

MEDICAL HUMANITIES REPORT

10th
Anniversary
Year
1987-88

MEDICAL HUMANITIES REPORT

MICHIGAN STATE UNIVERSITY

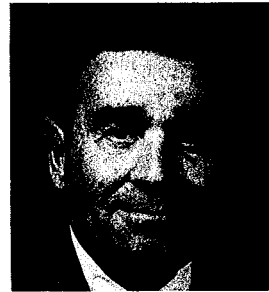
WINTER 1988

Medical Humanities Program Celebrates 10th Anniversary Year

Editor's Note: The following comments were selected from a series of interviews with some of the significant members of the Medical Humanities Program, its supporting units at MSU, and distinguished visitors.



Dean Weston



Dean Megan



Dean Tasker

What do you see as the past and present value and function of the MHP in the medical schools?

W. Donald Weston, M.D., Dean of the College of Human Medicine: It is an example of what is unique about MSU generally and the health program here in particular, namely the ability to pull together diverse units of the university to serve the needs of the educational challenge. Andy Hunt started in the beginning and now Howard Brody has continued to provide the kind of leadership which allowed the MHP to leap into national prominence early on and appropriately so. They have provided a major focus to the issues of health care and ethics, both locally and nationally, as past and future presidents of the national Society of Health and Human Values.

Myron Magen, D.O., Dean of the College of Osteopathic Medicine: It sensitizes people to the fact that there are aspects to medical care other than medicine, surgery, high technology etc. There is humanity in medicine. It allows for a forum to discuss

both sides of ethical issues and enables them to be explored. We have no other forum for discussion of that kind.

John Tasker, D.V.M., Dean of the College of Veterinary Medicine: It has made it possible for CVM to have a far stronger exposure for students in the areas of veterinary medicine and ethics than if we had to rely on faculty volunteers. The MHP cadre of faculty who participate in our course give it more consistency, class, and a more solid foundation.

What do you see as the future needs of the medical schools with respect to the MHP?

Dean Weston: I hope to see the work of the MHP expanding beyond just the health arena to look at all issues where science and technology intersect with health and the humanities. The College of Arts and Letters has brought additional leadership to the possibility of future expansion at both the undergraduate and graduate level, and it is clear to me that we need such efforts to face the future.

Dean Magen: It needs to be better integrated within the curriculum itself. It has to become more visible, more time devoted to it, more important.



Howard Brody



Tom Tomlinson



Leonard Fleck

Dean Tasker: I would love to see an increase in participation between CVM and MHP, but the realities of the funding outlook for at least the next few years does not make me very optimistic about any expansion. I want to compliment my predecessors for establishing the support we now provide to MHP, and say that despite the need for future restriction, I do not think the MHP support will be one of them.

Do you see the role or status of the MHP changing in the future at MSU?

Dean Weston: I see the MHP probably moving to a Center status sometime in the future, which is further evidence of its value to MSU and the community. There are three dimensions I hope to see arise in the future here; the training of future scholars in the health and humanities who will be able to help sort through the difficult policy issues; a broad interface on the whole impact of the health sciences from a humanities perspective; and to carry on the teaching of health education in light of the knowledge and awareness of the ethical issues and humanities.

Dean Magen: Increasing, but not necessarily changing. I don't think we need more courses in medical ethics, but rather more (medical) ethics as a component of the course offerings that are already being given at the university.

Dean Tasker: In veterinary medicine nationally, there is a lot of ferment and hope. Ferment with how and what we've taught in the past, and hope for the future that we will move away from the current overload in biomedical information. Many of us hope that this unsettled period of change will allow us to reconsider our value system in veterinary medical education, and that will include a move toward a philosophical approach to veterinary medicine and not solely medical science. The Medical Humanities Program then would be very helpful in such times.

Dr. Brody, you have been involved with the MHP since its inception in 1977. Since then several dozen graduate assistants and over a thousand medical students in the three colleges at MSU have been influenced by the faculty and program. In addition, the MHP faculty have given hundreds of talks and participated in dozens of conferences throughout the state of Michigan and elsewhere. With such diverse activity and wide appeal to different groups how do you go about evaluating the effectiveness of the MHP program with respect to its aims and purposes?

