Values and Voices in Teaching Gerontology and Geriatrics
Case Studies as Stories

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Case studies are used extensively in gerontological and geriatric education and practice, especially to present clinically relevant examples and to illustrate abstract concepts, principles, and theories in the study of aging. This article reviews the important pedagogical, clinical, and ethical issues involved in their design and use, and presents an argument that both case study developers and discussants need to become more reflective when they think about the nature of writing and listening to case studies as stories. The major themes from the literature in narrative and clinical ethics on case studies as stories are surveyed, including consideration of both facts and values, the debate on generalization versus specificity, and the need for interpreters and commentators. The implications of these insights for teaching and clinical education are considered, including the importance of addressing the need for rich description, multiple voices, open-endedness, and critical analysis.

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The use of case studies in teaching and practicing in gerontology and geriatrics is nearly universal. There are few faculty members or clinicians who have not written, presented, or discussed a case study in the course of their work. Educators in gerontology and geriatrics often rely on case study examples to stimulate discussion about key aspects of theory, illustrate applications of important concepts, and explore the ethical dilemmas in caring for older adults. Clinicians routinely present and discuss cases as part of their work in teams or at meetings to explore difficult or complex issues associated with some older patients.

At their core, such cases are essentially stories—whether based in full or in part on real events—presented by the instructor or clinician, and as such they have great pedagogical and clinical power. As a faculty member, I am always reminded of the impact of storytelling when I encounter former students who reveal that they remember the stories I told in class to illustrate important concepts or principles of aging, though they seldom remember the specific theories themselves. Despite their common usage, however, how case studies are designed and used is seldom the subject of scrutiny or reflection—the need for which is the subject of this discussion.

Case studies can range from anecdotes told in the course of a lecture to fully developed and detailed written clinical cases used as the basis for small-group discussion in classes or workshops. Stories in the form of cases enjoy a high level of popularity among both traditional students in academic settings and practicing health care and human service providers in continuing education programs. For the average student, stories or cases provide a concrete context, tangible issues, and the "grittiness" of everyday life—in contrast to the disembodied slipperiness of concepts, principles, and theories. They ground the discussion in the context of lived experience, whether real or fictionalized. They also allow the adult learner—the practicing clinician—to apply his or her extensive clinical knowledge and skills in grappling with problems similar to those seen in everyday clinical practice. Students’ eyes are likely to glaze over when abstractions are the basis of a classroom or workshop discussion, but it is amazing how students come back to life when the case studies are brought out for discussion.

Indeed, in geriatrics and gerontology whole textbooks have been written based on cases, especially in the health professions such as medicine (e.g., Ham & Sloane, 1997). The use of case studies is a prominent feature of problem-based learning (PBL) approaches to health professions education (Owens, Padula, & Hume, in press; Silver, 1998; Silver et al., 1999; Walton & Matthews, 1989). Recently, case discussions have been used to highlight the importance of ethical issues in interdisciplinary teamwork (Mezey et al., 2002). Educators in the field of aging have found that...
Case Studies as Stories

Anyone who has ever presented a case in a clinical setting or written a case for teaching purposes knows that it is much like writing a story. Despite calls for the use of “actual” cases—as opposed to “made up” cases—there is still a considerable amount of latitude involved in deciding what to include, why to include it, and how to include it. Pattison, Dickenson, Parker, and Heller (1999) suggest that, however realistic, case studies are authored or at least edited works, reflecting the assumptions, biases, perspectives, and blind spots of those who write them. Thus, they are simply one possible, but certainly not definitive, account of reality. Case studies are closer to the genre of story or tale than they are to objective reporting or description.

Reflecting this narrative constructionist perspective on case study writing, some observers have even gone so far as to offer specific guidelines on how to write a case that illustrates ethical issues in clinical practice. In their work with students and health care professionals, Kuczewski, Wicclair, Arnold, Pinkus, and Aumann (1994) ask that case studies be based on the real experience of students or professionals, rather than on hypothetical or fictional situations. They go on to define specifically that a narrative presentation of a case depends on the use of ordinary language to convey its storylike quality, tracing the themes and reflecting the conflicts intrinsic to it. The case should have a specific structure: the beginning, the action, and the climax. The last element is the point at which a dilemma is encountered and at which the case becomes ready for presentation.

