MEDICINE

PATIENT'S HISTORY

FACILITATION GUIDE

Overview

These caselets 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 caselet 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.

Caselets are organized by virtue and professional context, but many will resonate beyond their primary category. A caselet about curiosity in a business setting may illuminate curiosity in medicine or law. Instructors are encouraged to use caselets 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 caselet, 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 caselet 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 caselet'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 caselet 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.

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Discussion Questions

1. How do shortcuts to understanding patients, such as the labeling Mr. Henderson as lonely and coming in mostly to talk, shut down a physician's curiosity?
2. How can medical teams create a culture where curiosity is welcomed rather than seen as a barrier to efficiency?
3. How does the fact that medical education and practice relies heavily on pattern recognition impact curiosity?
4. How can doctors practice something like Narrative Medicine (listening to the story rather than just the symptoms) when they only have 15 minutes per patient?

Facilitation of this Caselet

Linger on the moment Sam puts her pen down. The pivot in the caselet is quiet but significant. Something stops Sam from interrupting, and she makes a deliberate choice to set efficiency aside and lean in. Ask students what they think is happening in that moment. The caselet attributes it to a subconscious check on her own due diligence, which is worth examining: is that curiosity, conscience, clinical instinct, or something else? The caselet does not fully resolve it, and that ambiguity is productive.

Start with the label, not the missed diagnosis. Before the discussion reaches the GI bleed, ask students to sit with the assumption Sam has already made about Mr. Henderson: that he is lonely, that he appreciates the chance to get out of the house, that his persistence reflects emotional need rather than clinical reality. That framing is not cruel or unusual—it is a reasonable inference from a pattern of frequent visits and normal test results.

Take the efficiency pressure seriously. Sam is behind schedule, she has serious cases waiting, and Mr. Henderson has a reputation for being talkative and medically unremarkable. The conditions that nearly produce a missed diagnosis are entirely ordinary, not negligence or indifference but the accumulated pressure of a system that rewards throughput. Ask students what a curious physician looks like under those conditions, and whether curiosity is a reasonable expectation when the structure of the work is designed around something else entirely.

Explore the language problem carefully. The missed diagnosis turned not on a failed test or an overlooked symptom but on a mismatch between how Mr. Henderson described his experience and the medical category that experience corresponded to. He was not withholding information. Instead, he simply did not know what was clinically significant. Ask students what this reveals about what curiosity in medicine actually requires: not just asking more questions, but listening for what a patient's language cannot quite capture and being willing to follow the gap.

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