Howard Brody, M.D., Ph.D., Coordinator, MHP: While success of this type is notoriously hard to measure objectively, I still think that effectiveness has been one of the most important features of our accomplishments in Medical Humanities at Michigan State. At first it might seem that we can't take credit for this as a program, because medical ethics and humanities has become a popular area for study and inquiry around the country; we could be accused of simply basking in the reflected glory of the Hastings Center, the Kennedy Institute, and other nationally renowned "think tanks." But this is not the case, for two main reasons. First, we have taken ideas from others but have reformulated them in special ways that particularly fit the unique needs of our local institutions. And, second, we have done our share to contribute fresh ideas and research.

One of our special accomplishments, which would not have been possible without the creative cooperation of many other people on and off campus, has been to tailor activities in medical ethics and humanities to the needs and opportunities of Michigan State University and the state of Michigan. These include the creation of a cross-college program that serves clinicians, clinical/professional students, graduate students, and undergraduate students in seven

different colleges at MSU; efforts to take medical ethics teaching into our scattered medical school community campuses around the state; and our most recent work with the emerging Medical Ethics Resource Network of Michigan. People with whom we worked several years ago, and with whom we are working now, generally seem satisfied with our help and want more in the future. That's because, I think, we take the time and effort to find out what their needs, their goals, and their circumstances are, before we come charging in with our own mission and our own agenda. We see our work, in this sense, as a new dimension of the long "land-grant tradition" at Michigan state.

Further, the record of our small group in publications, research studies, and other signs of national recognition is quite impressive, given our emphasis on teaching and public service as important program missions. Moreover, with further development of our ties to the College of Arts and Letters and the Department of Philosophy, we have a renewed chance in the future to contribute to the training of a new generation of scholars and investigators in the medical humanities.

Dr. Tomlinson, what do you see as the significant points in the MHP since you came aboard in 1980?

Tom Tomlinson, Ph.D., Assistant Coordinator, MHP: MHP has succeeded in overcoming several difficult obstacles to the development of a Medical Humanities Program, e.g., the lack of a curriculum in medical ethics, and the lack of any regular clinical opportunities for faculty. Despite these problems, MHP has significantly expanded its scope of activity; with the advent of the NEH grant in 1982 we expanded into colleges other than the College of Human Medicine including the Colleges of Osteopathic and Veterinary Medicine and the College of Nursing, where we continue to work with success.

What does the future hold for the Medical Humanities Program at MSU?

TT: With the development of closer ties with the Philosophy Department, MHP faculty have the opportunity to reconnect with their discipline and engage in scholarly collaboration and teaching with faculty and (graduate) students. I'm hopeful our involvement with the Philosophy Department will serve as a model for (our involvement with) other

departments. The way to incorporate the other humanities in the MHP is made easier through our summer program in London. It's a model for teaching in an interdisciplinary way. We've seen an increased progress along those lines over the three years it's been in existence. For the faculty it is also a good opportunity for developing international contacts, and back in the medical school it is useful for suggesting ways to integrate history into courses. Traditionally, humanities other than philosophy have been difficult to incorporate in the MHP; they're not as sexy as ethics.

A second major growth area will be through our involvement with MERN of Michigan, which will increase our impact in the outlying areas of the state. Our current resources of faculty and funding limit our expansion possibilities, but hopefully MERN will help spread the burden of meeting those needs out among its membership throughout the state.

Leonard Fleck, Ph.D., Assistant Professor, MHP: I agree. We will continue to see an increased need for MERN over the next ten years, especially with respect to hospital ethics committees' needs for training and resources. It's also likely that MHP will move into clinical work with 3rd and 4th year medical students and residents. We are all starting to recognize that unless the conversation initiated in Focal Problems (HM 514) is developed, supported and reinforced, it will slide. We need to engage in productive, careful and reflective moral conversations at a more sophisticated level, and the clinical setting is where that should occur.