Facts and Values

Two observations are worth making at this point. First, the use of a narrative approach in developing and presenting the case depends on a (re)presentation of the facts. The factual basis of the story is sometimes described as the raw, lived experience of the characters in the case. Insufficient factual material, perhaps due to too-heavy editing by the author, reduces the case to a simplistic account that lacks the richness of real life. The factual basis of the case cannot be “simply the facts,” but rather should be the “story behind the facts” that is free from jargon and reductionism. A narrative approach is seen as an antidote to the sterile presentation of “simply the facts,” which does not allow the reader to understand the interpretive and cognitive processes behind the facts that involve the characters in the story (Kuczewski et al., 1994). Simultaneously, a rich description allows the case to be set within the larger lifestories of the individuals in it, in which illness and health care are simply a subplot or subtheme (Clark, 2001).

Second, values—and specifically value conflicts—are often at the heart of a case presentation. Particularly in geriatric practice, ethical dilemmas are at the very center of what it means to address the health care needs of older adults (Kaufman, 1995). Value conflicts are often described as based on competing moral principles that vie for primacy in the clinical context. For example, autonomy on the part of the individual care recipient to live the way they wish—even if it means jeopardizing their own personal safety—may run counter to beneficence on the part of the care provider, who wants no harm to befall the patient or client in what the provider perceives to be an unsafe living environment.

As Potter (1969) has suggested, every problem has both a factual and a value component. A problem arises when a particular situation or state of affairs, empirically defined, threatens to affect certain cherished human values. Case study presentations that articulate issues to be addressed or problems to be solved should be equally sensitive to the need for factual information and the demand for moral reasoning.

Generalization Versus Specificity

The recent resurgence of interest in casuistry in ethics—the use of case studies to teach about clinical or applied ethics—brings to the forefront a longstanding tension between generalization and specificity. Historically, casuistry has had a bad reputation because it was considered to have degenerated into
nearsighted, case-specific moral reasoning that did not raise discussion to the plane of more generalizable ethical principles. However, efforts on the part of such philosophers as Jonsen and Toulmin (1988) to reintroduce the importance of focusing on the specifics of each case, in all of its richness, have had a major impact on promoting the use of cases in the teaching of applied ethics. Narrative ethics is sometimes distinguished from casuistry as a separate approach to ethical issues in geriatrics (e.g., Mahowald, 1994). For example, Hunter (1993) suggests that narrative ethics asks such questions as, “What is going on here?” rather than, “What decision should be made in this instance?,” which is more typical of casuistry. According to Mahowald (1994):

Narrative ethics [is] a morality of knowing rather than moral theory. As an approach to clinical ethics, it requires recognition that each case involves several stories told by different narrators to different audiences. The telling is not only through words but also through action and inaction, conveying feelings as well as thought. (p. 412)

Some philosophers have reacted against this “new casuistry” by raising concerns about the “tyranny of the story.” Callahan (1996), for example, suggests that focusing solely on cases or stories distorts reality, which is more likely to lie in a generalized, abstract, and universal realm. The details of particular cases may actually distract us from considering the larger, more universal issues at stake. In the literature on narrative and lifestories, this insight is reminiscent of the important distinction made by Bruner (1986) between paradigmatic knowledge (“trying to take a particular and see it in general terms”) and narrative knowledge (“trying to understand the particular case”). Much of the emphasis in clinical practice, especially in such fields as medicine, is on the former rather than the latter in an attempt to arrive at a diagnosis that emphasizes the general at the cost of de-emphasizing the specific—which results in distancing the physician from the patient.

In reaction to this concern, still other observers (e.g., Murray, 1996) point instead to the need for a middle ground between a myopic focus on the particulars and too broad a gaze on generalizations. We need to be balanced between the specifics of a story and the broader context within which it is being told. In the process of balancing these two aspects, we must become skilled interpreters and commentators.

Interpreters and Commentators

The need for insightful interpreters and commentators is a final theme in the literature surveying case studies as stories. In particular with regard to ethical reflection, there seems to be a natural affinity between case-based methods and the development of the “reflective practitioner,” to use Schön’s (1987) term for the professional who is equally comfortable with the scientific basis of practice (knowledge and skills domains) and the artistic basis of practice (those “gray” areas where moral dilemmas and ethical conflicts arise). This observation is made with regard to PBL approaches in particular. Both PBL and ethical inquiry deal with problems, with the dilemmas encountered in life; both confront, recognize, and tolerate doubt, uncertainty, dispute, and argument as the basic features of the way in which they organize and understand information and put it to use (Parker, 1995).

