

FIRST, DO NO HARM

FACILITATION GUIDE

Overview

These case studies are narrative accounts designed to stimulate dialogue about the virtues that shape professional life. They differ importantly from the ethical case studies most faculty and students encounter in professional training. Rather than presenting a moral dilemma to be resolved, each case illustrates the presence—or absence—of a particular virtue as it operates in everyday practice. The goal is not to reach a verdict on what a character should have done, but to explore what a virtue looks like in action—and what may be at stake when it is absent.

Cases are organized by virtue and professional context, but many will resonate beyond their primary category. A case about curiosity in a business setting may illuminate curiosity in medicine or law. Instructors are encouraged to use cases flexibly and across disciplines.

General Facilitation Tips

- Focus on virtue, not verdict. Keep discussion centered on how the virtue appears (or is absent) in the case, not on whether the character made the right call. If the conversation drifts toward "what should they have done?", redirect gently.
- Start with observation. Open by asking what students noticed before asking what they think. Grounding early discussion in specific moments from the case prevents premature judgment.
- Use questions as starting points, not a script. Follow student energy. If a student raises a more generative question than the ones provided, pursue it.
- Push back on easy agreement. If the room converges too quickly, the case's complexity may not have been fully engaged. Invite students to complicate their own claims and consider opposing readings.
- Invite connection to professional life. The richest moments often come when students link the case to patterns they've observed or anticipated: "I've seen something like this when..."
- Let silence work. Resist the urge to fill every pause. Students often need a moment to arrive at their most substantive responses.
- Close with reflection. Reserve a few minutes to ask students what will stay with them — a question, an image, an unresolved tension. A sentence or two naming what they now understand about the virtue that they didn't before is a strong closing move.

