TEACHING AND LEARNING ETHICS

Critique of the ''tragic case'' method in ethics education

J Liaschenko, N Y Oguz, D Brunnquell

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It is time for the noon conference. Your job is to impart a career-changing experience in ethics to a group of students and interns gathered from four different schools with varying curriculums in ethics. They have just finished 1½ h of didactic sessions and lunch. One third of them were on call last night. Your first job is to keep them awake. The authors argue that this ''tragic case'' approach to ethics education is of limited value because it limits understanding of moral problems to dilemmas; negates the moral agency of the student; encourages solutions that are merely intellectual; and suggests that ethical encounters are a matter for experts. The authors propose an alternative that focuses on three issues: the provider-patient relationship, the relationships between providers in the everyday world of health work and, the social position of healthcare providers in society. In this approach, teachers are not experts but more like guides on a journey who help students to learn that much of ethical practice comprises living through difficult situations of caring for vulnerable others and who help students to navigate some of these difficulties.

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Consider the case of a 9-month-old baby, born at 25 weeks gestational age, who developed necrotising enteral colitis resulting in short bowel syndrome requiring total parenteral nutrition. The baby now has liver failure and is judged not to be suitable for transplant because of neurological damage; the parents, however, are demanding a transplant. The parents are unmarried and have a history of domestic abuse. This should wake them up. Ask the students what they should do, then apply some principles and show them how tough their practice can be.

We call this approach to ethics education the ''tragic case'' method, and, although it is common, we assert that it is of limited value in helping students and staff to cope with the ethical challenges encountered in daily practice. Specifically, it does little to foster reflection on the kind of practitioners they are and want to be. This claim is based on two characteristics of tragic cases. First, such an approach separates the actor from the act.[1] In tragic cases, the case happens ''out there, to someone else'' and students and practitioners are asked to comment on what should be done in the future. Practitioners learn the rules of the case, ''the engineering model'' of bioethics, but do not necessarily learn judgement in situations including themselves as moral agents.[2] Secondly, such cases, for all of their drama, tend to obscure the complexities of day-to-day practice. This happens largely because orthodox bioethics is a principle-based approach that lends itself, in practice, to the neglect of judgement and an overly simplistic view of practice. Principles are not irrelevant, but are often inadequate for clinical situations experienced by and with distressed people in real time. Although this paper is not a critique of principalism, it relies on critiques that hold that the situation in question, including the moral agents, the issue, the relationships and the place, are essential aspects of the day-to-day context of clinical practice and therefore of teaching ethics.

The alternative to an exclusive focus on tragic cases is to approach ethics as an element of every relationship between providers and patients and families, as well as among providers. These relationships are contextualised by location of practice, the issues at stake, and the identity and status of the people concerned. An emphasis on contextualised relationships shows the interactions and moral dimensions of the work encountered daily by practitioners, at whatever level of training they find themselves. Numerous empirical studies show that the moral concerns encountered in practice are of the ''everyday'' variety. Studies of medical students disclose the same moral concerns as those that we are familiar with in regard to nursing.[3–7] For example, Christakis and Feudtner, at the time themselves medical interns in the throes of training, analysed cases submitted by medical students during an ethics class.[8] They identified issues such as degree of training required to carry out a procedure, obtaining informed consent, writing notes about others' examinations, pressure to be a team player and the witnessing of a problematic action by a supervising resident. They reason that an approach beginning from moral theory or grand cases does not consider the issues faced in daily practice at a critical period of training. They also advocate using cases which are realistic in the life of students as the best way to learn how to respond to the ethical challenges of practice. Similarly, this approach is central to all clinicians at every level, because it is the everyday issues, and not the great issues of public debate, on which books are written and careers made, that form the daily context of moral experience.[9–13]

See end of article for authors' affiliations

Correspondence to: J Liaschenko, Center for Bioethics, University of Minnesota, N504 Boynton Hall, 410 Church Street SE, Minneapolis, MN 55455, USA; jliasch@umn.edu

