

EDITORIAL

The Case of the Lowly Case Report

In the past few years editorial decisions in child psychiatry journals have changed the content of submissions towards what is perceived as more hard core “evidence based” studies, effectively closing the door on individual or serial case reports. Along with the actual EBM research, the collateral consequence has been the emphasis on guidelines, algorithms and rating scales. The editorial board of the CACAP, in conjunction with the executive board has made the deliberate decision to adopt a more nuanced policy, recognizing the inherent value of case studies as instruments of hypothesis generation and unusual exceptions to the rules that may challenge the validity of established categories. There is a long tradition of “case reports” in child psychiatry which merits its own history as well as a critique of advantages and disadvantages.

In psychiatry training programs residents are taught how to formulate biopsychosocially so that in effect each formulation becomes its own case study by integrating evidence with individual and family narratives. With each clinical encounter whether it be an assessment or a consultation, the accumulated wisdom of each N=1 case, integrated with new research findings, forms the experience base of trainees and eventually the reflective practitioner (Schon, 1987). In residency programs there has been an emphasis on critical reviews of the literature which usually means excluding case reports. Yet as a clinically based profession, in the corridors and at the water cooler, we think and discuss “cases” or “individuals” rather than results from studies.

Case Reports have been relegated to the bottom of the evidence triangle with RCT's at the top of the pyramid (The Evidence-Based Medicine Working Group, 1992). An internist of critical care medicine (Tonelli, 2006) argues that this hierarchical ordering of evidence is inherently flawed, with a resulting disservice to clinicians and patients alike as the two types of knowledge are portrayed as mutually exclusive rather than complementary. He puts forth the proposition that empirical evidence cannot be thought about in the same manner as experiential evidence as they are qualitatively rather than quantitatively different and, in addition to these two categories, clinical decision must incorporate patient goals

and values, pathophysiological rationale and systemic factors. He points out that the skilled clinician resorts to both practical and theoretical reasoning to arrive at the best choice for individual patients. If this approach is sound for critical care medicine, should it not be considered as suitable for child psychiatry?

While we should be cautious about prematurely sounding the death knell of the case report, it is interesting to note that in other areas outside of child psychiatry, qualitative research has experienced a vertiginous growth in popularity (Denzin & Lincoln, 2000). Case reports and case series with their emphasis on the meaning of individual experience are formulated with the conceptual tools of ethnography, anthropology and critical discourse theory, to name a few qualitative approaches. Psychiatric case histories with these qualitative conceptual tools have the potential to become so much more instructive, both as pedagogic tools and unique facets of patient and clinician experience, “data” unattainable with EBM approaches. However the “case report's” status on the endangered species list may become a footnote in history as child psychiatry aligns itself with neuroscience and clinical epidemiology and turns its back on its humanistic and social science traditions.

As the reader will note there is no case report in this issue as no submissions have come in for the *Journal*, nor are any waiting in the publication queue. It may be a one-off or a sign of things to come.

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References

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- Tonelli, M. R. (2006). Integrating evidence into clinical practice: an alternative to evidence-based approaches. *Journal of Evaluation in Clinical Practice*, 12(3), 248-256.