PAPER

# Food for thought: ethics case discussion as slow nourishment in a fast world

Roger Higgs

**Correspondence to**
Dr Roger Higgs, General Practice and Primary Care, Kings College London, London, UK;
rogerhiggs@btinternet.com

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## ABSTRACT

Case discussion offers important opportunities to do good medical ethics, but do we understand what the benefits might be? This paper looks at the 'Case Conference' series in the *JME*, its origins and methods, examines some cases in outline, and reviews issues that arise that are not usually taken into account. Cases are harder to publish now, not least because of ethical constraints. Ways past this apparently paradoxical outcome are suggested.

Good medical ethics can be practised in a variety of ways, and case discussion is one of those: but do we get the best out of these conversations? Busy clinicians will usually stop to focus on a case: it is part of the culture and is one of the ways medicine has progressed. But cases seem less commonly published now than when the *JME* started. I should like to examine case discussion in the early years of the *JME*, to see what it contributed that was different, and then think about the future. Where has case discussion got to now? Where might it go?

To make my case about cases, I need to begin near the beginning: that is, for my generation of early enthusiasts, 40 years ago.

## MEDICAL ETHICS DISCUSSION IN THE EARLY '70S

I can still hear his intake of breath behind my left shoulder as I pinned up a notice: the first medical ethics debate to be held in the doctors' mess. The neurologist's sardonic smile under half moons and curly grey hair were all of a piece. "Higgs, when I hear the word 'ethics' I reach for my golf clubs." He turned on his heel and was gone, leaving the corridor as empty as my chances of getting a reference.

Of course there were many seniors then in Britain who could see the gaping holes in medical education as well or better than us newcomers, and great leadership and encouragement was given by them to us across schools and disciplines: but as students many of us wanted to be directly involved in discussing the issues we came across, more constructively than we could round the student bar. Within the medical ethics groups then forming, opportunities were increasing.[1] Papers were circulated, and out of these arose a collection series named 'Documentation in Medical Ethics'. Though the ideas were sharp, the ethics were usually not, and so at last in 1975 a journal was founded. At a time when there was no medical ethics shelf in the university bookshop, and very little indeed on ethics at all, the *JME*'s first editor, Alastair Campbell, had already broken the ice with a book of his own.[2] We were not short of problems to examine, but how best to progress our understanding without losing touch with the special constraints of medical practice? One of the answers suggested was to establish and write up regular case discussion.

## CASES IN THE *JME*

The series was called 'Case Conference'. The focus was on situations where doctors felt they were stuck, facing moral problems of any sort: as much as possible we intended to get to the nub of why that was, where that 'stuckness' came from and how good medical care could be achieved. The net for the commentators to look at the issues was cast wide: as well as experts in the field concerned with the case, people were invited from a range of different but relevant disciplines within and beyond medicine. The debate took place either as a live discussion, recorded and transcribed, which sometimes read like a small play; or via the post, for individuals to write and exchange their comments.

The case itself was always real, either related by a colleague or occurring as part of my work in an inner city general practice. When names were needed in the original case they were of course changed, and to preserve anonymity the background too. But particulars may have a key moral importance, and so the aim was to maintain the real circumstances as much as possible.[3] Rather than erasing identifying details, the case background was merged or exchanged with another real one, so that, for instance, a supportive family with an ill sibling could be maintained in essence but not identified.

The series ran from 1975 till 1987, averaging during that time about three conferences per year, until the format was changed. The topics were largely clinical, although some looked at clinical teaching. Child and adolescent issues were often discussed, but a frequent concern was the care of patients of all ages with a terminal diagnosis: whether this represented the concerns of the time or the particular problems of new young professionals is not clear. The cases and the comments are of course all now available on the web, but of the case series, two stand out as the basis for this paper.