TT: Graduate student training is another area in which I foresee some significant growth potential. We hope to have a clinical practicum in place by sometime next year, and we will be exploring the teaching of graduate seminars in the Philosophy Department, with some of their faculty working here.

What about your own research interests—what lies ahead?

TT: Personally I hope to continue to do many different kinds of research. I think the issue of confidentiality has been poorly analyzed in the literature and I'd like to look at that. I'm also interested in professional autonomy, especially with respect to the nurse's role and in particular their care of AIDS patients. The determination

and criteria of death is something I'm working on now, and I'll be looking at computer assisted instruction in medical ethics. It has a place in some settings such as MSU where there are no teaching hospitals. Its chief value will be in learning essential concepts and methods of reasoning.

LF: My personal interests continue to be at the public policy level. Ethical issues in hospital management and administration have had little attention to date--it's been mostly directed at the hands-on caregivers. But the reality is that the decision makers are more the managers than the doctors, and that means we need to look at the moral responsibilities of hospital managers. Generally speaking these positions have been filled by physicians with no formal education in management, and none in ethics of management. It is not appropriate to simply look at business ethics and try to apply those principles and methods of reasoning to hospital management decisions and problems.

We also will see an increased need for work in public policy and legislative issues pertaining to the provision of health care. This will certainly occur at the state level, and much discussion and teaching about these issues at the national level will also have to be done. Future physicians need to understand and engage in meaningful moral conversations about policy development.

Interviews with a physician and a nurse who came to MSU to pursue degrees related to medical ethics, and currently work as preceptors in the MHP taught course, HM 514: Focal Problems.

How did you select MSU as a place to study medical ethics?

Melanie McLeod, RN: I was working as a charge nurse in Seattle, Washington and kept seeing recurring ethical issues in patient care, medical decisions, nursing education and so forth. I'd wanted to study philosophy for ten years or so, but couldn't afford to go back to school. Finally the opportunity to combine the two fields was made available at MSU because of an assistantship in the MHP, and so I took advantage of the offer. MSU was the only place I'd heard of with a program in philosophy and medicine.

James Waun, MD: I was an anesthesiologist in Ludington, Michigan, and heard of Howard Brody through my casual contact with MSU. I visited MSU and the MHP here when I decided to pursue bioethics full time, and became aware of Martin Benjamin and Bruce Miller in the Philosophy Department at that time. I also visited the programs in Tennessee and Georgetown. MSU was, for my purposes, the most promising as it was affordable, and had a decent reputation among its own graduate students. It has no clinical dimension, but I've already got that.

Why did you give up a career in health care to return to graduate school for several years?

JW: I'd done anesthesiology full time long enough to satisfy me. I still practice a few days a month to pay the bills, but medical ethics is my primary focus. It's new, intriguing, and I took it as a new challenge.

MM: The issues raised in patient care that I saw were not able to be addressed satisfactorily, and I decided to learn the ethical part of medical ethics. That turned out to be bit of a surprise actually. I came here to study ethics in the Philosophy Department and found out you can't get a whole degree in medical ethics--you get your degree in something else and do elective and dissertation work in medical ethics. As I took other philosophy courses required for my degree, I became interested in the philosophy of mind a great deal. Now I'm thinking more of doing that than medical ethics.

What is your new career objective now that you have seen medical ethics from the inside, so to speak?

MM: It's strange. I came here to do medical ethics, but when I got here the program was not formally structured to lead to a degree as I'd imagined. In taking other courses I've moved away from medical ethics as my main focus. I am still interested in medical ethics and hope to continue following it, but not as my central intellectual endeavor. But it's still early for me and I'm not committed either way. I'm still glad I came here, even though I've been awakened to a lot of misconceptions I had before arriving.

JW: I intend to work with health care practitioners and organizations and not so much in academia. My primary goal is two-fold: to work as a consultant in trying to figure out options to problems with ethics in decision making in medical management, and also to work on educational programs for health care providers on approaches to understanding medical-ethical problems and developing options for managing them.

