



## A Talk with Dr. E. James Potchen

by Scot Yoder

*Center for Ethics & Humanities in the Life Sciences*

Dr. E. James Potchen received his B.S. from Michigan State University, his M.D. from Wayne State, his M.S. from MIT and his J.D. from University of Michigan. He worked as a general practitioner and held positions at Harvard, Washington University in St. Louis, MIT and Johns Hopkins before coming to MSU to chair the radiology department.

**MHR:** *How did you get to Michigan State?*

**JP:** Michigan State was trying to start a medical school. At that time I was at Johns Hopkins as Dean of Management Resources and I participated in a course put on by the AAMC which was attended by the leadership of the new medical school at MSU. On meeting with them I had a chance to appreciate the difference between Hopkins and Michigan State. MSU was teaching doctors to do what doctors do. They had studied what physicians do with time and developed a curriculum to teach young physicians to be better able to do whatever that was. In contrast, at Johns Hopkins the primary emphasis was on the study of disease. Most of the faculty there obtained their income from their ability to study a specific disease. Students often thought that what physicians do was study disease. This difference between Hopkins and Michigan State was so dramatic that I felt the need to try to participate in this exciting change in medical education. I had already opened up a walk-in clinic at Johns Hopkins where I would see general illness. Many physicians there were so specialized they were ill prepared to deal with the issue of generic sickness.

**MHR:** *Did Hopkins do anything in general practice?*

**JP:** That's a good question. There was no family practice and there still is none. It's all specialty medicine.

**MHR:** *So in some ways it is just the opposite of what we have at MSU.*

**JP:** Well, it's very different. I became convinced that if we didn't teach students to care for patients and use the knowledge that places like Hopkins were generating, then in the long term society was not going to support Hopkins. The economic value added by an institution like Hopkins is to develop useful information. If that isn't something which will be used then it isn't something which will be supported. The Johns Hopkins of the world need to be complemented with places like Michigan State. The curriculum here was heavily driven by what doctors needed to know to care for patients. The curriculum at Hopkins was heavily driven by what someone's specialty research is. Both are very important to society. Michigan State hired me as a consultant because they needed Radiology to be an accredited medical school. They had a radiology search

committee and six people turned them down. They didn't even have an x-ray machine. A radiology department without an x-ray machine isn't a radiology department. I came out here and met with the trustees and deans, and after a lengthy discussion I came to the conclusion that I would take the job, that it was really worth doing. In fact, if someone didn't do it we'd miss a real opportunity.

**MHR:** *Were you still a consultant at that point?*

**JP:** No, I became a candidate for the position of chair and was eventually hired by MSU.

**MHR:** *Tell me about the course at Lyman Briggs.*

**JP:** When I came here I wanted to continue to teach what I had been teaching at Hopkins -- Issues on the Human Side of Medicine. Coming here, one of my understandings with President Wharton, was that I would be able to do that. I still wanted to continue to teach undergraduate students because I get very stimulated by students. I love the stimulus of bright students, or any students. That nurtures me and I need it. I started a senior seminar course in Lyman Briggs. Here we've called it all kinds of things, but generally, *World View as Seen in Classical Literature* is the generic title. It has to do with how different people see the world. What is the human perspective on what it is to be human? In it I've taught all kinds of literature and philosophy -- Plato and Aristotle in contrast, Marx and Freud in contrast, Gandhi and Hitler. We look at how do different people view the world with the same evidence, because that's why people make decisions differently. Decisions are heavily based on who you are, not only on what your external stimulus tells you. It is important to know where you are coming from.

**MHR:** *Do you teach medical issues in it?*

**JP:** Well, every issue is medical, I mean, it's life. I don't separate the issues. Is smoking a medical issue or a social one? Are auto accidents a medical or social issue? What is the purpose of medicine? I use the World Health Organization definition -- it is to decrease that component of human misery caused by disease. Disease is defined as the individual's perceived inability to cope with their physical, psychological, or social environment. Once you put that paradigm in your head, you begin to ask questions. What are we trying to do? What is the purpose of radiology? What is the value added? You have to understand how other people value you in order to add value. It is their perception of value, not yours.

