



## Ethics and Equity: Current Challenges in International Health

by Paul Farmer, MD, PhD  
*Partners in Health and Harvard University*

*This lecture was presented as part of the 5th Andrew D. Hunt, MD, Lectureship to the College of Human Medicine, Michigan State University (Sept. 19, 2003). (Howard Brody, MD, PhD, provides the following synopsis of this lecture.)*

I'm happy to visit the College of Human Medicine for the first time and honor the singular vision of Andrew Hunt and the other founders of this medical school. I'll try to show how this vision matters for all of us today by using a specific example from the hospital and clinic where I work in central Haiti. But the issues this will bring up are broadly applicable, both around the world and here in the US.

These slides show a child with a swollen eyelid and face. She was brought to our clinic by a relative who looked to be about 20—like most of our patients, neither knew their exact age. You probably won't recognize this disease, so I'll tell you that it's anthrax—this is how most cases of anthrax present to our clinic. The 20-year-old relative told us, "I think we have anthrax." We immediately started simple antibiotics and could assure both of these women that they'd be cured. But the older woman told us that a man in their village had recently died of anthrax. We asked why this happened, since if he had come to our clinic, we could easily have treated him, too. She replied that he had not come because he did not have the money for public transportation. We calculated that the cost to bring him would have been about two dollars.

The people we treat live in a large squatters' settlement. They are displaced peasant farmers who used to work the land in a fertile valley. The valley was then flooded by a hydroelectric dam built with US funding. The peasant farmers lost their land, but they received no water and no electricity. They describe themselves as living in "indecent poverty" and can specify what that means. *Decent* poverty, for instance, is having a tin roof and a concrete floor; *indecent* poverty is a thatched roof and dirt floor (a mud floor when it rains).

I want to describe to you today how we went about treating AIDS in our clinic. AIDS is hugely prevalent in Haiti. I first went to Haiti as a medical anthropologist to study Haitian culture. I found that they taught me a great deal. I am now in their debt for what they taught me, and my drive to provide decent medical care in Haiti is partly to repay that debt.

When we began, the public health experts told us to do a community survey to ask people what they needed. After that, you proceed to do what the public health experts said was best. We thought that was wrong—if you do a survey you should pay attention to what the people say. So we asked the displaced peasant farmers and they said, "We need a hospital." So we did both. We did all the good public health things like immunizations and oral rehydration, and we also built a hospital, even though it took us 10 years.

The experts then said that it's not cost effective to use anti-retroviral drugs to treat AIDS in settings of great poverty. There is no infrastructure, and the drugs are way too expensive. All that's affordable and sustainable is preventive efforts. That, of course, means that people who already are infected will surely die.

The experts often do not realize how contradictory their own authoritative pronouncements are. In the same article you can read both that antiretroviral treatment programs won't work because there is so much stigma attached to AIDS, and also that the reason that AIDS is stigmatized is that there's no good treatment for it.

So we asked the Haitians again. We found out that the people at greatest risk already knew that AIDS was a sexually transmitted disease and what you needed to do to prevent it. When these things did not happen, it was due to two factors—gender inequality and poverty. So we decided that those issues had to be addressed head on.

We began a project we called the “HIV Equity Project” and for many years, the foundations and agencies that you would expect would fund such work gave us no money at all. Finally we got this project going by grafting it onto an existing project for community-based treatment of tuberculosis. We found that the “missing infrastructure” that the experts said doomed any treatment program consisted of community health workers. The tuberculosis program worked because a community worker saw each patient every day and saw that they took their medication. We found the same approach worked for antiretroviral drugs.

The prohibitive cost of these medications is not graven in stone on Mt. Sinai. When we started the program we had to pay \$10,000 a year per patient for a common 3-drug regimen. Now with generics we have seen the cost fall to \$300.

So when we added up the results we found that we had effective clinical outcomes, with reduced hospitalization and mortality rates. The stigma associated with AIDS has been lessened, which improves medical staff morale and increases interest in HIV testing and counseling—showing that treatment aids prevention rather than being in competition with prevention as the experts had said.