Dr. P. J. Scott, M.D., from Auckland, New Zealand is a visiting professor in the Medical Humanities Program winter term. Since 1980 Dr. Scott has been the Chief of Medicine at the Medical School in Auckland and will return there in September as professor in internal medicine, with special responsibilities in the medical education of medical students, interns and residents.

Dr. Scott, what brings you to the U.S.?

I am one of three people charged with submitting a report to the Cabinet in New Zealand on the country's hospital and related services in New Zealand. The medical care situation is quite different in New Zealand from what you have here, and I am hoping to find some helpful perspectives from which I can develop some useful suggestions to include in our report.

What are the major differences between our two countries in the way health care is provided to patients?

There are two main differences. In the U.S. you have traditionally had a fee-for-service approach to providing health care, whether it is paid by private insurance or the government, (Medicare/Medicaid). In New Zealand we have a more centrally funded government program as the chief source of payment with private practice as an ancillary program. We do have a fee-for-service element but it is not as prominent. Access to the New Zealand Health Service is via perceived need rather than via ability to pay. In addition, New Zealand has only recently seen the emergence of a poverty cycle among a subsection of our 3.3 million citizens, while the U.S. has always had a well recognized segment of its population at or below what you call, with varying definitions, a "poverty level".

The second big difference is in the method of patients gaining access to the health care system itself. In New Zealand we have

both general practitioners and specialists, but almost all of the specialists are based in hospitals. The GPs outnumber the specialists about 5 or 6 to 1 in most areas, but 10 to 1 in other areas. Much of the provision of health care services (and therefore expense) occurs within hospitals where only the specialists have admitting privileges. Some GPs do obstetric admissions and some emergency room work, but for the most part they serve as the principle gatekeepers to the system by controlling the patient referrals to the specialists.

How did you select MSU as a place to study medical education in the U.S.?

I am chiefly interested in how you make determinations concerning the allocation and distribution of health care resources, and in particular how you go about teaching the related concepts and principles to medical students. I have been aware of Dr. Brody's work for some time and also Dr. Fleck's many articles in the literature. At home we pay a great deal of attention to the literature from abroad. I also had a hunch that the midwestern part of the U.S. was beginning to grapple with health economics and the distribution of health care resources, perhaps a bit before the east or west coasts.

A second area of interest of mine is medical research. Historically, the changes in the way medical research has been conducted have occurred as a result of legal reasons only, rather than ethical reasons, and that is wrong.

Have you found MSU to your liking so far?

Oh yes. My wife is with me and she does counseling work, so we are both very interested in observing the way you conduct similar services here. The MHP staff and everyone else have made us feel welcome and we are most grateful for that. Most of the time I spend meeting people, observing, and doing some research. The issues of resource allocation, ethics, the doctor-patient relationship and so forth are issues that must be faced by anyone in medical education, and you have recognized that at MSU.

What sort of impressions or message do you hope to leave behind after your visit here is completed?

I think it would be that the doctor-patient relationship, as it is traditionally con-

ceived, must be modified by both parties. That will be more difficult to do in the U.S. where access to health care has been based on one's ability to pay rather than on perceived need, as it is in the British Commonwealth. It's a philosophic difference basically, and a large part of the reason has to do with the huge difference in size between the two systems. Nonetheless, there are two points I would like to make. First, that medicine cannot make these allocation decisions alone; that is, 'medicine' as traditionally conceived as only doctors and other professionals. Secondly, that the major duty of medical education is to seek better ways to insure there is an informed public debate on the issues of allocation and resource distribution. If democracy is to survive, this second point must be emphasized. Public television and radio are a good start but they are not enough.

What about after the public meetings and debates?

Beyond the public meetings there must be statutory public committees with professional facilitators to guide discussion. The facilitator should not have a vote, but should take the committee report to a health commission or some such body and then the health commission can act upon it in an informed way. Such concepts do not automatically lead to a Marxist ideology or structure by any means, though some people seem to be terrified of "community" involvement through government in relation to allocating and rationing health resources.