Other authors suggest that the analysis of stories and the development of ethical reasoning are closely related (Carson, 1994). Ultimately, storytelling and storylistening make professionals more literary and literate in the language of ethics and reflection. Narrative represents the very foundation of moral discourse:

Just as ethics cases do not contain a kernel of pure knowledge that could be revealed if only the circumstances were stripped away . . . neither will the aggregated stories, the views of all the participants, add up to a solid representation of the pure and unalloyed truth. Stories are constructed and presented by human beings in an effort to understand and to be understood . . . . We sort through the stories we hear, testing them, wanting to know more or feeling satisfied that they fit or confound our general rules. In its subjectivity and in its transaction with other stories and the lessons we have learned from them, narrative represents openly the tentative, perspectival conditions of moral discourse. (Hunter, 1993, p. 102)

The natural affinity among ethical reflection, case studies, and interdisciplinary teamwork embodying the need for the multiple perspectives of different health care professions in moral discourse is evidenced in the development of recent publications intended for clinical geriatric instruction (Mezey et al., 2002). It will also be explored further as one basis for the case study example to be presented later in this article.

Implications

What are the implications of considering case studies as stories for teaching and practicing in gerontology and geriatrics? There are four major areas that offer some specific guidance for those who either teach or learn from case studies; these are, in order, the need for (a) rich description, (b) multiple voices, (c) open-endedness, and (d) critical analysis.

Rich Description

Several observers of the use of case studies suggest that they need to be developed with rich (some use the term “thick”) and complex descriptions, contexts, and situatedness. As Murray (1996) observes, “I have learned respect for stories that are rich and complex. And I have learned to be suspicious of stories that dictate beforehand what counts and what can be ignored” (p. 29). Arras (1991) warns against the danger of oversimplification in the educational realm:

If the purpose of . . . education is to prepare one for action in the real world, the cases discussed should reflect the degree of complexity, uncertainty, and ambi-
guity encountered there. . . . It won’t do, as is so often done in our textbooks and anthologies, to cram the rich moral fabric of cases into a couple of paragraphs.” (p. 37)

Of course, one can never know the “whole story” and some selective editing will always be necessary. In developing and using case studies many educators find that a common reaction from students is, “If only we had a bit more information, if only we had a complete picture of what was happening, then we wouldn’t have to struggle so much with the ethical complexity of the situation.” This kind of thinking, of course, is a danger to be avoided: We will never have enough factual information, we will never have enough detail, to release us from the need to grapple with those “gray areas” of geriatric practice where the “right” course of action is not unequivocally clear.

Related to this point is the importance of recognizing the need for “situatedness,” whether in terms of sociocultural dimensions, or with respect to the rich matrix of relationships in which characters in the case/story find themselves. There is growing awareness in gerontology and geriatrics of the importance of including social and cultural dimensions in any attempt to understand the experience of growing older and to provide meaningful care or services to older adults. Growing cultural diversity requires a recognition of the ways in which one’s values and meaning in life are shaped by racial and ethnic background; respect for these differences is an essential feature of providing appropriate and sensitive care.

Similarly, we need to be aware of the relational situatedness, the weblike context in which lives are lived and in which caregiving interventions are offered (Parker, 1990). Indeed, recognition of the central importance of relationship to moral discourse has been offered by Gilligan (1982) and others (e.g., Mahowald, 1994). Moreover, these aspects of context and relationship should be revealed in an active, unfolding, and dynamic process—the case study should be more like a movie than a snapshot (Hunter, 1993).

**Multiple Voices**

A second implication of case studies as stories—and one related to the need for rich description—is the importance of ensuring the presence of multiple “voices” in the story, or the need for different angles or perspectives on the issues presented in the case study. Just as a choral work is improved by the presence of several different voices, so too is a case discussion enriched by more than one perspective or profession (Aumann & Cole, 1991). Understanding may be improved by a kind of narrative triangulation that allows the reader to view the situation from different angles. Hunter (1993) refers to this as the “voices of multiple witnesses” (p. 98). This insight can be interpreted in two different ways.

First, educators and clinicians who develop or present cases need to be sure that the voices of both care provider and care recipient are heard. Because of the greatly unequal power of these two voices, and the tendency of professionally developed cases to emphasize only the dominant power of the provider (Clark, 1996), it is essential that both sides be incorporated into the presentation and discussion of any clinical narrative. Too often, the voice of the client—based on a life world very different from that constructed by the clinician—is drowned out by the techno-scientific voice of the provider—who reshaples the patient’s story to fit the requirements of the professionally constructed (re)presentation.