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CRITICAL APPROACHES TO BIOETHICS

During the past several years, bioethics has been criticised for its overemphasis on dramatic issues focusing on new technologies and interventions and for avoiding the everyday ethics that inhere in the places, or geographies in which we find ourselves, and that constitute the routines by which we live day to day. Three critiques are especially noteworthy in this regard and, although they share the same general point, they emphasise different aspects. Arguably, feminist philosopher Virginia Warren provided the most thorough critique of the preference of bioethics for ''crisis issues'' over the ''day to day domestic problems of life'' or what she calls ''housekeeping issues'', which constitute the overwhelming majority of health work in direct patient care.[14] Warren was blunt in her criticism of medical ethics.

We may as well admit it. Medical ethics has grown a bit stale. Hot new topics continue to arise, such as whether to withhold artificial food and fluids from patients or to harvest organs for transplant from fetuses and anencephalic newborns. But calling on the same list of basic moral principles does not produce the thrill it once did, although the issues are as relevant and heartbreaking as ever (Warren,[14] p 73).

Warren outlined four differences between these two types of moral issues. Firstly, with crisis issues, resolution is ''more or less final'' (Warren,[14] p 73), which is to say that a decision is made and life moves on after the momentary disruption of the crisis. By contrast, housekeeping issues are not resolved but are ongoing. Secondly, crisis situations command our attention and are seen as relevant, whereas housekeeping issues are seen as trivial. Yet, despite their triviality, these issues make up the fabric of our lives. Thirdly, crisis issues concern a relatively narrow range of possible actions, whereas housekeeping issues ''commonly require us to reassess large parts of our lives: our character traits, how we think about ourselves, and how we relate to others'' (Warren,[14] p 79). They influence how we see issues and how we characteristically act. Fourthly, crisis issues respond well to the application of principle-based ethics, whereas the subtle and complex psychological issues of how we think about ourselves and relate to others do not. Generally speaking, housekeeping issues are not life threatening, nor do they elicit impassioned stances on controversial matters. Rather, they reflect concerns about the kind of people we are and want to be as we move through the times and places that constitute our daily lives.

Another critic of the emphasis on crises, physician Paul Komesaroff, agrees. While laying out the structure of the content of everyday ethics in his paper, *From macroethics to microethics*, Warren emphasises the interpersonal context in which they occur. Komesaroff is equally forthright in his statement of the deficit: ''The underlying problem can be simply stated. The conventional approaches of medical ethics deviate fundamentally from the experiences of everyday medical practice.''[15] Medicine is practical; the aim is to do something, but the moral demands of the situation do not usually present themselves as dilemmas. Most of the moral issues in healthcare are housekeeping issues. They include practitioners facing practical problems about what to do and how to do them in ways that preserve integrity and honour what is meaningful in people's lives. Moreover, if ethics at the bedside is not about this, then either practice or ethics, or both, are misunderstood. Bioethics (bioethical theory) is deficient not only because it is unable to provide an account of day-to-day decision making in clinical practice but also because it limits what can be formulated as an ethical issue. For Komesaroff, ''Ethics is what happens in every interaction between every doctor and every patient''(Komesaroff,[15] p 68) (italics in original) and, therefore, medicine requires an approach that focuses on this level of practice—what he calls microethics.

Worthley also uses the term, ''microethics'', differentiating them in ways similar to those of Komesaroff. In Worthley's view, bioethics deals with the profession as a whole, whereas microethics deals with the practitioner. Macroethics focuses on the profession, concerns the extraordinary, recognises the grand scale realities, probes apparent, direct power and emphasises the clinical and technological. By contrast, microethics or everyday ethics focuses on the individual provider, concerns the common and routine, recognises humdrum situations, probes subtle, indirect power and emphasises the contextual and interpersonal.[16]

In *The morality of the mundane*, Caplan emphasises that the collective effect of these non-crises concerns is nothing less than the quality of life.[17] The relationships and routines that make up daily life reflect the material and social circumstances of our lives, affect the appraisals of our worth, in our own eyes and in the eyes of others, and influence our basic stance towards the world. This particular work is important because it points to the importance of location or place in the constitution of our everyday lives. Our location in physical and social space has implications for both the meaning of moral concepts and for those who control the definition of moral issues.