## TRUTH WITHHELD: 'OBSTRUCTED' DEATH?

In 1980 Mrs Jasper, a woman in late middle age, was lied to by her hospital physicians, in collusion with her husband, about the seriousness of her inoperable pleural tumour. Following an 'open and

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close' operation, she was told she would recover. She then lived on in a shadow existence in her flat for 5 months expecting, but failing, to get better; until her GP, visiting her at home, gave her a direct answer to her direct question as to whether she had cancer. The next day she called her friends in for a massive party, and the day after, she died. The husband frequently attended the same GP with chest pain, but avoided all discussion of his wife's death. We wrote up the case as 'Truth at the last—a case of obstructed death?'[4 5] Later on this became a special study by Scott Dunbar, visiting from Ohio, with comment by London colleagues.[6]

## UNHEARD VOICES: MORAL IMPLICATIONS OF HUMAN BEHAVIOUR AND EMOTIONS

There was a clear ethical issue related to telling the truth but we believed at the time we were also describing unusual but important human behaviours. The analogy with obstructed labour is unconventional, but it seemed to commentators that the deceived woman had been placed in some sort of limbo by the collusion surrounding her, compounded by the impossible constraints created for her personal physician who was trying to keep faith with both parties in the marriage. Little is still known about why terminally ill people die when they do: personal experience suggests that they have much more control over the timing than is normally assumed, and the final party was of great interest. The harms that deception may cause have been the subject of discussion rather than observation, and here we had a situation where two patients were clearly seen to come to harm.

It could be argued that examining unusual behaviours is not the business of medical ethics, and that this should be left to social sciences. Certainly this case could have been the jumping off point for such work. However, one of the strange features of modern medical teaching is that these sorts of problem situations still fall between disciplines. But 'abnormal normal' behaviour is exactly what often seems to spark an inappropriate response, particularly from busy doctors, and so certainly should be under the moral microscope. What does it all mean? What can clinicians contribute? That these questions are often not actually articulated at all is also an ethical issue.

Though medical ethics turned to philosophers for help there were other sources of enlightenment, such as novels, film, theatre and poetry; these would now include 'soaps'. 'Case Conference' actually helped to get a Granada TV soap series running.[7] The ideas would probably now be discussed academically in the context of narrative and medical humanities: but there does seem to be a gap here in medical ethics. The boundaries of scientific knowledge excite moral discussion, but the boundaries of human behaviour do so much less. Medicine is in constant flight from the subjective, and it may be hard for ethical thinking not to follow suit. One of the powers of case discussion is to shine light where light may not have been shone before, and illuminate ordinary but key issues that do not necessarily have names. These often concern ordinary human emotions, such as feeling unsafe or lost as a patient, or being overwhelmed and taken for granted as a professional.[8]

An intuitive 'eureka moment' may occur in a clinical relationship when either patient or clinician suddenly understands something they had been missing, attends to someone they had left out of the picture or sees an opportunity to make a difficult communication. Professionals in training rapidly become skilled at asking focused questions, but also seem to become good at setting up barriers to a problem they fear might *not* be relevant. Realising that there is something else here to be examined requires changing mode. A patient will need to make an intense effort to break through this professional barrier and this may create overwhelming negative emotion. This outburst takes us right to the origin of moral thought, where the river first breaks the surface. As a clinician I have come to look for an ethical problem whenever I meet unexpected strong emotion of any sort in practice, and failing to subject it to analysis in ethical debate is as senseless as leaving the Mozart out of a production of *Cosi*. A second case illustrates this.

## EARNING HIS HEROIN BUT SEEKING RELEASE

A colleague in general practice had been approached by one of his patients who was angry with the teaching hospital's care of his father-in-law. The elderly man was a retired cricketer who had severe and intractable resting pain from reduced circulation in one leg. The surgeon in charge, who was the senior surgeon in the hospital, had advised amputation. The old sportsman had refused: "I came in with two legs and I shall go out with two." The situation caused immense distress in the ward, and the old patient was under great and repeated pressure to have the operation, but stayed firm. After we conveyed the complaint the senior geriatrician became involved: the patient was given adequate opiate sedation and died peacefully on the ward.