Second, educators and clinicians must ensure that multiple professional voices are heard in any case discussion by including interdisciplinary perspectives on the issues, referred to by some as “all the major players” (Arras, 1991, p. 49) and by others as the “reflective health care team” (Hunter, 1993, p. 97). Because professional training and socialization instill different values (Clark, 1997), each provider comes to the case with his or her own perspective on such important issues as quality of life, which are at the core of geriatric practice (Clark, 1995). In this sense, the terms “values” and “voices” are synonymous for these different perspectives on the issues critical to geriatric care. Values affect how we see, what we hear, and how we frame problems and their solutions. At the very least, cases need to incorporate multiple provider perspectives to ensure descriptive richness.

For example, physicians tend to emphasize “objective” data in their attempts to “rule out” aspects of problems, to narrow them down eventually to a single diagnosis; social workers, on the other hand, “rule in” aspects of problems to broaden the discussion to incorporate larger, contextual issues of social, psychological, and economic importance (Drinka & Clark, 2000; Qualls & Czirr, 1988). Cases may need to be developed by interdisciplinary teams in order to ensure that multiple voices are, indeed, heard and that no particular, single voice dominates the discussion (Owens et al., in press; Silver, 1998; Silver et al., 1999). Additionally, there is growing awareness of the importance of teaching the ethics of interdisciplinary geriatric teamwork and of highlighting the contributions of different health care professions to recognizing and resolving the significant ethical dilemmas in providing care to older adults (Mezey et al., 2002).

**Open-Endedness**

A third implication of cases as stories is the need to ensure that the case allows for discussion leading to different possible interpretations, outcomes, resolutions, or meanings. Cases that can lead to only one possible conclusion should be suspect. For example, in the Rhode Island Geriatric Education Center’s work in developing case studies for teaching geriatrics to currently practicing health care providers (Owens et al., in press), lengthy, longitudinal cases were developed to follow a particular individual over several years to illustrate important insights into the aging process and its interaction with a chronic illness trajectory. In one particular case, six different “snap-
shots” were developed of a patient over time. Each segment allowed workshop participants in small groups to discuss the issues apparent at that particular time in the patient’s life, and to explore various potential outcomes based on different possible care decisions. Unfortunately, however, the next segment of the case was written in a way that made assumptions about how the previous one had been resolved; that is, it foreclosed the possibility of a different outcome based on what the group had decided was the best course of action. As a result, workshop participants expressed criticism that, on the one hand, open discussion and brainstorming were encouraged, but, on the other, meaningful discussion was cut off by preordaining which way the case would go.

In other words, good cases openly “move the story forward” by enabling discussants to create new possibilities, meanings, and outcomes (Ellos, 1998; Maciuunas & Moss, 1992). Cases need to have an open-endedness that allows for the discovery of new understanding and insight. Similar to stories that allow children to choose different plot directions at critical turning points, good cases must provide good starting points for examination and reflection—but not dictate specific end points. One should not be able, as in a novel, to read the ending before the story has a chance to unfold in a dynamic process of development and discussion.

Critical Analysis

Finally, a fourth implication of case studies as stories is related to the kind of skills they should teach those who read, interpret, and discuss them. This skill set is metaphorically based on critical analysis, a concept one applies to approaching major works of literature. For case studies, “critical analysis” means the ability to reflect on “what is happening here,” to apply what Pattison and colleagues (1999) term the “hermeneutics of suspicion” (p. 42) in asking critical questions about the case, how it was constructed, and what it means. This includes attention to the following elements (Jones, 1999; Pattison et al., 1999):

- **Genre.** Into what genre does this case study fall?
- **Author.** Who is the author of this narrative, and what are the author’s biases, prejudices, interpretive frameworks, values, and viewpoints? How would this case have been different if it had been constructed from someone else’s point of view? What are the implications of these differences for considerations of power and values?
- **Purpose.** For what purposes has this case been constructed, and how is it being used? Who benefits from having the case constructed in this way?
- **Language.** What kind of language is being used (e.g., medical, layperson) and what are the implications of this choice for creating the patterns of meaning from the case?
- **Emotionality.** What aspects of the case make it more, or less, engaging or gripping? What literary methods have been used to achieve this?
- **Plot.** What order, or plot development, has been imposed on this account of events and persons by the author?
- ** Literary devices.** What literary devices (e.g., narrative, rhetoric) have been used to develop this case, and what are their implications?
- **Missing elements.** What elements, perspectives, viewpoints, or context descriptions have been excluded from this case, and why?

