in the seventeenth century quaintly called soul experiences or heart occurrences – those experiences in the moral and spiritual life of individuals which invited scrutiny and interpretation. It may be possible to learn from that legacy how to construct teachable cases that engage the moral

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imagination as well as instruct the critical intellect.

In his discussion of the journal of an eighteenth century American Quaker, Daniel B Shea Jr points out that 'For [John] Woolman . . . the autobiographical act was indivisibly a kind of sight and a moral challenge'. Woolman 'describes his experience so that argumentation as such had limited uses . . . . What Woolman wanted, even more than notional agreement with his arguments, was the reader's attainment of an equal clarity of vision' (5). Insight was what was wanted, and recounted experience as argument was the means to that end.

The authors of these spiritual autobiographies referred to their works as case studies. They implicitly understood, as teachers of medical ethics who choose to avail themselves of the case method need explicitly to understand, the importance of maintaining a movement from experience to ideas and back to experience. Such a movement made the author of an autobiographical spiritual case study a more discerning judge of his own spiritual status. In the contemporary ethics classroom, it not only sharpens students' skill in resolving lived conflicts, but also cultivates forms of consciousness, a point of view, and habits of interpretation. As one student of spiritual autobiography has noted 'Both life and literature are made up of similitudes, so that things seen and things read equally invite interpretation' (6). Ethics teaching conditions students by its character as well as by its content. It therefore behooves teachers of ethics to demonstrate reflective-constructive modes of interpretation which aim at arriving at answers to questions of meaning, as well as analytical-critical modes which aim to convey the formal characteristics of sound argumentation.

The movement to which I refer is a dialectical one. If we begin with ideas of, say, love or fear, we should ask our students what kinds of experience these ideas represent. Here is where cases come in. A case that embodies such experience may be lean and trim and to the point. In constructing such a case, sub-plots and digressions are to be discouraged. Economy of construction is to be prized, but short-cuts are impermissible. The story related by the case – the case history – must persistently convey the particularity of lived experience (7). Teachers should then put the lived experience to the ideas to show students that in the absence of concepts and words, love and fear are often inarticulate and may not assume recognisable human form. But it is also essential to test the ideas against the experience that the ideas purport to make sense of, at times to be corroborated, at times discredited. This is moral inquiry of a wide-ranging kind. Without it, the experience captured in the cases is not morally alive and the case method is mere mechanics.

There are many pitfalls on the road to good ethics teaching by the case method. Two merit mention. Students, and especially physician-teachers, may become enamoured of the clinical details of a case. The details are often intrinsically interesting and certainly one is obliged in using case material to attend carefully to the evidence it contains. But to permit oneself or one's students to become captivated by some aspect of a case is to defeat the purpose of the teaching. It is also at times an acquiescence in the familiar by students hungry for clinical experience, even if only in the vicarious form of a case. An analogous temptation arises for moral philosophers and theologians teaching medical ethics and that is to put too fine a point on ideas from *their* disciplines.

It goes without saying that teaching by the case method should never be used to push a point of view. The lectern is not a pulpit and the classroom is an inappropriate forum for proselytising (8). What often goes unremarked, however, is the contrary temptation to keep all options open indefinitely, permanently to reserve judgement in the face of a need for a decision. Certainly one should resist pressures for premature resolution. The chief purpose of the enterprise, after all, is to identify the moral issues in a case and to guide students in analysing and interpreting those issues. But because cases are, by definition, concrete, situational, and often conflictive, they invite not only analysis and interpretation, but resolution as well. One of my commonest experiences in using cases in the classroom is for students to ask me what I would do. (If I have taught them well, they also ask me why.) I am persuaded that unless I wish to leave them with the impression that what transpires under my tutelage is a mere exercise and does not matter to me, I must answer their question.

This view is inhospitable to those who believe it possible to teach in a value-free manner, and it frightens those who suspect it to be a thinly veiled version of indoctrination. My view is that with a careful reading of a case as background, the students' questions occasion an opportunity for me to move beyond the hypothetical and to demonstrate how I read the case, how I weigh evidence, clarify concepts, make judgements, and finally, why I come down where I do.

Given time and a perceived need, one might then proceed to a sustained consideration of theoretical questions raised by the case analysis and the demonstration. (Timing is critical at this juncture, and curricula vary enormously.) I say one 'might' move from case analysis to moral theory. I do not think that teachers of ethics in professional schools should feel compelled to do this or think that they are selling their students short if they don't do it. These students are going to be health professionals, not professional moralists, and they may have no need for theoretical sophistication. If the end in view is a tutored attentiveness to patients' experiences, and an aptitude for acting accountably and articulating a rationale for actions taken, then the early introduction of theoretical considerations into one's teaching may obscure rather than edify. Required instead are vocabularies of morality and a knowledge of how to 'read' them and use them in an orderly way. (For this one needs

distance from a subject matter, customarily afforded by theory; but my point is that the subject matter under discussion is how to act in a morally accountable way, not how to recount the ways.)