One of our very smart Haitian doctors was opposed to spending money doing expensive viral load blood tests (the US standard) on these patients. He suggested that instead we simply weigh them. The photos I'm showing you of typical AIDS patient before and after drug therapy illustrate the wisdom of his suggestion—we commonly saw people who looked as if they were dying gain 20 or 30 pounds in the first month of drug treatment. But we decided that the audience we were trying to convince is not Haiti, but rather the international scientific skeptics, so we shipped blood back to Boston and did viral load studies. We were able to show that our patients both gained weight and also had greatly reduced viral load.

There are a number of lessons from our experience. Modern medicine has wonderful tools. We do not yet have an equity plan—how to use these tools to reduce or eliminate the gaps in outcome between rich and poor. Every medical program needs an equity plan.

The poor are usually the real experts in what their problems are and what needs to be done. We should listen to them. They should not have to bear the burden of proof to document that what they need is “cost effective.”

We need a movement in the world today that includes the scientific experts, and the afflicted, and everyone in between to start to address these problems head on and to devote the necessary resources.

Paul Farmer is the author of *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2003).



## Clinicians' Fears, High-Risk Patients, & the Duty to Treat

Point —

Are There Moral Obligations to Treat SARS Patients?

by Leonard Fleck

Center for Ethics and Humanities in the Life Sciences

John Arras raised the moral question in the late 1980s as to whether the care of HIV+ patients was a responsibility of the medical profession *as a whole* or *each and every physician*.<sup>1</sup> He defended the latter view. That was a very divisive issue at the time because there were significant numbers of physicians who expressed the view that they had no moral obligation to care for HIV+ patients, given their perception of risk to their own lives. The salience of that issue has diminished substantially as we came to understand how limited the routes of transmission of HIV were, and how easily physicians could protect themselves. An HIV+ patient's sneeze does not pose a risk of HIV-infection to that physician. The issue that Arras raised became, after a time, "merely academic." However, the outbreak of severe acute respiratory syndrome (SARS) has made the issue salient again.

SARS is worrisome because it has many and easy routes of transmission. It has deadly consequences in 10-15% of cases. There is no cure for SARS. There are no quick diagnostic tests. Patients present with symptoms that mimic the flu, and they are infectious at that point in time. Finally, health professionals are disproportionately at risk of becoming infected. There were 182 cases of SARS in the Toronto area, and slightly less than half involved health professionals. Three of those health professionals died after exposure. These statistics would seem to justify the belief that SARS poses more of a threat to the lives of health professionals than HIV. Further, in one highly publicized case, nine health professionals seeking to intubate one SARS patient became infected with SARS, even though they were fully protected by gowns and masks that should not have allowed that to happen.<sup>2</sup> It was a difficult intubation with many infected airborne particles produced by the patient's coughing. There has been much speculation as to how that could have happened, but no scientific resolution. That leaves significant psychic space for fear and uncertainty. Suddenly Arras' question has become salient again.

I believe Arras gave the right answer to the question the first time, and I would affirm that answer again. That is, every physician has a *prima facie* moral obligation to provide needed care (within their range of competence) to SARS patients. To put it another way, no physician has a moral right to refuse to provide needed care to a patient infected with SARS, especially if the primary reason for their refusal is the fact that the patient is infected and is perceived as posing a risk to that physician. Further, it is morally irrelevant that there are other physicians available who are willing to provide that care. This last point can be clarified by means of an example. If a physician had as a policy his unwillingness to care for any members of some disfavored racial or ethnic group (because he just did not believe that "such people" were worthy recipients of his medical talent), we would condemn such behavior from a moral point of view. Moreover, it

would be morally irrelevant if he pleaded in his defense that plenty of other physicians would provide needed medical care for “them.” His actions are morally wrong as such because they are invidious acts of discrimination.

Now the SARS cases we imagine are not typically thought of as involving invidious discrimination, though this was likely part of the problem with HIV+ patients. Rather, two other considerations are invoked by some physicians as morally relevant reasons why they are not morally obligated as individuals to care for SARS patients....

