



## Just Caring: Health Care Rationing and the Medically Least Well Off

by Leonard Fleck

What does a just and caring society owe in the way of meeting health needs to those who are medically least well off? One answer that might be given is that we owe them anything and everything that might yield medical benefit for them simply because *they are the medically least well off*. How, the argument goes, can anyone with a shred of decency or compassion not be responsive to the needs of those who are suffering greatly and/ or are faced with the risk of death in the near future? Think of the victims of Hurricane Katrina. Many of them have literally lost everything but the clothes on their back. Can we imagine anyone having a serious moral discussion about whether or not we (the fortunate many) really had a moral obligation to come to the rescue of these individuals and provide them with food and shelter and health care and other basic life necessities? However, I will argue in this essay that the analogy with the victims of Hurricane Katrina is an inapt moral analogy that very badly skews our moral judgment with respect to our moral obligations to the medically least well off. More generally, I will argue that we do have justice-based obligations to meet some of the health needs of some of the medically least well off. But the medically least well off as a generic class do not have automatic top priority for having their health needs met, most especially in a world with only limited resources for meeting virtually unlimited health needs.

The cost of undoing the damage done by Katrina is currently estimated to be more than \$200 billion. This is the most expensive natural disaster the US has ever experienced. Given an \$11 trillion economy, these are costs that are manageable and that we are morally obligated to meet. A major morally relevant consideration is that we can effectively undo most of the harm that victims of Katrina have endured. Also morally relevant is the fact that this is an extraordinarily rare sort of event. If we were faced with one hundred of these disasters every year, then we would be faced with the impossible task of generating \$20 trillion worth of aid out of an \$11 trillion economy. In the matter of meeting the health needs of the medically least well off we are closer to this latter state of affairs rather than the former.

Who are the medically least well off? There is no simple answer to this question. They represent an extremely heterogeneous group of patients, both in terms of medical conditions and medical prospects. We might say that individuals faced with a terminal outcome in the next few weeks or months are surely among the medically least well off, and we might also say the same of those whose quality of life has been severely diminished by disease or accident, i.e., someone who has suffered a major stroke with permanent cognitive and physical disabilities. This, however, is precisely where our moral problem begins. Is the point of putting all these patients under the single rubric of the “medically least well off” that they are *equally* entitled to anything and everything in the way of medical resources that might yield anything at all in the way of benefit? Is this what a just health care policy would require of our society?

Imagine two patients who both go into total kidney failure. Both are faced with imminent death in two weeks if nothing is done. One patient is 45 years old and can easily live an additional fifteen years with renal dialysis at a cost of \$54K per year. The other patient is 86 years old and in the advanced stages of Alzheimer disease with a probable life expectancy of two years on dialysis. Does justice require that we provide both individuals with dialysis because they are both among the “medically least well off”? This, I argue, is one point at which the analogy with the victims of Katrina breaks down. Providing needed aid to the victims of Katrina will remove virtually all of them from the category of those who are “least well off.” That is, the aid will be effective; and this is a matter of substantial moral significance. Dialysis will also have this effect in the case of the 45-year old patient but it will not in the case of the Alzheimer patient. So I conclude that it would be morally permissible (not unjust) to deny dialysis to the Alzheimer patient, even though dialysis represents two extra years of life for that patient.

My critic might argue that there is a Duty to Rescue (even at great cost) that should govern our behavior in the case of Katrina, and the same duty applies to those who are medically least well off. However, what makes that Duty to Rescue a feasible and actual moral obligation in practice is that such costly rescue events are rare occurrences for a tiny portion of our population who, if the rescue effort is successful, go on to live well the rest of their lives. But if this same Duty to Rescue is applied without qualification to health care, then virtually our entire population will be in need of medical rescue at one time or another given our advanced life-sustaining medical technology (and frequently medical rescue will be necessary multiple times for individuals who are afflicted with several chronically degenerative medical conditions). Further, unlike the whole lives that will be restored in New Orleans the lives “rescued” through medicine today are very often extremely attenuated lives both in terms of length and quality. For example, how morally proud ought we feel about “rescuing” Terri Schiavo from death for fourteen years at a cost of \$100,000 per year?