**MHR:** *You're not talking about value in the abstract, but the value to an individual at a particular time.*

**JP:** Exactly, that's where the decisions are made. The decision to purchase is made by somebody all the time. That's how transactions work. I study human choice.

**MHR:** *You've been doing this in a very interdisciplinary way. You've got background in medicine, business, law and philosophy. What do you see is the value added that you can not achieve through any one of those?*

**JP:** Let me complete the circle for you. At one time I was chairman of the LCME which accredited all the medical schools in the United States and Canada. We wanted to close a

medical school. They tried to sue us, and I got really mad at the legal profession. On that committee was Sandra O'Connor and she talked me into going to law school. I went to law school down in Ann Arbor, got a law degree and was admitted to the bar. The study of law was relatively easy after the other things I had studied since I looked at every one of these disciplines as the study of human choice.

**MHR:** *Is the theme human choice?*

**JP:** That's the unifying theme, they're all the same thing -- how human beings make decisions. Where do choices come from? In medicine, doctors make decisions for which they are paid all day long -- so do business people, so do lawyers, and so do judges and juries. These professionals are variations of the same phenomenon, "human decision making."

**MHR:** *When you teach medical students, do you teach them human choices as physicians or in a broader perspective?*

**JP:** In the broader perspective. Absolutely. That's the only way to do it. You have to have the database relative to medicine and know the implication of that database, but the database isn't the only consideration which drives the decision. Let's look at the subject of mammography. When we started attempts to improve the quality of mammography -- it was a travesty. There were storefront mammography installations and you couldn't read anything on the films. A lot of people here at Michigan State were really responsible for setting up a national paradigm of quality mammography, which has now become national standards. Initially we paid attention to the quality of the image. Now when you see a mammogram from two different institutions, they'll be of equivalent quality. But the image is only one part of the system. You start off with the need to get that image, but then the information from that image is going to flow through a physician's brain. He has to put a report out which will have an effect on the patient. The noise in the system now is not the image, the noise in the system is the behavior of the physician. We've done studies all over the world of the variations of professional performance. We have a new corporate venture in this department called Professional Assessment Services (PAS). We're setting up a national registry of the performance of professionals and how each individual varies in their false positive and false negative rate, their ambiguity levels. We are seeking how much value one person adds to a chest x-ray vs. another.

**MHR:** *You're measuring the human element.*

**JP:** Absolutely. We take the exact same set of 60 chest x-rays and show them in Texas and New Hampshire. We can tell the difference between institutions and areas between Tennessee and Ohio and how this differs from Cambridge, England. We have an international registry of how professionals respond to the same database. We give them the feedback -- we can tell each observer how they vary from the norm. For twenty-some years I've been studying how doctors make decisions. What factors on the film influence the decision? I used to think it had to do with the quality of the film, but that has relatively little to do with it. On a bad film a good doctor does a better job than a bad doctor does on the best of films. The noise in the system is heavily, heavily dependent on the personal behavior of the person making the decision. Some people can't make a decision. Other people are definitive and right. And this brings everything together. It's a philosophical type of inquiry. Where is quality? What is important? What is the purpose? Why are we here? These are very old questions. They're not novel, but maybe we can look at them

differently. And that's the fun of looking at them from a liberal arts point of view. All I want to do is share with students the tremendous excitement of continuing to learn. The human brain is not a vessel that gets filled up with knowledge. What we learn and teach is how to continue learning. That's what I enjoy doing.

**MHR:** *Your breadth of study shows that.*

**JP:** It's the fun of learning. If someone goes to college, or medical school, or law school, or business school and says I'm done with school now, they haven't learned. What you teach people is the excitement of inquiry and the thrill of recognizing what you don't know.



## The Thick and Thin of Interdisciplinary Work

by Judith Andre

*Center for Ethics & Humanities in the Life Sciences*

Philosophy and bioethics today, and many other fields as well, call for "thick" descriptions of cases, counter examples, or situations to replace the "thin" descriptions once common. At its best, interdisciplinary work provides the kind of fuller, richer understanding being sought. Yet there is a serious danger that it will accomplish just the opposite: superficiality rather than depth. I have two particular worries, one concerning scholars traditionally trained, the other about students in interdisciplinary degree programs.