Case Study Example

It would be ironic to close a theoretical presentation of case studies as stories without giving an illustrative example of the kinds of issues and principles explored in this discussion. Thus, the following case, adapted and summarized from Aumann and Cole (1991), is presented as an example of the kinds of implications and applications discussed earlier. This case captures well the elements of rich description, multiple voices, open-endedness, and critical analysis. It focuses on the situation of an elderly woman with Alzheimer’s disease who is living in a nursing home. This particular case is presented primarily as first-person accounts of the resident, rather than in the third-person format that is typical of many case studies. This approach tends to make the discussion more “real” and compelling—an interesting element in how the authors of the case chose to present it. Additionally and importantly, the case presentation as published includes photographs of the resident as a young girl and young woman, as well as a nursing home resident—which substantially enrich and enlighten the descriptions of her previous and current life, making the contrast between them all the more apparent. The pictures also provide a visual dimension that complements and makes more compelling the verbal one provided by the voices of the health care professionals and a family member.

Family Practice Resident

The story begins with the “conventional medical voice” of a family practice resident presenting the medical case history at grand rounds:

Mrs. Judith R. is a ninety-year-old Alzheimer’s patient with severe dementia since age seventy-eight, and a history of hip fracture with surgical repair three years ago. She has been in a local nursing home for the previous thirteen years. Since her hospitalization for hip repair, she has been fed by nasogastric [NG] tube and has continuous wrist restraints to maintain the NG tube. Her physical condition is unremarkable, except for some abrasions around her wrists and some muscle wasting and flexion contractures of her legs. She is severely disoriented and refuses to tolerate anything near her mouth. Her present physician, Dr. Johnson, “inherited” her when Mrs. R.’s family physician died suddenly. Dr. Johnson does not want to continue the NG tube for Mrs. R., because it irritates the patient’s nose and necessitates restraining her. The only option is to place a gastrostomy tube. (Aumann & Cole, 1991, pp. 45–46)
Although this view is one perspective on the patient and the question of whether to place a gastrostomy tube into the resident, we need to have other views of this person, her situation, and her life for a richer description of the case. This depersonalized, biomedical voice makes it difficult for the physician to understand the distinctiveness of the patient and to develop empathy for her.

Mrs. R.’s Physician

The next voice to be heard in this case discussion is Mrs. R.’s personal physician, Dr. Johnson, who describes his growing awareness of the issues involved in her care:

I first found out about Mrs. R. because her case was assigned to me. . . . I did not anticipate how difficult [it] would be—what issues that would involve, because as soon as I picked her up, I had to say, “Now I’m responsible for the fact that she’s being tube-fed and has been for three years.” I did not spend very much time seeing the patient; I’d go in briefly and examine her and talk to the nurses. Mrs. R. couldn’t speak for herself in any way. (Aumann & Cole, 1991, p. 46)

This voice suggests an unexpected quandary for Mrs. R.’s physician, who now has a patient whom he does not know and for whom he is responsible for making major medical care decisions. The need for other voices to contribute to our understanding of this nursing home resident is now becoming more apparent.

Gerontological Clinical Nurse Specialist

Further insight into the dilemmas of how to care for this patient is provided by the voice of a clinical nurse specialist:

My first meeting with Mrs. R. was when we were trying to get her to eat using a baby bottle. For me, that was just the . . . you know, the attempt to eat is one thing but here’s this woman, this elderly woman who surely had history and dignity, and they were trying to get her to eat with a baby bottle. It just didn’t feel right. (Aumann & Cole, 1991, pp. 46–47)

The clinical nurse specialist begins to articulate the issues of personal history and dignity that depend on a more in-depth understanding of the resident’s story and the ethical dimensions of her situation—which are now described in the voice of her personal physician.

