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Editorial

Case studies and medical education

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In this issue of the journal Christopher Coope presents three sorts of worries about the use of case studies in medical ethics teaching. The first is that heavy reliance on case studies 'tends to exaggerate the degree to which morality is controversial'; the second is that 'it is often quite unclear what problems count as moral problems'; the third is that there are 'limits as to what we may regard as open to discussion' – both because some questions '*do* not arise' (a similar point was more briefly made by Minerva of the *British Medical Journal* (1)); and because some questions '*ought* not to arise'.

Each of these worries deserves careful reflection, especially by those of us who are heavy users of case studies in teaching medical ethics to health care students and professionals. Use of controversial cases undoubtedly needs to be supplemented by analysis of uncontroversial cases, and the use of cases needs to be supplemented by some degree of theoretical analysis – a sort of to and fro process between cases and theory that seeks 'reflective equilibrium' or 'coherence' (2). And undoubtedly too there is a substantive philosophical issue about 'what problems count as moral problems', though it is unclear why this is supposed to be a particular problem in relation to teaching by case studies as distinct from any other sort of ethics teaching. Suffice it to assert that for everyday ethics teaching a straightforward response is provided by Professor Raphael's account of ethics as 'philosophical inquiry about norms or values, about ideas of right and wrong, good and bad, what should and what should not be done' (with philosophical inquiry being 'the critical evaluation of assumptions and argument', including the clarification of relevant concepts) (3). Students and practitioners who argue that these accounts are inadequate should be encouraged to pursue further philosophical studies!

The third of Mr Coope's worries is that some sorts of cases should not be discussed, either because the moral problem depicted simply does not arise or because the moral problem depicted ought not to arise. Medical students and doctors tend to agree entirely that there is no point in discussing issues that do not in practice arise. But while it is therefore wise not to overdo discussion of such cases it would also be foolish to rule them out altogether, for two reasons. First it is clearly worth anticipating cases that *might* arise, so that we can work out what our moral response to them should be – obvious examples suggest themselves in the context of the new genetics. Secondly, the use of imaginary cases and hypothetical variants of real cases allows us to perform moral thought-experiments – what ought our moral response to be *if* this or that happened. To suggest that such cases, are not 'open to discussion' seems to manifest an excessive concern that may itself be morally problematic in seeking to restrict the scope of moral reflection about different types of cases.

The second group of cases that Mr Coope regards as 'not open to discussion' are those that describe or assume moral (or immoral) stances that should not be contemplated. Again the short way with this claim is simply to agree with it on pragmatic grounds – medical students and doctors would find it not only disgusting but also utterly irrelevant to discuss, as in Mr Coope's example, moral distinctions (if any) between different ways of murdering mentally ill patients for Nazi research purposes. But the idea that such imaginary case studies should not be 'open to discussion', and the correlative implied advice that if such questions were raised in an exam paper 'we would I assume tear up the paper and walk out' seems to conflate two quite separate moral enterprises.

The first is moral analysis. Mr Coope acknowledges that moral analysis and explanation of why the presupposition of his Nazi exam question is wrong – ie, why it is morally, and should be legally, forbidden to kill mentally ill patients for the purposes of experimentation – is of great moral importance.

The second moral enterprise is development of appropriate attitudes and behaviour in response to the outcome of moral analysis; development of moral character both in ourselves, and, when we are educators, in those whom we are responsible for educating. Mr Coope proposes that the appropriate attitude if confronting his imaginary examination question should be to tear it up in contempt, on the

grounds that certain possibilities or 'temptations' are not to be weighed and considered. But we cannot decide whether or not he is right in this claim without prior moral analysis and justification. And would not such analysis and study be stimulated by 'contemplation' and discussion of the case? More generally, without such analysis how can we decide which sorts of ethics examination questions (and other moral questions) can be properly torn up or otherwise ignored and which sorts ought to be 'contemplated', even answered, regardless of our disapproval?

