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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).

Ronald A Carson is Kempner Professor and Director, Institute for the Medical Humanities, University of Texas Medical Branch at Galveston.

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 the 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.

Key words

Case method; ethics; teaching.

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

felt there was no need for open communication realised she was prevented from speaking truthfully by the experience of having been woundingly deceived as a child (1). A new general practice trainee, unnerved after narrowly avoiding assault, talked of her previous reactions to caring for a sexually assaulted child when she was a paediatric house officer (2). The new professional can only learn about herself when she is allowed to reflect on such cases, and how they have affected and been affected by her. There is almost no time provided or allowed in most medical training programmes for this activity: the consequences to generations of doctor-patient relationships from such a dearth of reflection is only gradually being realised.

In teaching and in our own professional lives, therefore, the challenge of an individual case, particularly one that strikes 'home' by jarring us in some way, is the beginning of a necessary reflective process. Many who take a particular generalised view of an issue may be challenged when looking at an individual case, by important concepts which had not originally been taken into account. This may lead to other views about the case, which should have been taken seriously but may not have been, or which may reveal that the professional's professed ideas and attitudes are not reflected in his or her own practice. This is a method of self-audit which should be part of every health worker's routine.

If these concepts are too psychodynamic for some, firmer ground is reached when we consider the methods of work of our partners in medical ethics, the lawyers and the philosophers. The former use cases to create law, to expand and refine understanding by concrete example, proving (ie testing) the rule. In a similar, but to outsiders apparently less practical, style philosophers test an idea to destruction by using cases which stretch generalisations to fit particulars until they burst. Neither discipline claims to be a science, yet Karl Popper would enjoy some of the attempts to disprove hypotheses that these methods imply. It is too often forgotten that most medical sciences started, like Platonic dialogues, from individual situations, and that the ideas behind most major advances are derived from the shock of an individual case; whether animate like Jenner's milkmaid or inanimate like Snow's pump handle. Research in medical ethics, as in many of the areas in medicine where behaviour is still requiring much study, should take note that progress may be initiated by finding and studying important cases, rather than rushing headlong down the Gadarene hill into a morass of figures like someone infected with the deadly Questionnaires Disease. Finding out how most Danish general practitioners think best to act will not necessarily be of more than passing interest, unless we are able both to test these ideas in reality (how they really do act), and to define where principles clash or the true focus of an argument lies, or what attitudes and concepts are behind the descriptions of an individual's aims and motives.

This brings the discussion back to teaching. Case studies are useful surrogates for life experiences, as Professor Carson implies, and provide such experiences both for those who have never had them and for those who have forgotten that they ever had them; but they also present the learner with the shock of divergent views, deliberately taking him away from consensus into areas of cognitive or emotional dissonance. This is uncomfortable, and very difficult for professionals whose very *raison d'être* is that a set of standardised approaches may be used to reduce chaos for themselves and their clients and to create order and control.

Most stick with the standardised approach by forgetting not only that individual views may be awkwardly different, but that even other professionals may not share the same perspective. One of the best moments on medical ethics courses is when nurses suddenly point out to doctors that there is more to team decision-making than falling in behind the medical lead! But this process of professional work blunts our appreciation of the many facets of individual experience, and makes a two-dimensional image out of what is a three- or four-dimensional event. Case work should constantly remind us of the disturbing extra dimensions, the complexity of a real-life dilemma. Without an attempt at realising this for ourselves, we can only make unethical decisions, however well versed we are in reasoned argument.

There is more to this than the careful balance of emotion and logic. A case is always seen from a particular, albeit possibly changing, viewpoint, but we also have to face the paradox implied by ideas like empathy in health care, and examine the impossibility of caring fully for someone both in the professional and the personal sense at the same time (3). How can a person be paid to care? This and similar difficult concepts, where something both is and is not itself at the same time and which Western philosophy teaches us to shun, are actually at the centre of the professional work of nurse, social worker, or doctor. I believe that only the constant attempt to gain some understanding of these ideas by regularly examining the interactions of ourselves and others with those we seek to serve can maintain true ethical behaviour, inform real ethical teaching and create proper ethical research.

As well as being the journal's Case conference editor Roger Higgs is a General Practitioner and Director of General Practice Studies at King's College School of Medicine and Dentistry, London

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