I want to emphasize that all doctors, but especially the medical students, interns and residents, must be trained to function in this new environment of social consciousness. If we are going to change the way health care is distributed among the population, in order to insure that we meet better the real needs that exist, we must marshal arguments to make this need for public debate appear as important for physicians to learn as, say, new concepts in pharmacology.

Literature Reviews

AIDS and the Law: A Guide for the Public, edited by Harlon L. Dalton, Scott Burris, and the Yale AIDS Law Project, Yale University Press (1987) 382 p. + xvii.

AIDS: Ethics and Public Policy, Christine Pierce and Donald VanDeVeer, Wadsworth Publishing (1988) 241 p. + x.

For most Americans the law is opaque, but mostly irrelevant to their daily lives. For health care professionals the law is opaque and vaguely threatening to large areas of their professional lives. The law is supposed to embody our intuitions of fair treatment, but its opacity frequently precipitates the impression of arbitrariness. This is especially problematic when the social problem needing legal adjudication is large, visible, multi-faceted, and threatening to deep social values, such as the AIDS problem. A most welcome response then is the volume AIDS and the Law: A Guide for the Public, which is a product of the Yale AIDS Law Project, edited by Harlon Dalton and Scott Burris. It is eminently clear, comprehensive, and practical.

The opening chapter by Burris is a superb introduction to the law for non-lawyers, which essentially lays out the logic behind our legal system. Dalton recognizes that AIDS is a unique phenomenon; but still, as chapter after chapter documents, the law already has in place a conceptual framework and principles, procedures, and precedents that will facilitate resolution of the legal issues raised. This is not to suggest that legal solutions will be easy or obvious. As Dalton notes, a basic assumption of the law is that we are all rational, self-interested beings. Law frequently appeals to the standard of the "reasonable person." But one of the troubling features of the AIDS problem is that it is largely rooted in deep, irrational fear. The hope offered by the law is that it provides a public forum in which such fears can be recognized rather than denied, and assessed rather than assailed through a rational process of challenge and response. Such a process will not extirpate the fear, need not legitimate it, but may allow for its constructive management.

I emphasize that this is a practical volume, but it does not offer pat predictions on how specific cases are likely to be decided in the future. In the chapter by Banks on "The Right to Medical Treatment" it is noted that private physicians may not have a legal duty to treat AIDS patients because the relationship is consensual, but anti-discrimination legislation may be used to assert a legal duty to treat. There are a lot of conceptual fine points that need to be sorted out, probably through the legal process itself. However, the law is clearer in requiring treatment by physicians who are employed by a hospital or HMO, at least once a patient has been accepted by the program or facility.

There are six large sections to the volume that cover medical background, government response to AIDS, private sector response to AIDS, AIDS and health care, AIDS and institutions, AIDS and special groups. A concluding point to bear in mind is that while much law exists that can effectively cover legal issues raised in each of these areas, new law can be made, and the quality of that law depends largely upon the moral commitments we wish to make as a society. As Dalton writes: "Like it or not, we must decide what kind of society we will be: mean-spirited, short-sighted, and judgmental; or compassionate, clearheaded, and accepting" (xiv).

For legal aficionados on the topic of AIDS I would recommend the special issue of Law, Medicine, and Health Care (Summer, 1987) on "AIDS, Law, and Policy." There is intense legislative activity regarding AIDS—over 800 bills were introduced into state legislatures during 1987. Gostin and Ziegler provide an excellent overview in their article of what is really a very diverse legislative effort. A major focus of much legal effort is protection of victims of AIDS against discrimination through appeal to anti-discrimination law already in place. But Wendy Parmet argues in her article "AIDS and the Limits of Discrimination Law" that this may not be the all-purpose strategy for which some hoped. Screening issues have received a lot of media attention and academic analysis. But there are other critical legal areas concerning AIDS that should have some public attention. One is the issue of whether criminal law ought to be invoked with respect to the transmission of AIDS, discussed here by Field and Sullivan. The other pertains to the liability concerns faced by drug companies that develop vaccines against AIDS. As things stand now, there are large legal obstacles that could frustrate bringing a potentially effective vaccine to market. These concerns are carefully discussed by Mariner and Gallo.