Further still, many of our very costly medical rescue efforts have a very low probability of actually “making a difference” in terms of medical outcomes, and as a consequence, it is becoming more common to spend more than a million dollars per life-year saved. (See the discussion below of Implantable Cardiac Defibrillators [ICDs].) If we had infinite financial resources, then this discussion would have no point. But the fact is that our financial resources are limited. We cannot afford to “rescue” all the life-years that in principle our advanced medical technologies would allow us to rescue. Hence, we have to make choices among lives to be saved, most especially the lives of those who are medically least well off and medically most costly. And we must do this in accord with shared understandings of health care justice

In 2004 we spent about \$1.8 trillion on health care in the US, about 15.3 % of our GDP, compared to 5.2% in 1960. Enormous advances in medical technology in virtually every area of medicine have been the primary cause of these cost increases. Many of these advances are very expensive at both the individual level and in the aggregate. If there were a medical intervention that cost \$1 million and only ten patients per year needed that intervention, we could not plead poverty as a reason for denying that intervention to those individuals. But bypass surgery costs about \$65K and we did about 500,000 of these procedures in 2004. That represents a cost of more than \$30 billion per year. We also did more than a million angioplasty procedures at a cost of about \$35K each, which yields an aggregate cost of more than \$35 billion per year. If each of these interventions represented five to ten extra years of life that were gained for these individuals, that would be a strong morally relevant consideration in support of these costly interventions. But all we know for certain is that these interventions improve the quality of life for these individuals. There may be no more than a very marginal gain in life expectancy for the vast majority of these patients.

I do not believe that the above cardiac patients should be thought of as being among the medically least well off. Here are some other candidates that illustrate the moral concerns I have. Patients in the end-stages of COPD now have the option of lung reduction surgery. This surgery has costs of about \$70K and represents a potential extra year of life. We could do 200,000 of these procedures per year. Is a just and caring society morally obligated to provide that? Likewise, patients in end-stage heart failure now have the option of the left ventricular assist device [LVAD] at a cost of about \$180K for an extra year of life, maybe slightly more. We could do 200,000 of these procedures as well per year. Is a just and caring society morally obligated to provide that? These are interventions for individuals who are very near to death's door. They certainly look like candidates for inclusion among the "medically least well off." Still, I do not believe that is sufficient to generate just claims to the expensive, marginally beneficial health interventions they need.

What about individuals who are at risk of sudden death from a cardiac arrhythmia because of flaws that had developed in the electrophysiology of the heart as a result of medical insults of some kind? An Implantable Cardiac Defibrillator [ICD] can prevent that sudden death at a cost of about \$40K each. We will implant 200,000 of these devices in the US this year. In the next four years we could be implanting as many as 600,000 per year. The problem is, according to a recent article in the *Annals of Internal Medicine* ( 4/19/05) that we ought only be doing about 50,000 per year. These are the patients who are *most likely* to be saved by this device from an otherwise fatal arrhythmia. At the 600,000 level the vast majority of those individuals will die of something other than a fatal arrhythmia. That is, the device will have done no good at all, which is why at that level the cost per life-year saved is about \$1.4 million. At that level total social costs for this device are about \$24 billion, as opposed to \$2 billion at the 50,000 level. If we funded ICDs only at that lower level, some relatively small number of lives would be lost for lack of that device. But such a loss, I claim, would be unfortunate, not unjust. Again, if we had unlimited resources for meeting unlimited health needs, there would be no point to this essay.