TEACHING BIOETHICS: PERSPECTIVES AND METHODS

The pedagogical question of the nature of the subject matter and the method of teaching ethics reflects the teacher's view of what constitutes the body of knowledge described as ethics. The current dominant vision has been founded on some combination of a philosophical approach and practical problem solving. The philosophical approach cited most often is some version of principles or duties, either deontological or utilitarian, although other versions such as virtue, narrative, casuistry and feminist ethics are also cited.[18 19] The practical ''case and issue'' based approach is reinforced by the traditional healthcare teaching model in which knowledge is passed on through a series of case encounters.

Early in the history of the discipline, analysis by principles, especially publications such as the *Belmont report*[20] and Beauchamp and Childress' *Principles of biomedical ethics*,[21] helped bioethics to develop as a discipline and to establish a place in the world of medicine. This was because the method of reasoning fit well with mainstream medical discourse and because the nearly exclusive focus on tragic cases seemed unquestionably important. As Warren indicated, principles tend to work well in ''crisis'' issues and these cases, like all other ''horror stories'', had a lasting effect on healthcare professionals.[22] As a result, bioethics with a focus on analysis by principles became accepted as a crucial element of professional education and practice.[23] The initial benefit of this approach, however, has diminished, and the dominance of the tragic case approach has evolved into a barrier to ethical discourse in bioethics education for healthcare professionals. Now, at its best, the tragic case approach encourages students to think solely in generalisations; at its worst, it encourages simplistic, routinised analysis and action that is decontextualised and does not help the student or practitioner to learn from experience. Contemporary mainstream bioethics education, at least in the US, reflects the evolution of bioethics during the past few decades. Although challenges to the dominance of a principle-based approach have grown, most ethics teaching starts with a simplified introduction to the theories of ethics and justification of a principle-based approach, most often the four principles of Beauchamp and Childress.[24] The courses continue with the application of this knowledge to the well-known cases or some version of them. Sometimes the sequence of the pedagogical steps changes, but the content

remains the same. Generally, the main goal of the courses is to develop competence in a kind of reasoning about ethical issues, which is seen as a method for applying to all ethical issues encountered in day-to-day practice. Competence in identifying ethical dilemmas in our own practice is also viewed as a manifestation of a successful ethics education.[25 26] Alternatives to a principle-based approach have also been articulated by orthodox bioethicists in a manner that emphasises the personal and interpersonal contexts of moral reasoning[27 28]; recent attention to the balance of distance and particularism comes closer to an adequate emphasis on the context of moral decisions.[29 30] It is feminist scholars, however, who have developed this argument most completely.[31–38]

Although the tragic case approach is not irrelevant to ethical education, it does not focus adequately on the moral agency of the practitioner, relationships with patients, their significant others and colleagues across all disciplines, or the contextual elements of the situation. This method of teaching actually undermines the development of the healthcare professional as a moral agent because it suggests privileged knowledge of ethics that can be achieved once the method of analysis is learnt. Such an approach negates the moral agency of the student as a person and makes all future ethical encounters a matter for experts. Tragic cases leave students focused on dilemmas and solutions,[39 40] as if they were the only moral problems.[41]

Although such cases do have a role in our curriculums, exclusive utilisation of them can lead to a view of the nature of ethics and ethical practice that deludes the student (and subsequent practitioner) into thinking that ethics concerns are rare and are therefore of minor concern in training. Furthermore, should they be encountered, they are resolvable once and for all.[42] Tragic cases can do several things. For some they result in a feeling of helplessness, whereas for others they lead to the idea that ethical concerns will never lead to moral distress because the right solution will always be attainable by the appropriate application of principles. In both cases, the knowledge that much of ethical practice entails living through difficult situations of caring for vulnerable others is absent.[43] In either case, tragic cases encourage students to distance themselves, as moral agents, from the situation by seeking a solution that is merely intellectual in a situation that is more fully human. Because tragic cases are generally decontextualised, they emphasise a single decision and tend to ignore the sense of emerging issues and the experiences of the multiple parties associated with them. They hide important issues from view, including the meaning of the experience to patients and, frequently, the role of family and significant others, the influence of organisations and employers, and, perhaps, most importantly, our vision of ourselves as moral agents.