Mrs. R.’s Physician

It started to sink in what the responsibility was. One of my residents asked, “What if she should have a serious illness? Do we do CPR or not? How far do we go with this lady who has endstage Alzheimer’s and is on tube feedings?” Obviously, none of us knew what her wishes were, but we would not want CPR or aggressive management for ourselves or our family members in the same position. So I said, “Well, I don’t know.” So I started finding out who spoke for this patient and who was her family . . . a niece, the only relative we knew about. . . . Little by little, Mrs. R. became more real to me. . . . We finally got hold of the niece, who gave us all kinds of information and started sending us pictures, and all of a sudden, this lady just burst into view as a person! In some ways it makes you even sadder that Mrs. R. is now in this state. Also sadder that if we did remove the tube, this whole life would be gone. And I’m even more saddened at that idea now than I was when I was just considering her more as a case, a medical case. . . . (Aumann & Cole, 1991, p. 47)

Dr. Johnson is now starting to see Mrs. R. more as an individual, with a unique and compelling lifestory, whose own voice is becoming more evident through the words of her niece.

Mrs. R.’s Niece

My aunt was born in 1897. . . . As a young woman she had thick, auburn hair. She was a sweet, loving person, and she took a lot of pride in herself. . . . She was very active, and I know that if she could have her will, she wouldn’t have wanted to have this extended unfortunate situation because she loved life. It is just very, very sad. . . . She would rather go off in peace, I think. But if you take her off it [the feeding tube], I don’t know how the hunger pains would be. . . . If they [the nurses] had just known her when she was in her prime, they would have loved her so much. . . . (Aumann & Cole, 1991, p. 48)

Nurse

To the voice of Mrs. R.’s niece is now added that of a nurse at the long-term care facility, who describes her changing circumstances while a resident of the nursing home:

When I first knew Mrs. R.—in her early eighties—she was on the [less acute care] floor. She was always pleasant, and she walked. She walked up and down the hall and hummed this tune. Or she might sing a few words, but she couldn’t sing the whole thing, the lyrics. She would say a few words of it and then she’d hum the rest. She seemed very happy. . . . After she broke her hip, she didn’t want anything in her mouth. I don’t know why. We tried several times to feed her without the feeding tube. And she just quit . . . nothing worked. . . . I try to put myself in their [the patient’s] place. . . . Like I say, I think Mrs. R.’s sight got worse and worse, and I don’t think she could always see. And if I couldn’t see and somebody came and grabbed me or something, I’d probably yell, too. So I felt that it was important to talk to her. I would go in and I would speak to her: “How are you doing this morning, Mrs. R.? How was your night?” She’d always do “Uh huh.” Always do that to you. She seemed pleasant to me. She seemed content. . . . I just have this feeling that maybe getting old is different, but I feel like getting old is not . . . a privilege; I think it’s a blessing. I feel like, when you’re old, you should be treated with respect, not put out to pasture or sent to the glue factory like they do horses. I’d like somebody, even if I’m demented, to treat me like a person and talk to me. . . . (Aumann & Cole, 1991, p. 48)
Case Commentary

As more and more voices—those of the other health care professionals and the niece—are added to the initial, depersonalized medical history offered by the family practice resident, the reader begins to get a richer description of Mrs. R. and the context, the situatedness, of her lifestory. As those caring for her begin to see her more as a person and less as a case, they develop a new appreciation for her situation as it continues to unfold under their care. Their dilemma of what to do has not disappeared, nor has her caregivers’ pain over considering their choices gone away. There continues to be an open-endedness to this case, with no clear-cut resolution. However, the providers of her care now have a much richer and fuller account upon which to base a decision. Moreover, in the process of applying critical analysis to the case of Mrs. R., the reader has certainly come to have greater appreciation and insight into the art of clinical practice with older adults and has become more familiar with the reflective demands of case presentations. Though the case study allows no easy solutions, it enriches the reader by providing insight both into the situation described in the case and into the reader himself or herself.

Conclusion

Ultimately, the goal in the use of case studies as stories should be the teaching of critical analysis in the creation of the “reflective practitioner” who is equally adept in the domains of technical skill (the “facts” of scientific practice) and moral discourse (the “art” of being able to deal with ethical conflicts), as Schön (1987) has suggested. The use of case studies in gerontological and geriatric instruction and practice is becoming increasingly popular—arguably because of its effectiveness in conveying important insights about aging and the problems that may accompany it, and because this method engages students “where they are at” in presenting practical descriptions that fit into the world of the practitioner. However, the case study method cannot be used uncritically without recognizing both its strengths and its weaknesses. In this sense, we need to be reflective educators in the development of case studies—aware of the power we wield in choosing what we include and what we do not, and for what purposes we design and use them. If we do anything less than this we are ultimately being intellectually dishonest and professionally unethical, undermining the development of the very qualities we are trying to encourage in those who use the products of our work.

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