The teacher's responsibility in all this is to see to it that the same rigorous modes of interpretation and standards of performance that obtain in the undergraduate and graduate ethics classroom prevail in the teaching of ethics in the professional setting, but also to expect more than mere rigour from students who are destined by virtue of their career choice to encounter human experience in all its untidiness. Teaching by the case method can hone analytic acumen, and that is all to the good. But for doctors-in-training such acumen is not an end-point; it is rather one means to understanding, in which responsible action is rooted (9).

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References and notes

(1) Veatch R M. *Case studies in medical ethics*. Cambridge, Massachussetts: Harvard University Press, 1977: 1.

(2) See, for example, Veatch R M. *A theory of medical ethics*. New York: Basic Books, Inc, 1981, especially chapter 13; Beauchamp T L, Childress J F. *Principles of biomedical ethics* (2nd ed). Oxford: Oxford University Press, 1983, especially chapters 1 and 2.

(3) Rousseau G S. Medicine and literature: the state of the field. *Isis* 1981; 72: 263: 414.

(4) For a learned perspective on the uses of casuistry in contemporary bioethics, see Toulmins S. 'How medicine saved the life of ethics. *Perspectives in biology and medicine* 1982; 25: 4: 736–750 and The tyranny of principles. *Hastings Center report* 1981; 11, 6: 31–39. For an interesting discussion of the evolution of the case history in modern therapeutics, see Burns C R. Richard Clark Cabot (1868–1939) and reformation in American medical ethics. *Bulletin of the history of medicine* 1977; 51: 353–368.

(5) Shea Jr D B. *Spiritual autobiography in early America*. Princeton, New Jersey: Princeton University Press, 1968: 44–45, 64. See also Kaufmann U M. *The Pilgrim's Progress and traditions in Puritan meditation*. New Haven, Connecticut: Yale University Press, 1966, especially chapter 4.

(6) Starr G A. *Defoe and spiritual autobiography*. Princeton, New Jersey: Princeton University Press, 1965: 22.

(7) In the medical arena several different sort of examples come readily to mind: Freud's case histories; many of Roger Higgs's case conferences in the *Journal of medical ethics* (see especially Cutting the thread or pulling the wool – a request for euthanasia in general practice, 1983; 9: 45–49); and Oliver Sacks's patient biographies which attempt to convey 'the real and full presence of the patients themselves'. *Awakenings*. New York: Vintage Books, 1976: 13.

(8) Kopelman L. The case method and case-method fallacy. *Notes*, newsletter of the Society for Health and Human Values 1985; XV, 1: 2–3.

(9) An earlier version of this paper was prepared for a conference on teaching ethics in the undergraduate professions at the Hastings Center. Thanks to my colleague, David Barnard, for a helpful critique of that penultimate draft.

Commentary

Roger Higgs *Case conference editor*

The study of an individual problem is central to the work of a professional in any field. Whatever the theoretical background, the rules or the science, the proof of skill is skill in action, the rationale and the reward is in the doing. It is thus in medicine. All these years of training revolve round the central activity of medical people, the encounter between a doctor and a patient. A community physician may think in terms of populations, or an immunologist in terms of antibody systems, but each makes sense of this work by reference to the need of a person to seek or prevent himself having to seek medical help. Thus what the patient presents, and the doctor perceives, the case in question, is the focus of medicine, yet it would be easy as an outsider reading most medical journals and textbooks to miss this idea completely. Whether this derives from misunderstanding, disdain, or fear of contamination, case studies within scientific medicine have become almost taboo. They are hardly mentioned in formal teaching, almost never used as the basis of research, and relegated to the status of 'anecdote'. Yet when doctors talk to each other informally, conversation is scarcely about anything else. Other health professions appear to be in similar but less extreme positions.

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It was therefore a great relief to read Ronald Carson's exposition on case method in medical ethics. In a similar way it comes as a great personal relief for some to start work in general practice, where case studies will form the basis of much education. It was what we always knew was there, but never dared to look for. Professor Carson discusses the uses of case method in teaching medical ethics. In doing so he purposely draws narrow boundaries, but I should like to explore a little beyond these, both to examine the implications in practice and in research, and to follow a short way along the direction that this thinking might take us.

The implications in practice have been touched upon, but for the aspiring professional the individual case is more than just the substrate of his or her new work. To the newcomer's surprise, there is an internal reaction as well. She likes, is repelled by, or is fascinated by certain situations, people or conditions. This greatly modifies the service she gives, and may even, if she is not aware of it, determine the service she is capable of giving. The account of a student discussion of truth telling is an example: a student who