All of the above types of cases represent individuals who might be thought of as being among the "medically least well off." But, for moral purposes, they are not at all like the victims of Katrina who are "least well off." By way of contrast, imagine a 25-year old in a terrible automobile accident left as a vent-dependent quadriplegic. The cost of giving him his next year of life will be about \$1.4 million. The cost of his next 24 years will be about one million dollars. I contend that individuals like this are clearly among the medically least well off, that they have a strong just claim to \$2.4 million worth of care, and that they "fit" the Katrina victim analogy because we have the capacity to restore them to a life they will find worth living. Likewise, imagine individuals who have the most severe and crippling forms of arthritis such that their quality of life would be at the .2 level. Imagine a drug that costs \$500 per month that can increase their quality of life to the .8 level. I contend that from the perspective of health care justice we ought to fund such a drug for twelve individuals with severe arthritis before we would buy an extra year of life through lung reduction surgery for the individual with end-stage COPD. My assumption is that we are only adding to the quality of life for these individuals with arthritis, not prolonging their lives at all. My point is that we must make distinctions among the just claims to needed health care for those who are properly thought of as being among the medically least well off.

Consider individuals who are HIV+ whose immune systems have been substantially compromised. They will be faced with the end-stages of AIDS unless they have access to protease inhibitors at a cost of \$20K per person per year. Roughly 700,000 US citizens are on these drugs now at a cost of about \$14 billion. HIV will mutate around these drugs after several years and require the use of fusion inhibitors, thereby boosting per person per year drug costs to

about \$35K. High quality extra years of life are thereby gained. It can be argued that these patients are not among the medically least well off, though end-stage AIDS patients would be. Nevertheless, it is not unreasonable to assert that these HIV+ patients in relatively better health have a stronger just claim to limited health resources that will prevent them from progressing to end-stage AIDS than those who are already there who might require \$100K worth of care to eke out one extra year of life. In other words, a just and caring and prudent society can rightly choose to invest more resources in prolonging length and quality of life in relatively earlier stages of a degenerative disease process by taking resources away from very costly, merely marginally beneficial life-prolongation interventions in the end-stages of such disease processes *even though such individuals are correctly thought of as being among the medically least well off.*

I cannot offer in this brief essay the somewhat complex mix of arguments that would provide good reasons that would justify my more controversial claims. What I have tried to show through well-chosen examples is that individuals who are among the medically least well off do not have unlimited just claims to all the medical resources they might need to sustain their lives. Some “quality of life” health needs justly trump “prolonging lives” health needs. I have also tried to show that, among the medically least well off, the just claims to life-prolonging health care are highly differentiated. Some such needs deserve the highest level of priority in the entire universe of health needs while others deserve the lowest priority. That such needs are attached to individuals who are “medically least well off” provides little in the way of morally relevant information for making sound priority judgments.

Finally, as I have argued in many of my essays, this whole discussion is about health care rationing. Often there are no dominant moral arguments that make perfectly clear what is the “most just” rationing choice we ought to make. Under such circumstances we need to appeal to careful processes of rational democratic deliberation aimed at legitimating specific rationing protocols and priorities in specific concrete circumstances. Such conversations should generally occur when we are in essentially good health, when we are generally ignorant of our own future health needs, and when we know that we are likely at some point in the future to be among the medically least well off without knowing the precise details of that future medically impaired version of ourselves. The goal of such public conversation is to achieve fair enough and reasonable enough agreement regarding rationing decisions for our future possible selves, given that we have only limited resources for meeting virtually limitless health needs. That we are making such choices for our own future possible selves minimizes the risk that we would endorse invidiously discriminatory choices against persons with disabilities.



## Creating a Black Agenda in Bioethics

by Faith E. Fletcher

While studying abroad in South Africa this past summer, I received an email from Dr. Vanessa Gamble, director of the Tuskegee University National Center for Bioethics in Research and Health Care inviting me to attend a small, interactive conference at Tuskegee University from June 17<sup>th</sup> – 19<sup>th</sup>, 2005. The conference was titled “Creating a Black Agenda in Bioethics” and its objectives were strengthening the network of Black bioethicists and beginning to craft a concrete action plan advancing bioethical issues in the Black community. Questions to be addressed included: What are the current topics and areas that Black bioethicists are tackling? What are we missing? How do Black bioethicists become more visible in the multiple discussions and activities around bioethics that are relative to the Black community? How do we nurture and support Black bioethicists and their work? Where do we go from here?