One reason is that physicians are not morally obligated to assume unreasonable risks of death. Their fear is that they will become infected with SARS in caring for such patients with a fatal outcome for themselves. They point to the reported 10-15% death rate as being excessive or beyond the call of duty. The other morally relevant consideration that gets invoked is “professional liberty.” Some physicians contend that they have the right to choose who their patients are so long as they are not engaging in invidiously discriminatory practices. I find neither of these arguments especially persuasive.

To begin with, I do agree that there are excessive risks to life and well-being such that no physician could be reasonably regarded as having a duty to take that risk. That 10-15% risk looks like it might be in the vicinity of the unreasonable. However, that statistic is misleading for several reasons. First, health professionals infected with SARS have not died at that rate. Their risks might be in the 3-5% range (if that). Individuals with compromised immune systems are at much greater risk of death than individuals who are otherwise perfectly healthy and become infected. Second, if a physician is asked to care for a SARS patient, that physician is fully masked and gowned (and the patient will be masked as well, unless certain procedures are being done). So it is not as if there is a 3% risk of death from SARS among all health professionals who care for SARS patients. The vast majority of health professionals who take the requisite infection control measures will not become infected (and be put at some risk of death). Hence, the actual risk of death from caring for SARS patients (if called to service) is quite low, yet higher than the risk of becoming infected with HIV from caring for HIV+ patients.

Some might be tempted to say that they still see the risk as “too great for them.” The implication is that their personal judgment of excessive risk needs to be respected (morally speaking), but that conclusion is far from obvious. I concede that reasonable people could reasonably disagree as to whether the 10-15% risk of death is excessive, from a moral point of view. I will also concede that there is no perfectly objective moral standard of what risks of death are reasonable for a physician. However, there is a relative risk test that is useful and morally compelling, in my judgment. If a physician gets in his car every day and drives twenty miles in an urban area, there is a definable risk of death associated with that. If the risk of death involved in caring for a SARS patient is less than that, then a physician would have no moral basis for refusing to accept that risk.

Risk is part of the profession of medicine, as it is part of the work of the police, firefighters or soldiers. No one has any moral obligation to enter any of those social roles. If, however, they chose to enter public safety roles, then society has the legitimate moral expectation that they will accept the risk attached to those roles. In the case of medicine society at large has underwritten (i.e., through taxes) the bulk of the costs associated with medical training, as well as the very large costs associated with medical research. This gives physicians the powerful tools that allow them to be effective healers and to be rewarded with the social status and economic perks attached to successful medicine. Both the morale and efficiency of police and firefighters and soldiers (not to mention the confidence of the public) would be substantially undermined if individuals in these roles refused to perform their duties in the face of the normal range of risks associated with their roles (as opposed to occasional extraordinary risks, which may be justly

regarded as supererogatory for any individual). The same is certainly true in medicine, especially when the rewards to individuals are so much greater than in any of those other risk-bearing roles. I should also note in passing (as Arras has argued) that there is a justice argument to be made. In brief, as more individual physicians refuse to provide care for SARS patients, those physicians remaining to provide care face proportionally greater risks.

Some might be inclined to argue that physicians clearly have the right to choose their area of specialization; consequently, there is nothing morally objectionable about choosing areas of specialization that would permit physicians to avoid contact with SARS patients. This is true as a broad generalization, but will prove false in many predictable circumstances. The thought some may have is that SARS patients need to be cared for by physicians specializing in infectious disease. This is true. However, SARS patients may also have cancer or heart disease or broken bones or psychiatric problems; and these problems may well need that sort of specialized medical attention while they are infected with SARS. In reality, very few (if any) areas of medicine may provide safe haven (morally speaking) so far as SARS is concerned.