My first worry arises from the difficulty of evaluating work in areas where one has little depth. As a philosopher doing bioethics, for instance, I often cite epidemiological studies. Last year I took just a few hours of an epidemiology course. That short exposure was chastening; I realized that I had been citing any published study as if it were both sound and conclusive though I had no way to distinguish good from bad. I've become a little more discriminating, but more importantly, I've become more cautious.

It is a caution I learned late and that others have not learned at all. Too often "findings" are seized and cited without attention to the work which yielded them. For instance, I recently reviewed a book on women's health written by a biologist. What counts as proof in biology is often inadequate in studies of human subjects; people differ enormously, and cannot be put in the kind of controlled environments that are ethical for laboratory rats. As a result, much larger numbers are needed in order for us to feel confident about the results. The biologist gave little evidence that she understood the criteria for good human studies: she simply relied on what others had chosen to publish and to cite. In ordinary life that is probably good enough. It is not good enough when those studies are the crucial premises in one's own argument.

Something analogous happens when non-philosophers use philosophical concepts. ("Autonomy" is the best example. This word is torn from its philosophical roots and used to mean "a right to do what one wants.") Sociologists, historians, theologians, literary scholars must all cringe when the rest of us appropriate and distort their concepts and findings.

My first worry about interdisciplinarity, then, applies to scholars working in fields for which they are not trained. My second concerns students in interdisciplinary programs -- can they get sufficient depth to be critical in *any* field? This concern is more serious at the graduate level than at the undergraduate. Undergraduate education is a preparation for adult life, for seeking meaning, for being a responsible parent, spouse, friend, and citizen. For these one needs knowledge, a habit of intellectual inquiry and skepticism, appreciation of one's own cultural heritage, and respect for that of others. These are not light things, but they are different from what is needed to *contribute* to art, philosophy, or science.

Graduate study, in contrast, at least at the doctoral level, is meant to prepare a student to work within a field, to help it grow and evolve. Learning to do so takes time; it demands learning not only a body of knowledge, and a set of concepts, but above all a method of inquiry. "Methods of inquiry" cannot just be set down in a rule book. They include all kinds of embodied and implicit

knowledge, habits of perception, ways of handling lab equipment, data, and texts. They are learned only by taking part in an activity for a long time. In an interdisciplinary program, by necessity, that time is lessened, probably cut in half. This makes it difficult to learn how to conduct serious inquiry within any one of the fields.

Master's level work may be a different matter, partly because it's not always clear what master's degrees are about. Sometimes they are preparation for doctoral study, sometimes they are meant simply to satisfy an intellectual need, sometimes they help people get raises or promotions. Often they do all or several of these things. One might argue that this ambiguity about the purpose of master's degrees provides a desirable openness, a space for exploration not shaped, as the doctorate is, by the needs of entrenched profession (e.g., laboratory research, the professorate). One might also argue that once a great deal of material has accumulated about a particular subject, mastering a lot of it necessarily contributes to intellectual sophistication. Clearly there is an advantage in balancing the claims of several fields, since specialization and isolation tend to allow each field to believe that it alone has the key to wisdom.

All of this is possible. I am less skeptical about interdisciplinary Master's programs than about such doctoral programs, and most skeptical -- in fact strongly opposed -- to anyone's pursuing interdisciplinarity through an entire academic program, from the baccalaureate through the Ph.D.

Interdisciplinary work, therefore, is indispensable for the "thick" descriptions so prized these days. But it can also lead to a thinness no one could praise. We need to be wary of the dangers even as we pursue the richness.



## Bioethics in Japan: At First Glance

by **Howard Brody**

*Center for Ethics & Humanities in the Life Sciences*

I had the privilege of spending three weeks in Japan last Fall as part of the exchange agreement between the MSU Department of Family Practice and the Department of Primary Care at the Kawasaki Medical School in Okayama. My principal hosts were some of the Japanese pioneers in family practice and primary care, a field which remains a small (but growing) movement within a medical system dominated by specialists. In my role as visiting primary care physician I spent time at the Kawasaki Medical School; the Saga Medical School in Kyushu; the University of Hokkaido at Sapporo; and the annual meeting of the Japanese Academy of Family Medicine in Tokyo.