The method of education that uses primarily tragic cases aims at making the healthcare student a member of the universe of professional values. As such, it is a kind of initiation process that reproduces the values of a healthcare profession, inhibiting the continuous evolution of moral growth. When education is merely initiation in the formulaic use of a technique, there is the danger of endorsing the values of the club without submitting those values to critical analysis. In addition to this, as mentioned earlier, the moral agency and knowledge of the person is negated or ignored. In failing to start from the values that the person brings with him or her to professional school, one misses the opportunity to critique those as well, thus missing an opportunity to create harmony between them.[44 45] In this model, it is appropriate to name the educator as a teacher and the one whom he or she educates as a student. The teacher teaches the values as well as the justifications and actions that protect them.

Much of this teaching focuses on the ethical dilemma, which identifies ethics as something exceptional rather than inherent in every professional interaction. Yet, it is, thankfully, atypical to encounter a classic ethical dilemma in which all available actions have competing and equally valid claims to being the right action. Such cases do exist and do deserve attention. Importantly, however, these cases fail to disclose that even while an ethical course of action is being debated and decided, the patient does not disappear and time does not stop—the patient must still be cared for.[46] If such cases are taken as the core element of ethical practice, students tend to ignore the constant flow of relationship and use of self, which form the basis of ethical practice and from which solutions to dilemmas more easily flow. Tragic cases of dilemmas, decontextualised and incomplete, contribute to an orthodox moral education by applying a set of principles that abstracts the moral agent from the situation and by seeing only the ''crisis'' aspects. Consequently, students have a wrong impression about the meaning of ethics and its relationship to themselves as moral agents. This makes ethics a subject that belongs to tragedy, which consists of a unique, almost surreal situation that rarely occurs. Tragedy always dictates a superior and controversial power against the person and leaves no room for moral agency, but asks for heroic conduct. In tragedy, the moral dilemma is an externalised one formed out of human experience and control, rather than life lived in real time and in real places. We believe that ethics education should aim at much more than this.

ETHICAL PRESUMPTIONS: CURRENT ETHICS TEACHING AND THE CHALLENGE OF EVERYDAY ETHICS

In our view, teaching ethics to professional healthcare students is a practical task that requires teachers to have particular knowledge and skills. Students need knowledge of formal coursework in ethics but, as importantly, knowledge of the importance of relationships in healthcare, including relationships between teachers and students. Of special importance is recognition and acknowledgement of the centrality of emotions in human relationships.[47]

The critiques by Warren, Komesaroff, Worthley and Caplan describe in theoretical terms how best ethics can be contextualised if teachers are to focus on the ethical challenges of practice and, therefore, what is of concern to students.[48–51] Ethics instruction in its current dominant model, with a focus on tragic cases analysed by principles, accepts the current healthcare system, its institutions, its definitions of the responsibilities of providers and its definition of the roles of patients, leaving these sociological, personal and interpersonal attributes unchallenged. For example, as Sherwin has argued, the cultural authority of medicine is visible in practitioner–patient relationships, but this is rarely challenged, and the institution of medicine is taken as a given.[52]