I next turn to the liberty argument. This argument is also off the mark in the real world. Physicians do have considerable moral liberty with respect to the patients who will make up their practice. However, SARS patients are not “out there” completely unattached to a primary care physician. Many of them will have a primary care physician when they suddenly find that they are infected with SARS. Does a physician then have the morally permissible liberty right to refuse to provide care for that patient when that needed care is within the scope of their practice? What precisely would be the morally relevant considerations that would warrant patient abandonment at that point? None are obvious to me.

Finally, it must be emphasized that physicians themselves are not the health professionals who are most at risk of becoming infected with SARS. Those are nurses and other personnel who spend much more time in direct contact with these patients. It is morally discomfoting that physicians who assert these strong liberty rights for themselves are not equally vocal in asserting the same liberty rights for nurses and other health professionals who have more extensive and direct responsibilities for these patients. That has all the appearance of generals sending the troops to war from the safety of a distant and secure undisclosed location.

I have asserted that each and every physician has a presumptive moral obligation to care for SARS patients should they be confronted with such a patient having a medical need in their scope of practice. This is a general rule that, of course, has reasonable exceptions. Physicians who are themselves significantly immuno-compromised may have a legitimate excuse for being exempted from such care because the real risks to them are so much greater, maybe even unreasonable. Lacking such excuses, physicians have no moral right to pretend to be generals.

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## Clinicians' Fears, High-Risk Patients, & the Duty to Treat

**Counterpoint—  
Caring for High-Risk Patients: A Duty or a Virtue?**

**by Tom Tomlinson**  
*Center for Ethics and Humanities in the Life Sciences*

The emergence this year of severe acute respiratory syndrome (SARS) has raised a number of medical and scientific questions about its cause, about its proper diagnosis and treatment, and about effective methods to limit its spread. With its high rate of infection among health care workers, it has also resurrected an old ethical question: Do physicians and other health professionals have a duty to provide clinical care to patients with deadly infectious diseases, even at some risk to themselves and the others they might in turn infect, such as their families?

This was a lively controversy fifteen years ago, when the AIDS epidemic was similarly a cause of medical uncertainties and professional anxieties. At the time, the American Medical Association took the position that physicians may not ethically refuse to provide care within their area of competence to a patient merely because the patient is infected with HIV. An editorial in the June 4, 2003 issue of *JAMA* has taken the same position with respect to SARS, asserting that physicians and nurses have an “obligation” and a strong “duty” to treat these patients, even at some risk to themselves.<sup>1</sup>

Fifteen years ago I was not entirely persuaded. Many refusals to care for HIV patients were morally wrong, even reprehensible. But this was because they were so often motivated by prejudice, not simply fear. It was not the duty to take chances that was violated, but the duty not to be hateful. At least when it comes to the duty to take chances, I’m still skeptical. I think that the language of “duty” and “obligation” is the wrong ethical language to use. I want to suggest instead a different way of understanding the ethics of caring for risky patients.

A “duty” identifies a minimal ethical standard, which as such is incumbent on everyone (either as persons, or as occupants of a role). Persons who fail in their duties (absent acceptable excuses) are subject to moral censure; those who perform their duties, having only done what they must, are deserving of no special praise.

Why should we think that caring for SARS patients is a “duty” of this sort? There are a couple of arguments typically given. Perhaps the most common of these arguments points to the special privileges (e.g., of license monopoly, social status, income, tax support for professional training) that society bestows on health professionals, physicians especially. In return, society rightfully expects that those of its members who are ill will receive the care they need (well, at least if they can pay for it). The problem with the argument is that the terms of the contract do not require that each and every professional be ready to provide care to any patient who might come before them. Medicine’s end of the bargain is kept so long as there are enough physicians willing to provide care so that the needs of SARS patients are met. Here someone might argue

that the only way to make that happen is to threaten the fearful with moral censure, a threat that a moral duty of care makes possible. But more on this in a moment.

Another argument refers to the defining values of the profession. One cannot profess to be a doctor without making a commitment to caring for the sick; avoiding SARS patients is therefore a basic betrayal of professional identity. The problem with this argument is that those who avoid SARS patients have not stopped their practice of medicine. They are still caring for lots of sick people, just not people sick with SARS. Of course, there may be some specialties or practice settings for which it is a defining commitment to care for these patients. A general pediatrician who avoids SARS patients is one thing; an infectious disease specialist who does so is quite another.