After some negotiation a case discussion at the medical school between the family and the doctors involved was set up as a teaching situation open to all the school's students. It was agreed that if possible it would be published.[9] The senior surgeon would not participate, but his colleagues did. Verbal punches were not pulled. The geriatrician was able to put across the point that the case was that of a dying man, not a dying leg. The family were impressed with the views expressed, and although they backed their relative's cause, released from needing to defend him they began to see the reasons behind the surgeon's advice. Afterwards the family confessed it had been an immense relief to have this meeting, and a great weight had been lifted from their minds. Interestingly, the only person to have openly talked of litigation was the surgeon, who at one stage had threatened to take the old man to court to try to get permission for surgery: however, it seemed clear that had the emotions of this case not been 'lanced' in this way, some costly litigation might well have ensued.

## REFRAMING THE CASE, FROM DIAGNOSIS TO PROCESS

The skill shown by the geriatrician lay in seeing the practical and moral path forward. Many have commented on the way in which modern clinicians may be blinded by their correct therapeutic enthusiasm to noticing that their patient has actually come to the end of his life.[10] Restraining the '*furor therapeuticus*' is accepted as a responsibility for ethics in research, but much less so in clinical practice. Of course it is hard in anticipation unless all involved are empowered to ask the crucial questions. It is a double tragedy if sick individuals have to go to law to make their point, when what is needed is to open up a conversation. It was partly the generosity of all concerned with the cricketer which finally enabled this to take place, but the 'starting gun' was fired by the complaint of the relative and the action of his personal physician. Boyd[11] has talked persuasively about the move from controversy to conversation. But there are still many structural barriers to open discussion that, if anything, are higher today than when the cricketer died. Both professional and management cultures in modern medicine often militate against openness. Money and power are great inhibitors. Thus medical ethics, involved as it rightly is in getting the best *outcome* (and looking for good theory at the same time), often avoids noting that it is the

*process* that is wrong. The debate needs to be started again in a different way.

## A MIDDLE WAY

Much medical ethics writing gives the impression that there is a right answer waiting to be found. The feeling seems to be that if only the other guys would think clearly, would use my (good) methodology or theory instead of their (lousy) one, or would even try to be different sorts of people, progress would be made. The model is from the debating chamber, but the looked-for results are from the sports field: one or other side loses and limps off to lick his wounds. But the case above is an example of the possibility, even the desirability, of a different outcome. Whether it is a virtue or else *une déformation professionnelle* of a general practitioner to look for compromise, in community contexts the doctor has to continue to act as such for an individual or family after a dispute unless they chose to leave her care. Ethics in medicine has often contrasted itself with other disciplines because it cannot go on just talking; it needs a practical outcome—and fast. But an ethically alert approach realises that the claims asserted by the 'losing' side still have validity, and possibly remain very strong. Unacknowledged or not dealt with they may surface elsewhere, as litigation, alienation, illness, or loss of trust. This moral fact has to be encompassed by any ethical solution that is more than half good. Ultimately, as Auden wrote, we must love one another or die.[12]

## DIFFERENT PERSPECTIVES: HOW IS ETHICAL TALK ACHIEVED?

If conversation starts, will the parties who then meet be able to understand each other's moral language? Has medical ethics made this easier? Our *JME* case commentators applied themselves well, and were coming from a wide spectrum of society, professional and lay, yet to modern eyes there was a conspicuous lack of analysis in what was produced, however clear and sane the comments. Progress has been made in harnessing ethical theories to fit medicine since 40 years ago, and clinicians, certainly, are now better equipped for discussion. But the fact remains that none of the moral systems on offer, clarifying and illuminating as they may be, will of themselves lead to a solution. The conversation still has to happen using the different theoretical terms and positions of professional participants *and* encompassing the intuitions of ordinary people. Ultimately, as Aristotle so clearly told us, we have to make a judgement between dissimilar goods as well as between conflicting arguments. Medical ethics is to a strong degree *sui generis* and must take nourishment from wherever it can find it: and academics in the area have to follow suit.