Our approach to ethics education begins not with grand theories or with cases of tragic dilemmas but with an attempt to understand the nuances of the provider–patient relationship and the relationships between providers in the everyday world of health work, as well as a careful understanding of our place in society as healthcare providers.[53] As such, it deals with our personal histories; our own mental image of how we must act as providers in our specialty; our understanding of the relationships among those in a given discipline, between disciplines, between professional and non-professional caregivers, and between institutions and practitioners; our knowledge of the geographies of our practice; our conceptions of the good for patients; and how we analyse and shape the relationships we have with patients. In this approach, we

start with the clinical experiences of students, asking them to describe situations of ethical concern or, in the absence of clinical experience, asking them what they envision encountering that will be of concern to them. In either case, the focus is the student as a moral agent and on the context of his or her agency. Recent reviews of medical education have indicated the importance of early clinical experience in the making of doctors.[54] This practice may be helpful to the approach to ethics education that we are advocating, because thinking about our experience is necessary to thinking about how and why we act in the world. In our view, however, it is not sufficient in and of itself. The success of the call for experience will depend greatly on the breadth and depth of the teacher's knowledge and wisdom.

This examination of the students' own moral agency within the ''taken-for granted'' aspects of their particular practice and the world of healthcare delivery is imperative to ethical practice. Therefore, students must understand the social and metaphorical space that they will occupy when their training is complete, and, indeed, do occupy as students. Although some authors refer to this as ''role'', they are not unanimous in their endorsement of the concept for a professional in ethics. None the less, each of us agrees that ''role'' refers to a social legitimisation of action and a social recognition of the cognitive authority and expert knowledge afforded those labelled professionals.

We believe that the issues arising in everyday practice are critical to the moral development of professional practitioners; yet, in mainstream ethics pedagogy, they rarely arise when moral issues are articulated primarily as dilemmas within the context of tragic cases. For each of us as a practitioner, the one constant element of the care we provide is our self and our understanding of the relationships in which we are engaged in the real time and space of daily work. In both didactic and practical settings, ethics instruction should begin with the identification of the moral concerns of students and an analysis of why they are a cause for concern. An examination of professional identity and relationships and how these are situated and interact with the organisational and institutional context provides a rich format for appreciating that the simplest and most basic interactions with a patient reflect ethical sensitivities, issues, knowledge, patterns of action and social sanctioning or disapproval.

Finally, our approach recognises that moral development is a process. Likewise, professional ethics education is also a process that superimposes on moral development and, ideally, gives it new direction. It is important to recognise that personal identity and professional identity intersect strongly[55 56] and, therefore, ethics education in a profession should take the basic moral development of the person into consideration, constructing itself on this process. For this reason, we conceptualise the relationship between the educator and the educated in ethics not as a teacher–student relationship but as a mentor–colleague relationship. In our view, the ideal would be a relationship in which the mentor serves as a guide as the student navigates the geography of daily—that is, ordinary, and not tragic—practice. During an ideal journey, moral development—that is, sensitive perception and judgement—would be deepened, critiqued or sometimes shed in the reassessment of personal morality in conjunction with professional work and a professional morality. This learning process is authentic in that the mentor has accumulated ethical understanding through experience seasoned by moral perception, attending and judgement.[57] The mentor, skilled in moral perception,[58] knows what is crucial to look for and knows how to respond to ethical challenges that are encountered. Still, the journey is an authentic one because it is, primarily, the journey of the colleague. The point is not to produce a carbon copy of the mentor but to nurture the development of moral sensitivity, judgement and capacity for action in his or her companion, which will sustain moral agency and ethical practice. Mentors have neither all of the answers nor even all of the questions, because the mentors themselves are changed by every journey, continuously refining their own moral development. What mentors do have is the experience to help their colleagues in seeing the issues, in evaluating their reactions to them and in identifying their values.[59] The ethical concerns they face on the journey are the issues raised by the colleague and belong to his or her daily life.[60] But mentors do not allow problems that can help the moral development of their colleague to pass unnoticed; they point them out or clarify them.[61] The everyday routines of healthcare professionals are full of ethical issues, enough to support their moral development; there is no need for tragic stories from the edge of life. Our approach asks for more work from the mentor, who must be able and willing to do the emotional work that this level of engagement requires. Although the way that we articulated this approach seems to require a one-to-one relationship, it can just as well be established between a mentor and a group or a class. This can be even more productive as colleagues engage with each other.