My trip also allowed me a glimpse of the study of bioethics in Japan. Of some 14 presentations I made at various sites, some were almost exclusively about primary care, but most were about ethics to some extent. (The turnout for many of those talks was quite sparse, suggesting that health professionals in Japan still see little need to study ethics.) I was able to spend time with Tamayo Okamoto, who received her philosophy Ph.D. at MSU and now teaches in Hiroshima; Masashi Shirahama, MD, who developed a pioneering, case-based elective for medical students at Saga; Masayuki Obayashi, Ph.D., and his colleagues in the Department of Humanities of the University of Occupational and Environmental Health in Kitakyushu; and Akira Akabayashi, MD, Ph.D., who heads the bioethics program at the University of Tokyo. I also discovered one of the primary care faculty at Kawasaki, Chang-Duk Chang, MD, Ph.D., at work on empirical research on truth-telling and advance directives.

I feel extremely humble at offering any summaries or conclusions about bioethics in Japan. I received the impression that the Japanese culture is quite difficult for an American to understand. According to at least some analysts, dependency and social harmony play roles in determining Japanese behavior and social systems somewhat akin to the role which individual autonomy and individual rights play in the U.S. But I was also told that Japanese culture and medicine are rapidly evolving, and that impressions gained by a foreign visitor only a few years ago may already be out of date. At any rate, it seems impossible to understand a number of aspects of Japanese bioethics without understanding both the larger culture and the nature of the medical care system.

A few brief remarks about truthful disclosure of serious diagnoses may illustrate. It remains common in Japan for patients with cancer not to be told the exact diagnosis. Dr. Chang's pilot research among patients at his primary care clinic (aged 40 and above) showed perhaps half of respondents wanted to be told the complete truth if they later developed a serious illness, but a substantial minority (perhaps 20-25%) wished to be told only partial or elliptical "truths."

Dr. Shirahama offered the view that the short length of most Japanese medical encounters -- perhaps only 2-3 minutes on average -- strongly militates against any policy of truthful disclosure of diagnosis. When I spoke to a Japanese regional bioethics society at the University of Kyushu about physician-assisted suicide, I discovered during the question period that I had to

review carefully the definitions of euthanasia, assisted suicide, etc. to prevent serious misunderstandings. To a U.S. audience, "euthanasia" or "assisted suicide" almost always imply at least the goal of voluntary patient consent. But in a system where so many patients do not know their true diagnosis, there remains a very high likelihood that any act of euthanasia (and two major cases have attracted considerable attention in Japan since 1990) is undertaken without the patient's informed consent or even voluntary request.

Another debate that has attracted much scholarly attention is organ transplantation and brain death. Brain criteria for death have never been officially adopted in Japan, and it remains a potential criminal offense to remove a heart for transplant. This forces some Japanese to travel abroad in hopes of getting a life-saving transplant operation. Brain death, while somewhat controversial, has been fairly well accepted in the U.S., at least in part because our common-sense idea of death is something that occurs at a discrete point in time — one minute you're alive and the next minute you're dead. By contrast, according to traditional Japanese beliefs, death is more of a gradual process in which the soul of the dead person is presumed to remain in the vicinity of the body and survivors for a period of years after heartbeat ceases. In such a belief system, taking an organ from a still-oxygenated body has far different implications than in our own culture.

The Center for Ethics and Humanities is currently exploring the possibility of establishing a bilingual website for U.S. Japanese bioethics exchanges, especially around case studies. We hope that this will make MSU a continuing focus for better understanding of Japanese bioethics — and a better understanding of U.S. bioethics as well.