## GOOD ETHICAL THEORISING

Comparing is how we shop, and it is how clinicians have classified disease. It is how we talk ordinary morality. In case discussion, can we get somewhere deeper than just an exchange of views? We share our intuitions, and it is not just in medico-moral debate that we find we disagree with others when we thought we knew what friends or relatives thought. It is not only new patients who may be 'moral strangers'.[13] Casuistry has got itself rather a bad name, but we cannot do without it in its simplest sense. But can we get further? Can we derive a firm theoretical structure that will 'answer the case'? Can we get guidance from thinkers beyond the boundaries of medical ethics?

Kagan examined this issue and concluded that though our moral intuitions deserve more respect than they are normally given, he found that we cannot yet extract reliable theory from our intuitions.[14] Yet something happens when we make a judgement that must be more than mere caprice. Those early moments of understanding, indeed, have recently received support from an unusual quarter. Dennet, having previously in a famous interchange with Searle dismissed his fellow philosopher's arguments as 'mere intuition pumps', has recently changed his tune, and gone into print at some length to describe how important these mechanisms are for us all (although it is hard to understand what intuition pumped intuition pumps from negative to positive status in his thinking!).[15] In clinical work intuitions have to be given respect, partly by the requirement to work at speed: impressions are checked by further tests. Is this a model we can apply to medical ethics? If case discussion offers particular insights, as I have tried to claim, can it become an even better way of doing ethics?

## GOOD MEDICAL ETHICS AND THE CURRENT PARADOX

However you define that little adjective, part of the point of *good* medical ethics is to challenge or to re-examine our presuppositions and our behaviours in the light of further understanding or reflection. Thanks to the development of our discipline, we seldom now meet responses like those of my neurologist, because moral reflection is an accepted medical behaviour and the ethical rules that cover medical work have been clarified and promulgated. One of the key preconditions of clinical work is proper consent—including the clear rule that cases normally may not be discussed other than for the patient's own care without the permission of the individuals involved.

But consent has in some senses now become a barrier to the very thing we seek to do. Most cases arise from a difficulty, often from a disagreement. Even to ask permission, let alone obtain it, for cool collaborative thought, and l*et al*one consent for publication, from warring parties may all be near to impossible. Reactions may be hard to predict. During publication of this issue of the *JME* one paper had to be altered because of concerns that we might lay ourselves open to libel. Cases are hard now to publish. We are thus in some way caught in a machine of our own devising, and seem to be the worse off because of it.

Perhaps we have foolishly allowed a good rule to become an absolute principle, as Rhodes[16] has suggested in this issue. We are stuck in a bunker, and probably my neurologist colleague would be laughing over his clubs on the next green. But we still have to hit the ball from where it has landed. The old method of anonymising may work, but it leaves complaint as a risk: novelists too are not free from the accusations of people who think that they have had their story stolen. Perhaps we should accept that moral conversations have to be just that, and are not to be written out in a journal: but that puts the clock a long way back. Published books seem to have less difficulty in dealing with cases: one with detailed and apparently true psychological accounts was on the best-seller list in Britain for months.[17] This points the way to one type of solution: Jungian analysts use the expression *vas bene clausum*—a well sealed vessel—to describe their confidential case discussion: maybe medics and ethicists just have to tighten up the professional boundaries.

I have one further suggestion that might offer a possible way through. Teaching hospitals warn new patients that students are part of the clinical scene. In a similar way potential patients could be asked to agree, formally or informally, to their cases being anonymised and used for teaching including ethical discussion as part of medicine's ongoing need to reflect and educate. I do not think the neurologist would have liked it, but since his echo left the corridor I have had a life punctuated by important conversations about medical ethics. They have been good, but good can always get a lot better.

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