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HOW ETHICAL IT IS TO TEACH BIOETHICS FROM CLINICAL CASES?

¿QUÉ TAN ÉTICO ES ENSEÑAR BIOÉTICA A PARTIR DE CASOS CLÍNICOS?

É ÉTICO ENSINAR BIOÉTICA A PARTIR DE CASOS CLÍNICOS?

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One of the challenges of teaching of bioethics is to combine theory and practice. It would seem less complicated to do so with bioethics, given the large extent to which its contents are oriented towards practice (1). There are even authors who question the very possibility of teaching bioethics, arguing that the fundamentals of ethics are imparted at home and their presence in university curricula is unwarranted.

Seemingly, the mission of medicine itself is already set, and it is hard to find differing points of view on the objectives that are so peacefully accepted. Perhaps the problem is one of misconception, since those objectives now are perceived largely from a technical perspective in which knowledge and know-how take precedent and where investigative skills and those that lead to the best possible management of the generally scarce resources allocated to health are what matter the most.

A few years ago, the Hastings Center led a multicenter study in fourteen countries on "The Goals of Medicine: Setting New Priorities" (2). The concern of contemporary medicine was evident in three main areas in countries with different cultures and with different health systems as well; namely, the appropriate objectives of medical research, the provision of health care and medical education.

The area perceived as a priority was precisely medical education. Yet, surprisingly, it also was the area where most of the study participants considered themselves to be satisfied. The predominant general model for many years has been to "diagnose and treat". In other words, application of the scientific method in a system of causality and relatedness leads to a technological response. When the origin of a disease or condition is discovered, medication is developed to treat it.

However, there are obvious limitations with this model of education. The physician-patient relationship does not lend itself to any sort of reductionism that assumes the patient is merely a broken mechanism capable of being repaired through technoscience or marginalizes complex pathologies, especially those of the chronically ill or disabled, neglects prevention and health promotion, and undervalues the medical humanities.

This explains the initiative to place medical students in contact with patients as early or prematurely as possible.

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The idea is to eliminate, from the beginning, the barrier that prevents a relationship between the health agent and the patient that is based more on human contact, with psychological and experiential components, than on the context of a blueprint or predetermined model (3).

It is not good practice when patients are diagnosed and medicated properly, but complain about not being treated as persons (4). The clamor of those who receive health services - wrongly labeled as users or customers - suggests the providers of those services are missing certain skills, ones that are stunted or only part of the "decoration" with which these professionals show themselves in their daily activity.

Usually, there is an attempt to dispel this concern by organizing courses on "humanization," so as to encourage a sense of solidarity or motivate health professionals to practice their profession in a way that is closer to people and to safeguard it from negative interference. However, the results of these initiatives are temporary in nature. Changes, if any, are only fleeting and, sooner or later, the problems reoccur and the complaints again reach levels that spark renewed concern, given the nearly endemic spread of dehumanization (5).

There are very few initiatives that are operating worldwide to improve medical education (6); that is, to ensure the curricula – in addition to purely professional content - include other kinds of knowledge and foster other skills, so as to respond fully to the concerns of patients and health service providers. These other kinds of content can mesh or tie in with what is referred to generically as the "medical humanities" (7).

The question of where to position the medical humanities within the curriculum is also a subject of debate. Should it be at the start of medical studies, when students begin to have contact with medical practice, or at the end, when they have acquired a reasonable amount of practice? Others argue the medical humanities should be present throughout the curriculum, with all subjects being taught having anthropological, ethical and bioethical contents. However, this requires a preliminary step: teachers must be prepared to impart these same contents and must have the basic and clinical materials to do so, which will have to be developed. In other words, as part of continuing medical education, teachers must receive these contents beforehand and the methodologies to teach them in a preeminent, confident and competent way.

In the job of teaching, we have seen that one tool for teaching the medical humanities, among others, is the use of clinical cases (8). Work done previously by Jonsen and Toulmin serves as the basis for applying theory to practice (9). But the opposite approach is also feasible: reflections drawn from real or fictitious situations or events can be used to construct and consolidate a theoretical basis (10). Since one of the resources for teaching bioethics is the use of clinical cases, it is appropriate to question their applicability from an ethical perspective.

Despite an abundance of literature on the subject, this particular aspect of the matter has not been addressed sufficiently. In short, how ethical is it to teach bioethics on the basis of clinical cases? To answer this question and to apply, in practice, the notion put forth by Italian Professor Paul Requena, *Person and Bioethics* offers this edition featuring academics from seven universities in America and Europe who examine the subject of clinical case evaluation from an ethical perspective.

A variety of concerns may arise when using clinical cases to teach bioethics. For example, can we be certain that confidentiality was respected when the case was written up? Is it possible for the identity of the participants to be revealed on the basis of the information that is provided? Can all situations be resolved the same way a problem is solved by using a clinical case? In other words, can such solutions be generalized? Is it a valid strategy to draft clinical cases that do not correspond to reality and become mere fiction? Can clinical cases be used in bioethical committees? Is the use of cases restricted to certain areas of medicine, or may they be used in all areas? Who is the ideal person to teach on the basis of clinical cases: someone who knows the theory or a person who is involved in clinical practice?

These and other questions may arise and we hope to have provided the answers to some of them in the following pages. For now, here are some thoughts to serve as a guide.

A lack of a global reflection, at least from a methodological standpoint in terms of an ethical review of clinical cases, has been one of the structural weaknesses of bioethics in recent years. This is despite the efforts undertaken at the international level through documents such as "Good Clinical and Laboratory Practices" and the various codes of conduct.