## Special Summer Programs

### **The Iowa State University Model Bioethics Institute at Michigan State University, May 13-17, 1997**

**Objectives:** The Institute is designed to help faculty in the life sciences learn basic methods, principles, and pedagogical strategies in bioethics. It will focus on issues such as the environment, hunger, animals, development, population, global survival, and agriculture. The workshop will provide hands-on sessions introducing case studies, classroom exercises, bibliographies, and other strategies used successfully to introduce ethics into life science classes.

**Participant Support:** Participants receive four lunches in addition to books and materials on ethics. Participants not from MSU receive \$250 as partial reimbursement toward expenses.

**Eligibility:** Tenured and tenure track life science faculty are eligible to apply. The deadline for applications is April 1, 1997, with preference given to those received by March 1.

**Time and place:** Michigan State University in East Lansing, MI. It convenes 7:30 p.m. Tuesday, May 13, and ends at 5 p.m. Saturday, May 17.

**Staff:** The project director is Dr. Gary Comstock, Coordinator of the Bioethics Program at Iowa State University. He will be joined by Dr. Fred Gifford, Philosophy Department, Michigan State, and other internationally recognized experts in bioethics.

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**MICHIGAN STATE**  
**UNIVERSITY**

### **Medical Ethics and History of Health Care, London, June 16 to July 25, 1997**

**Description:** The course will look at how the British National Health Service (NHS) functions and how it came to be what it is today. The NHS and the U.S. health care system will be compared and ethical issues that arise when the differences are assessed will be examined. Regular course lectures will be supplemented by a range of guest speakers who are involved in providing health services. Outside the classroom students will visit a number of hospitals, museums and institutes to take best advantage of London's resources.

**Eligibility:** There are no prerequisites for participation in the program. Enrollment deadline is March 14.

**Staff:** MSU Instructors for the course will be Howard Brody, M.D., Ph.D. and Stephen Rachman, Ph.D. Brody is a professor in the departments of Family Practice and Philosophy and is director of the Center for Ethics and Humanities in the Life Sciences. Rachman is a professor in the Department of English and an associate of both the Center and the American Studies Program.

**Cost:** The cost of the program is approximately \$2,270. This does not include tuition and fees, round-trip transportation to London, or meals or local transportation in London.

For more information contact:  
Office of Study Abroad  
109 International Center  
Michigan State University  
East Lansing, MI 48824-1035  
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**Medical Humanities Report Winter 1997**  
**Vol. 18, No. 2**



## Center News and Announcements

On February 4th **Howard Brody** was awarded the Distinguished Faculty Award at MSU. This award is given in recognition of outstanding contributions to the intellectual development of MSU.

In November **Leonard Fleck** spoke to the Lansing Rotary Club on "Genome Technology and Reproduction: Values and Public Policy."

In December **Leonard Fleck** led a workshop, "Shades of Gray: Ethical Issues in Providing Services to Older Persons with Mental Illness or Older Persons with Dementia," for the Tenth Annual Symposium on Geriatric Medicine in East Lansing.

**Leonard Fleck** presented "The Ethical Challenges of Managed Care" for the IPPSR Public Policy Forum Series in December.

**Judith Andre** is spending the spring as a Visiting Scholar at the MacLean Center for Clinical Medical Ethics at the University of Chicago.

At the Eastern Division American Philosophical Association **Judith Andre** participated in a panel on ethical issues in managed care. Her topic was the possibility of reconciling business ethics with medical ethics.

"Justice, Rights, and Alzheimer Disease Genetics," by **Leonard Fleck** will appear as a chapter in the forthcoming *Ethics, Genetics, and Alzheimer's Disease*, edited by Stephen Post, Johns Hopkins University Press (mid-1997).

**Leonard Fleck** presented "Just Caring and the Uninsured: Addressing Fairly the Uncompensated Care Problem in a Competitive Health Care System" to the annual meeting of the Massachusetts Hospital Association in January.

**Leonard Fleck** spoke on "Genetic Testing of Embryos, Fetuses, and Children: Emerging Ethical and Professional Challenges" for the Professional Standards Development, medical student section at MSU in January.

**Howard Brody** presented "Is There a Treatment for Cynicism?" for the Medicine Grand Rounds at Tampa General Hospital on February 6th.