Sometimes these two arguments are encapsulated in an analogy between the practice of medicine and other risky professions. A physician is like a firefighter. We do not think firefighters can excuse themselves from getting on the truck when the alarm sounds, or from entering a burning building to search for those trapped inside. Such behavior imperils the success of the mission which fire departments are created to serve. You cannot be a firefighter if you cannot serve the mission; and you cannot serve the mission unless you are prepared to take substantial risks. But the analogy proves too little. It imposes a duty on physicians to take risks only when their failure to do so imperils the mission (e.g., endangers patient care). But since there are plenty of circumstances in which a particular physician's avoidance of particular SARS patients would not imperil the mission, the duty implied by the analogy is not a minimal duty borne equally by all.

Each argument fails in a fundamental way. At most, they show that some physicians, under some circumstances, have a duty to provide care to patients with serious infectious diseases. This falls far short of establishing a minimal duty incumbent on every physician.

If we cannot say that caring for these patients is a basic duty, it does not mean we can say nothing. For now we can say something different: providing care for patients with SARS is a very good and selfless thing, which exemplifies the highest ideals of the profession. Some physicians, perhaps many, will fall short of this ideal, not being able to master their fear, for themselves and for their families. For that they should not be condemned—which is what the language of duty demands—but helped to rise to the occasion. That is best done by example. Those who endanger themselves for their patients should be held up as heroes, for example, the physician and two nurses in Toronto who have died of likely occupational exposure to SARS. Since they were not merely dutiful, we can celebrate and praise them, and in so doing inspire a response from others who will provide the care that SARS patients very much deserve.

At this juncture, those who insist that there is a basic duty to take chances will agree it has its limits. There comes a point where the risk becomes too great, and those who take it anyway have indeed gone above and beyond the call of duty. Where is that point? Perhaps the most common way of defining it is by reference to the background level of risk that physicians typically assume in their normal practice, or in their everyday lives. If the risk of caring for a SARS patient is comparable to the background risk that one assumes with other patients, then one cannot justify treating the SARS patient any differently.

There are two problems with this reasoning. The first is that it appears to concede by definition that it is not a duty, but an act of courage, to care for patients with SARS or other diseases whose lethality and infectivity are higher than “average,” especially in the early stages of the emergence of diseases, when little may be known about their risk profiles. This is a concession I am happy to accept. The other problem is that such an argument assumes there is a duty to take chances for patients, it does not prove it. When it comes to my duties, I am required to be consistent. If I think I have an obligation to take chances for the sake of Mrs. Smith, and

Mr. Jones poses exactly the same risks as she, then absent some special moral consideration, I have the same obligation to him. By contrast, I do not have to be consistent in the pursuit of ideals that lie beyond duty. My selfless and courageous care for Mrs. Smith does not bind me to do the same for Mr. Jones. I may be disappointed in myself for my weakness, but I cannot be required by others to be courageous at all times. Sainthood is always optional.

There is, then, no basic duty to take chances in the care of risky patients. This does not mean that decisions not to care for such patients are always beyond moral criticism, since particular decisions might violate other duties to patients or to colleagues. Nevertheless, when we speak of the ethics of caring for risky patients we should prefer the language of moral celebration over the language of moral censure.

#### **REFERENCES**

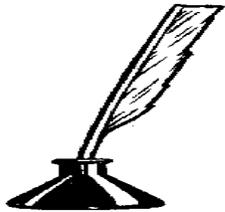
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## Editor's Note

Readers of the MHR will note we've made changes to our printed format. In order to bring our readers a broader discussion of topics in medical humanities and bioethics, we're trying a new strategy: printed copies of the MHR will provide an overview and introduction to numerous articles, with full texts available at our new website at <http://bioethics.msu.edu>.