For example, suppose a medical ethics examination in contemporary Britain set the question: 'There is some empirical evidence that fetuses after the first trimester can feel pain. Should abortion methods after the first trimester be modified so as to ensure fetal anaesthesia? Discuss in the context of counterarguments to your own position'. There may be many students who find abortion to be morally repugnant. Ought they to be encouraged to tear up the examination question, or to answer it? Some would argue, against Mr Coope, that the morally appropriate response would be for the student to answer the question, making it clear that he or she disapproves of the practice of abortion – the premise on which the question is based – and indicating why. The student could then either argue why one or other option was morally preferable, given the premise that an abortion was to be done, or alternatively argue why it was morally preferable to defend neither option (for example, because such support might be construed either as implicit collaboration with an evil practice or as a lack of concern for the pain that fetuses might be undergoing). Perhaps the student might add arguments against setting ethics examination questions that presuppose evil practices, or practices that many would regard as evil.

Why might such a response be preferable to tearing up the question and walking out? Because one of the main purposes of medical ethics education is development of the skills of moral reflection and argument in the light of moral positions opposed to the student's own. Such a claim depends on several underlying assumptions. First, that such reflection and argument will lead to better moral outcomes in health care practice. Second, that being able to explain why one has a strong moral revulsion for a particular practice and why one responds in the way one does to that practice is morally preferable to simply having such a moral revulsion and acting on it. Third, that such moral reflection, argument and explanation is more likely to lead to moral development both in the student and in the student's interlocutors (who include the medical ethics teachers), than is mere assertion of moral revulsion and a refusal to discuss cases of which one disapproves.

If such assumptions about medical ethics education are accepted, then similar counterclaims apply to some of Mr Coope's other confidently delivered moral prescriptions about what doctors and students should not discuss by way of case studies. Thus he asserts that 'doctors who are in charge of the weak and vulnerable have a special duty not to so much as dream of harming them, even in the interests of "good causes".' Doesn't it depend on what we mean by harm and how much harm? For example, medical treatments often involve some degree of harm – but we can properly contemplate this in the pursuit of net benefit for the patient. Even if the benefit is for others and not the patient, a very small risk of major harm or a larger probability of minor harm is widely justified in the context of non-therapeutic research, given some stringent safeguards. If we took Mr Coope's commands literally, not only would this be forbidden, but we should not even discuss cases in which it seems justified.

Then Mr Coope tells us: 'Nor, where trust is so important and yet so fragile, should they [doctors] become involved in earnest discussions about whether a lie might not be for the best in a certain situation – a situation devised especially to make a lie a tempting option'. In several parts of the world lying to patients about their fatal prognoses is still widely considered by doctors and their societies to be the morally right thing to do in many cases. Can Mr Coope really be proposing that their reasons, their justifications, should not even be considered in the context of their real case studies?

Of course, there may, rarely, be circumstances in which case studies incorporating morally offensive propositions should not be considered. Societies may deteriorate so far as to suppress moral reasoning and debate, and their protection may require illiberal responses, even force of one sort or another.

But in societies such as our own, in which moral discourse is freely permitted and can be expected to influence political and social life, the toleration and even the promotion of moral intolerance of the sort apparently advocated by Mr Coope may be dangerous, and is more likely to encourage than prevent the development of moral fanaticism and despotism. After tearing up the abortion paper the morally courageous – and fanatical – student may feel encouraged to reach for a gun and shoot the examiner – just as in America morally courageous fanatics may shoot doctors who carry out abortions.

References

(1) Minerva. *British medical journal* 1995; 311: 1514.
(2) Beauchamp T, Childress J. *Principles of biomedical ethics* [4th ed]. New York, Oxford: Oxford University Press, 1994: 20–28.
(3) Raphael D D. *Moral philosophy* [2nd ed]. Oxford, New York: Oxford University Press, 1994: 1–10.