CONCLUSION

Although the current attention to difficult and tragic cases is one element of teaching ethics, the overemphasis on this approach is inadequate for developing the moral agency of the student. By abstracting the student from the situation, the tragic case approach can lead to untoward side effects, including the illusion that students will be moral experts, which, in turn, reinforces the arrogance of the cognitive authority of medicine. The approach reinforces power relationships, including the teacher–student relationships in the field of ethics and the provider–patient relationships in practice.[62 63] Ethics education, as proposed here, is aimed at nurturing the capacity of students for moral sensitivity, perception, judgement and action, and not merely a system of reasoning, whose primary aim is justification of action.

This model is accomplished primarily through discussion focusing on the experience of the student and through time set aside to look specifically at relationships and institutional and social contexts in an otherwise unremarkable case. An educational approach founded on everyday ethics, as we propose, makes for ethics consultants rather than ethics experts and mentor–colleague relationships rather than teacher–student relationships. It also emphasises the need to reflect continuously and to challenge, as necessary, the values of the healthcare professions as a way of promoting change instead of the mere reproduction of values and practices. This approach also claims that ethical behaviour is not only an issue when dramatic dilemmas are at stake but also relevant in the everyday routines of work and life.

As with any approach, there are inherent difficulties for both students and teachers in this method. For one, an approach based on analysis of everyday interactions introduces a high degree of uncertainty into daily moral practice. Uncertainty is especially difficult for physicians.[64] If the abstraction of tragic cases is not allowed, the practitioner must regularly confront issues of power, privilege and influence that challenge the basic presumption of the virtue of our chosen profession. The very practice of abstraction shields the person from many features of social life that are relevant to our moral lives.[65] It can be especially difficult for teachers to give up the dominance of their own value claims and to accept the mentorship; to open their universe of values to challenge; and to renounce the power and privilege that their role has traditionally provided.[66] But when this does

occur, it is a form of testimony in which the teacher recalls and the student learns that they are not the experts, the final arbiters of moral knowledge, but that they are members of a moral community. In the proposed journey, the student renounces the unlimited irresponsibility of being a student, and becomes liable as a real moral agent. It is quite a different form of learning, different from the secure and comfortable learning that the position of observer provides. This way of learning can be considered a painful experience of life performance.[67]

This form of learning is especially harsh for those who have internalised the idea of being an organic tool and who do not wish to see themselves as the decision makers in healthcare systems and, in fact, use the moral advantages of this status.[68] For practitioners, teachers, students and patients alike, the primary difficulty lies in the transformation from the approach that praises finding the right or good conduct to the approach that praises creating the right or good conduct. This is a question of creativity. The most important task of mentors who participate in an ethics education process is to activate the moral creativity that exists in their colleagues. This goal cannot be achieved solely by the use of tragedies as the standard, especially when the student has not been engaged in the tragic situation, but the goal can be approached by starting from where the colleagues are, from the geography of their daily life and the knowledge at their disposal.[69]

It is also essential to recognise the time and emotional energy required to adopt an approach that does not make presumptions of the moral authority of the professional. It demands an encounter between the practitioner and patient and between practitioners themselves, in which the presumptions and expectations of each person are made explicit and negotiated, and re-negotiated as the people and their relationships change.[70]

We recognise that there are several ways of teaching bioethics, and some of them may have much in common with the method we suggest; empirical data on the differences and commonalities between teaching methods are still missing. We believe that bioethics education of the future must take the moral agency of the student as its starting point and the overall moral development of the person as its goal. In this sense, it is an individualised education, but one that is anchored in the real time and geography of everyday practice.

Authors' affiliations

J Liaschenko, Center for Bioethics and School of Nursing, University of Minnesota, Minnesota, USA
N Y Oguz, Ankara University Faculty of Medicine, Ankara, Turkey
D Brunnquell, Children's Hospitals and Clinics, Minneapolis and Saint Paul

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