We are also introducing a series of semi-regular columns on various themes in bioethics and the medical humanities. The first of these highlights work of MSU students in these disciplines. Finally, the MHR continues to welcome your feedback: your responses to what you've read here, suggestions for future topics, as well as your own contributions!



**InkLinks** is a regular column in which readers reflect on issues related to the lead article. In this issue of MHR, the lead article provides an overview of this year's Hunt Lectureship. InkLinks contains reminiscences about the man behind those ideals. All are written by men who worked with Andy Hunt in the turbulent, exhilarating years when CHM was born.

**Andrew Hunt, MD, Founding Dean of the College of Human Medicine**

## **An Eastern Patrician in the Rough and Tumble Midwest**

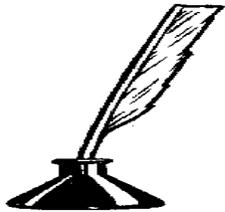
**Art Kohrman, MD**  
*Northwestern University*

Andrew Dixon Hunt, Jr., was an unlikely candidate for the task he accepted. An Easterner with patrician credentials and a stint at Stanford, he came to lead a medical school born of a classic Midwestern knock-down-drag-out political battle, this one involving the state legislature and the very powerful University of Michigan. Those who brought Andy here had detected his tenacity and strategic sense. They put him in charge of realizing their vision: a medical school to serve the citizens of Michigan, one that fit MSU's land-grant mission.

In fact, Andy was well matched to the job: a good listener and perceptive questioner with an apparently inexhaustible ability to take part in meetings. The venues were countless—political, fiscal, academic, and community—and took place all around the state. Open as he was, however, he did not accept pettiness or unthinking traditionalism.

Hunt recruited faculty and administrators to MSU's College of Human Medicine (CHM) by testing their vision, not just their credentials (although many were extremely well-credentialed.) Once recruited, faculty were encouraged to find new ways in medical education, with the assistance of the newly created Office of Medical Education. A string of initiatives followed: the Doctor-Patient relationship sequence, the development of community campuses, Focal Problems, Track II and many others. Less well documented, but essential to the evolution of CHM as we know it, was Andy's insistence on diversifying the student body long before "diversity" was common jargon. Today's Ethics and Humanities program is a tangible result of Andy's initial commitment to relate CHM to the larger university community.

I could go on and on, citing the many critical junctures where Andy's support of unorthodox initiatives made all the difference. Of all his characteristics, the most important for me was his understanding that innovation by faculty and students requires vision and support from above. MSU's College of Human Medicine under Andy's leadership was a wonderful first job; what a great model and friend Andy has been over the years.



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## The Initial Vision

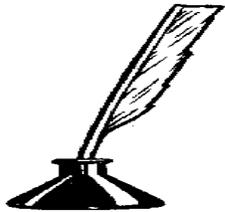
**William Weil, MD**

*Pediatrics and Human Development*

Andrew Hunt came to Michigan State University in 1964 on invitation from President Hannah to start a new two-year medical school. Andy's background with the role that behavioral scientists played at the Children's Hospital of Philadelphia (where he trained), his experience at the experimental Hunterdon program in New Jersey, and his role in revising the ambulatory care programs at Stanford were all instrumental in his approach to the proposed school at MSU. Andy was interested in a school that would be non-traditional and would focus as much on the social/behavioral aspects of medicine as much as on the biological/clinical ones. To emphasize the continuum from undergraduate to professional education, he incorporated the final year of undergraduate education into the two basic years of medical training. Thus the two-year program actually was three years: years 4, 5, and 6. Although the plan was to admit students after three years of undergraduate experience, most of the applicants had already completed their Bachelor's degrees when they enrolled. This allowed an opportunity to create some innovative courses and increased time for independent study or research.

The concept was that the curriculum would have human development as a focus and would begin with the newborn and progress to geriatrics. Although this did not work out quite as planned, the concept provided the impetus for many innovations and for a very different focus on the preclinical years than was true in the more traditional schools. Initially this led to pass/fail grades and no National Board exams; Focal Problems and the creation of "Track 2"—the opportunity to choose small group, problem-based learning—soon followed.