Finally, there is the very useful collection of essays AIDS: Ethics and Public Policy edited by Christine Pierce and Donald VanDeVeer (Wadsworth, 1987). Volumes like this are much needed to inform the public debate surrounding a broad variety of AIDS-related policy proposals. The introductory essay provides a fine overview of factual matters relating to AIDS, conceptual matters regarding AIDS and ethics, and substantive moral issues. The large moral and policy issue that is at the root of much debate is the extent to which society might restrict

the liberty of those infected with the AIDS virus on grounds of protecting the public health. Everyone recognizes that AIDS is a deadly disease, but the risk of being infected with the virus through casual non-sexual contact is utterly minuscule. To what extent then does the magnitude of the harm itself warrant serious restraint of individual liberty by the state when the actual risk of harm is so slight?

Excerpts from Devlin, Dworkin and Feinberg comprise part two of this volume and speak to the broad philosophic issues at the root of this policy debate. Part three is comprised of seven essays that address, from a moral point of view, a range of policy issues, including AIDS testing by the insurance industry and proposals for quarantining HIV-positive persons. Of these the clearest, most persuasive and most comprehensive is the article by Ken Howe, "Why Mandatory Screening for AIDS is a Very Bad Idea." He neatly presents moral, political, and economic arguments against mandatory screening. As important are the technical statistical arguments, which are usually incomprehensible to lay people, but which are here presented with exceptional grace and lucidity through a clever analogy.

The fourth part of this volume has several essays speaking to sexual autonomy and the constitution, and excerpts from the Bowers v. Hardwick decision of the U.S. Supreme Court, which upheld a Georgia law prohibiting sodomy between consenting adults in the privacy of one's home.

Leonard M. Fleck

Michigan's MERN to Meet

The recently formed Medical Ethics Resource Network (MERN) of Michigan will hold its first annual statewide meeting April 29-30 at Madonna College in Livonia, Michigan. The MERN meeting will be in conjunction with the annual meeting of the Midwest Region of the Society for Health and Human Values (SHHV). The theme of the joint meetings is "Institutional Ethics Committees: Education and Evaluation". Howard Brody, who is President of the MERN Council and President-Elect of the national SHHV, will serve as chairperson.

Program highlights of the two-day affair include presentations by a variety of nationally known figures in medical ethics including a keynote address by Jack Provonsha, M.D., Ph.D., Professor Emeritus, Loma Linda University School of Medicine. Also scheduled are workshops and paper sessions

conducted by Howard Brody, M.D., Ph.D. (MSU), Eugene Grochowski, M.D. (MSU, Kalamazoo Clinical Program), Anne Hargrove, Ph.D. (Western Illinois University), Drew Hinderer, Ph.D. (Saginaw Valley State University), Pat Lange, R.N. (V.A. Hospital, Detroit), Kevin O'Rourke, Ph.D. (St. Louis University), Eugene Perrin, M.D. (Wayne State University), Dennis Robbins, Ph.D.

(V.A. Hospital, Detroit), Mark Sheldon, Ph.D. (AMA, Chicago), Allen Verhey, Ph.D. (Hope College), Leonard Weber, Ph.D. (Mercy College of Detroit).

Program details and registration information is available through the MERN office, 1305 Abbott Road, East Lansing, MI 48823. (517) 337-1615.

MHP Calendar

Amway Grand Hotel
Grand Rapids, Michigan

March 24
Perinatal Health
Care Professionals

27th Annual Michigan Conf.
on Maternal and Perinatal
Health "Ethics at the
Intersection of Perinatal
Practice" **Len Fleck**

Zeeland Hospital
Zeeland, Michigan

April 4

"Current Issues in Medical
Ethics" **Howard Brody**

Clinton Memorial Hospital
St. Johns, Michigan

April 12

"Ethics and Do-Not-
Resuscitate Policy"
Howard Brody

VOLUME 10 NO 2

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Published by:
Medical Humanities Program
C-201 East Fee Hall
Michigan State University
East Lansing, MI 48824