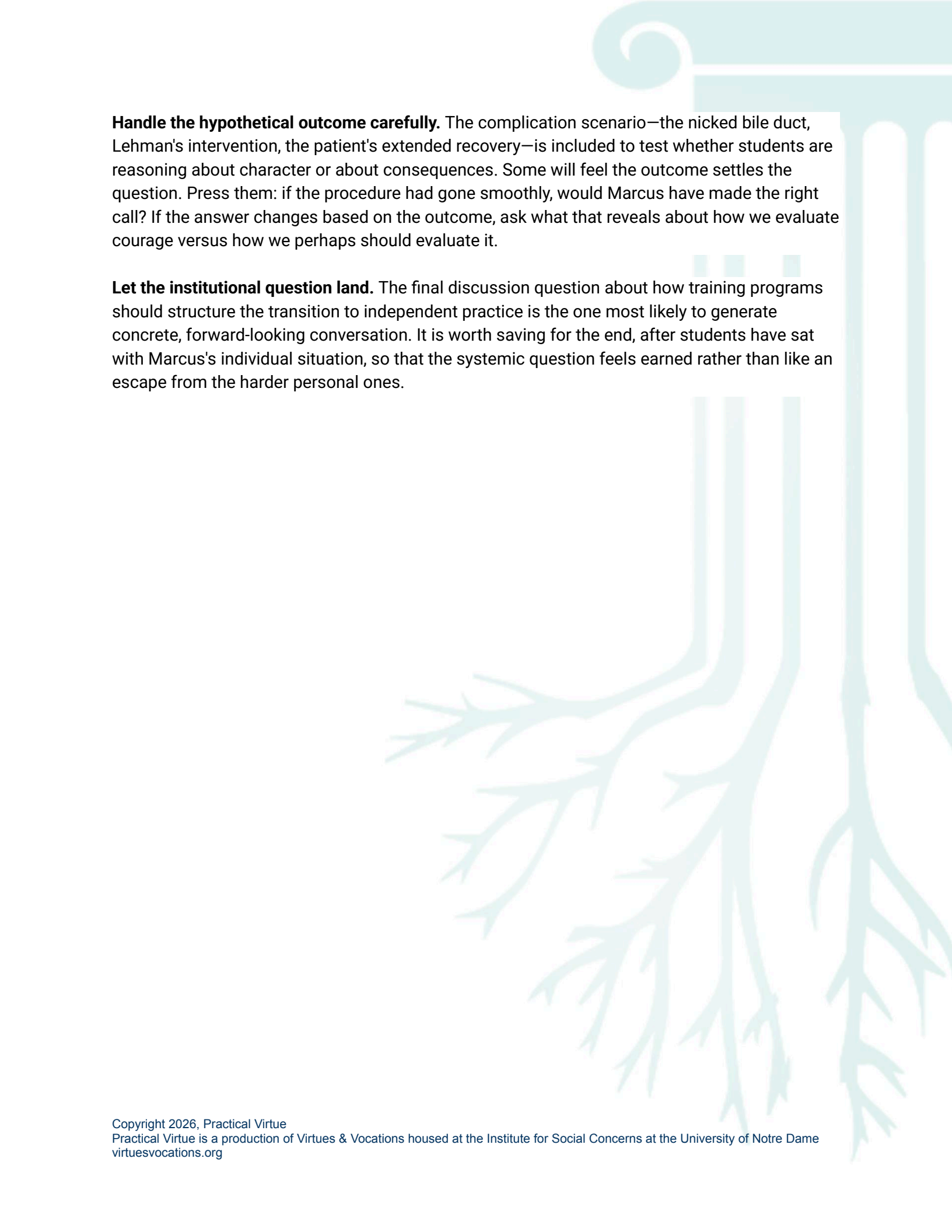
Discussion Questions

1. We often think of courage in medicine as the willingness to act under pressure. This case suggests there may be courage in not acting, or in asking for help. How does that complicate the conventional picture?
2. Dr. Lehman's confidence in Marcus is real, and his belief in experiential learning is not unreasonable. Does that make him responsible for what Marcus is walking into, or does it make Marcus more so?
3. Aristotle described courage as the mean between cowardice and recklessness. A coward refuses to act when action is warranted; a reckless person acts without sufficient regard for the real risks involved. Where does this case fall on that spectrum — and does the answer depend on what Marcus knew about himself, or on what actually happened in the operating room?
4. Consider the following: *During the procedure, Marcus encounters the bile duct variant and, uncertain how to proceed, makes an incision that nicks the common bile duct which means a serious complication requiring immediate intervention by Lehman and an extended recovery for the patient.*
 - a. Would this change your evaluation of Marcus's decision the night before? Should it?
5. Surgical training requires residents to eventually operate independently. How should institutions structure that transition in a way that doesn't make silence feel safer than honesty?

Facilitation of this Case

Complicate the "too much courage" reading. The fact that Marcus decides to proceed can be read as an example of excessive courage: He acted when he should have held back. But push students on whether that framing is quite right. Marcus does not charge forward with confidence; he proceeds while uncertain, which may be closer to a failure of a different virtue altogether. Is this really courage in excess, or is it something courage is frequently confused with like the performance of readiness, or the avoidance of the appearance of doubt? That distinction is worth spending real time on.

Consider Marcus's reflection on his journey. The case begins with a quiet but important observation: that Marcus did not get to this residency by expressing doubt, but that is not the same as never having felt it. This distinction is worth surfacing early. Ask students what kind of environment produces that gap between inner experience and outward presentation, and what it costs a training culture when that gap becomes normal. The virtue question is already live before Marcus even enters the operating room.



Handle the hypothetical outcome carefully. The complication scenario—the nicked bile duct, Lehman's intervention, the patient's extended recovery—is included to test whether students are reasoning about character or about consequences. Some will feel the outcome settles the question. Press them: if the procedure had gone smoothly, would Marcus have made the right call? If the answer changes based on the outcome, ask what that reveals about how we evaluate courage versus how we perhaps should evaluate it.

Let the institutional question land. The final discussion question about how training programs should structure the transition to independent practice is the one most likely to generate concrete, forward-looking conversation. It is worth saving for the end, after students have sat with Marcus's individual situation, so that the systemic question feels earned rather than like an escape from the harder personal ones.