Clinical activity by the faculty was limited so that their educational activities could be paramount. Thus the early years of the school were marked by innovation and close faculty-student relationships—values of Andrew Hunt's that shaped CHM for years to come.



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**Andrew Hunt, MD, Founding Dean of the College of Human Medicine**

## **In the Midst of the Crossfire, Protecting His Faculty**

**James G. Lyon, MSW, MPH**

*Office of Medical Education and Research*

As a member of the Dean's staff for 30 years, I think back to what CHM was like in 1969, the year I joined the faculty. On campus it was "tent city," mostly filled with protestors against the Vietnam War. There were also ongoing civil rights demonstrations and other social protests. At the national level, the need for reform in medical education had been recognized and new medical schools were being established to meet the challenge. Within this context Dean Andrew D. Hunt had recruited a remarkably talented and focused group of chairs and faculty, passionate about the need for change in the way medicine was taught. They were committed to more humane patient care, to a curriculum that included the behavioral and social sciences and to a medical education more responsive to societal needs. I think back on the many college retreats that were held on how to integrate psychosocial content, on new ways of approaching the basic sciences, on how to involve community physicians and hospitals. The CHM culture was taking root, led with courage by our visionary founding dean.

Generally, people resist change. Reform in medical education was no exception. The leaders of traditional medical schools were skeptical of the new approaches. Andy thought many of the old schools were elitist, and he fought their influence over the Liaison Committee on Medical Education (LCME), the accrediting body for medical schools. He withstood its buffeting while allowing his reform-minded faculty to move forward. Andy bore the brunt of criticism from a few basic scientists who viewed him as anti-research, a charge that rose from his emphasis on the art of medicine and, probably, the way the college budget was allocated. Undaunted yet anguished, he led CHM into national recognition for medical education reform.

Andy's portrait in the Life Sciences Building reveals a stern and dedicated leader and reformer. It captures the man, but his image in the medical humanities may be even larger. As the first director of the program that is now known as the Center for Ethics and Humanities in the Life Sciences, Andy brought the same passion and zeal that he had brought to reform in medical education. Today he would be reveling in debate about the ethics and wonders of molecular medicine, and about what students need to learn to practice medicine twenty years from now.



## Center News & Announcements

Congratulations to **Howard Brody**, who has been named University Distinguished Professor. This award, for recognition of faculty achievements in teaching, research, and public service, is among the highest honors that can be bestowed on a faculty member by the university.

**Len Fleck** chaired and served as a panelist for a session titled “Behavioral Genetics and Public Policy: Do We Need Revisions? Should the Public Have a Role?” at the joint meeting of the American Society of Bioethics and Humanities and the Canadian Bioethics Society in Montreal, Quebec, Canada (Oct. 23-26, 2003).

**Judy Andre** is spending the year in Toronto, Canada, as a Visiting Scholar at the University of Toronto’s Joint Centre for Bioethics. Many people at the Centre, and in the Public Health Sciences department, are working on issues of global public health, which is part of her research focus for the year.

**Linda Hunt** and **Tom Tomlinson** have received an MSU Intramural Research Grant of \$34,949 for a project entitled “Family and health professional perceptions of PVS patients.” The goal is to better understand the conceptual, ethical and cultural sources of disagreement about the level of awareness and responsiveness of patients in persistent vegetative state. The project starts in September 2004.

At the 2003 American Anthropological Association meetings in Chicago, **Libby Bogdan-Lovis** co-organized a double session, “Gift Horse or Trojan Horse?: Evidence-based Practice Transforming Medicine.” As part of that session she presented “Negotiating Power Relationships: Certified Nurse-Midwives Reliance on Evidence-based Practice” (Nov. 2003).

**Clayton Thomason** presented a paper entitled “Religion and Spirituality in Medical Education” as part of the ASBH/CBS Meeting, Montreal, Quebec, Canada (Oct. 25, 2003).