In the last few decades, bioethical reflection on clinical activity had to compete with unforeseen and unpredictable cultural challenges that emerged from the encounter-confrontation between increasingly sophisticated and advanced technology, biology that is capable of providing new clues for interpreting biological phenomena never before considered within the bounds of natural law, and clinical ethics that also is forced to deal with the principle of self-determination by the patient, which is constantly hypertrophied when it comes to opposing new rights and new requirements in the patient's dialogue with the physician. This gave rise to a revolution that was mounted on the complicated frontiers of culture. Making use of the necessary reference to a multi-cultural and multi-professional approach, a Babel of languages of such intensity has been created that it is difficult to handle them in the specifics of the individual cases to be examined. Clinical bioethics suffers from disorientation, largely because it is at the crossroads between multidisciplinary theoretical reflection, which constantly comes up against the patient's subjectivity, and the structural link of informed consent, which is a prerequisite for any medical activity and is guaranteed in rules and regulations.

Proceduralism in the United States represented an exemplary effort to return methodological unity to the variety of abilities that are called on to intervene in the development of a nuclear decision on what to do, how to do it and why. The emphasis on the method to be used to reach a decision, and not on the ethical dimensions of the actual conclusions the decision should lead to, gave rise to a form of problem solving that was more apparent than real, one with specific efficiency, but often unable to stand up under subsequent arguments that serve to unmasked the initial premises.

Hence, an ethical review of clinical cases is changing in terms of substance, even though its procedures remain stable. In fact, those who do not see themselves in the proceduralism of Beauchamp and Childress have raised important questions about its basis, as well as its application and use.

For example, the difficulty in achieving a balance between rights and principles, as opposed to public morality or external factors, has been particularly challenging, especially when it comes to justice for minors and minorities, not to mention concern for the weakest members of society. The right of the mother and the child in an abortion is a case in point; or the right of a child to have a father and a mother, in the case of adoptions by homosexuals; or the variety of rights at stake in an economic program that favors certain health conditions and diseases over others. The clinical bioethicist is increasingly confronted with many questions in the face of complex problems, such as the rise in cancer cases related to added exposure to pollution brought on by a lack of waste disposal, or by mistaken investments in the rise in industrial production, as occurred in the case of asbestos or steel.

An adequate method for clinical reasoning is necessary and always desirable. However, as in many situations that arise in clinical observation, it is needed but not sufficient in and of itself. More is expected of clinical bioethics than the mere substantiating of logical steps and their internal consistency. It is urgent to assess to what extent the well-being of the patient is defined correctly in the final decision and to evaluate what is done to achieve it fully, under the specific circumstances as they exist, and for the therapeutic team as well. Clinical bioethics must refer explicitly to the life sciences and organize this thinking to understand if and how the person's quality of life is related to their personal dignity and their existential projects.

This special issue of *Persona y Bioética* takes a historical and theoretical look at the subject. It also proposes methods aligned with ontologically founded personalism and with recovery of the teleology characteristics of Edmund Pellegrino. It is an approach that comes largely from clinical practice and a personal relationship with the patient. So, it can be understood easily by health professionals.

An analysis of proposed clinical problems, addressed in terms of the logic typical of those who use a problem-based approach, cannot overlook the perspective of the doctor-patient relationship, a true hinge, not only procedural but also substantive, to position themselves simultaneously in three ways that are different, but interrelated, and able to offer an overall assessment in terms of clinical bioethics.

Specifically, there is the analysis of the clinical problem, which acts as a trigger or an intellectual challenge in an ethical, scientific and clinical sense. There is the analysis of the subject, who is urged to intervene in the decision by virtue of being the main character, the one who experiences the immediate consequences of the decision that will be taken. Then, there is the professional, the clinical person or medial professional who feels called upon to act in a general assessment, with his or her know-how, actual skills and reasons for clinical action in one way or another.

The line of thinking characterizing this entire issue that of Tambone and Ghilardi. "The system of ethical review, which is not intended primarily to review borderline cases in medicine, or so-called cases on the *frontier of bioethics*, seeks to serve as a simple method to understand or conclude the good or bad in the actions physicians perform daily."

The authors describe a scenario in which the method obeys a moral assessment of actions from the standpoint of good or evil. As such, it is oriented fundamentally towards everyday life, as opposed to emergencies or exceptional situations. Clinical bioethics must be rediscovered, especially as a science, and this must be done here and now. It must be viewed as a science of the ordinary actions of the physician and his or her interaction with the patient, avoiding the deception of considering bioethics as a science of the extraordinary and extricating it from the discipline that regards it as the backbone of medical action in connection with professional conduct.

It does not escape the authors that the proposed approach looks at clinical bioethics as a system in keeping with the technical meaning of this term; that is, as a system of analysis designed for a multidimensional reality. On the other hand, a clinical setting has a wealth of facets, levels of intervention and possibilities for actions that have to be regarded in light of their complexity, in which only a multidimensional assessment is acceptable as a coherent response to problems. However, the wide range of issues for analysis, according to the different dimensions being considered, ultimately must lead to the good or bad of medical acts that are performed daily, which are the filigree in which clinical bioethics develop.

This issue combines authors from Latin America, the United States and several European countries, all of which helps us to understand how we can move towards globalization in "taking care" of the human person.A special edition of a scientific journal certainly is not enough to exhaust this vast topic. Therefore, we hope these pages will spark a debate that *Persona y Bioética* has promoted and will continue to nourish.

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