As a graduate student studying bioethics I was honored to be invited to an invitation-only bioethics conference. Returning to Tuskegee University, my alma mater, as a conference participant was an overwhelming experience. When I arrived, I noticed that there were only forty participants and only three were students. This conference was much smaller than other conferences that I have attended.

The first night began with a mixer to help everyone get to know each other better. Conference participants introduced themselves by saying something that was unique about themselves and by explaining their interest in bioethics. As I listened to everyone’s stories, I realized that bioethics was more than an academic endeavor for them; it was their passion. Everyone had their own story that brought them to the field of bioethics and ultimately brought us together at that special moment in time to share those stories. Although my story wasn’t as defined as others, it still had significance. One participant commented, “There’s a sort of kinship you develop as a reader with the author and there’s just an aura you get from being in the midst of those people. To put faces with the words is overwhelming.” As she made that statement I looked over to the tables of Gamble, Dorothy Roberts, Dr. Annette Dula, and Dr. Charmaine Royal (whose work I had read and cited on numerous occasions) and I was finally able to put their words with their faces. Moreover, being among my former professors and mentors—people who were instrumental in introducing me to the field of bioethics—was a privilege.

As a sophomore undergraduate student at Tuskegee University I enrolled in a Philosophy and the Law course. At the end of the semester, I was required to select a philosopher who had written a piece that combined philosophy and law and to critically analyze the piece in 10-15 pages. I knew if I had to write 10-15 pages, I wanted to write about something that had meaning to me. For that reason I avoided the writings of the traditional philosophers we had studied all semester. I stumbled upon a piece about the incarceration of Black crack-addicted mothers by Roberts. I didn’t know if she was a philosopher or a lawyer or both but I knew I wanted to write my paper on the topic.

Last Spring in a sociology graduate course, I was assigned *Killing the Black Body: Race, Reproduction & the Meaning of Liberty*. For some reason, as the reader, I felt a closeness with



the author, but I couldn't figure out why. In my graduate Bioethics and Law Course I was given a similar end of the semester assignment and I chose to write about the involuntary sterilization among minority women. A couple of days after turning in that assignment, I was looking through some of my old files and I found paper on the incarceration of Black crack-addicted mothers. I couldn't figure out where the paper came from but almost every sentence began with "Roberts said," "Roberts maintained" or "Roberts believed." I then realized that I had written about a similar bioethics and law issue three and a half years ago reported by Roberts. As an undergrad, I am sure I rushed through the paper without giving much thought to who was writing on the subject even though it was of interest to me.

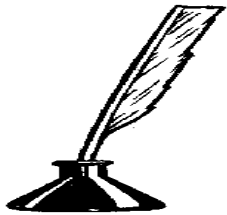
Having the opportunity to meet Roberts, a Kirkland & Ellis Professor of Law at Northwestern University School of Law and returning to my school as not only as a Tuskegee alumnus, but as a participant in a bioethics conference made me cognizant of my academic and personal growth. I even happened to have my book *Killing the Black Body: Race, Reproduction & the Meaning of Liberty* with me that Roberts signed quickly to avoid feeling embarrassed in front of her colleagues. She wrote, "Faith, it was great to meet you in Tuskegee. Best wishes for a successful and meaningful career in bioethics! Dorothy Roberts."

Many of the questions that we set out to answer in the conference engendered other questions. For example, an initial question was "What are the current topics that Black bioethicists are tackling? What are we missing?" Some questions that arose from discussion of this initial question were: "How do you define a Black bioethicist? Does a Black bioethicist have to focus on Black issues or do they just have to be Black? Is there a specific methodology that Black bioethicists have to use? If I am a theologian, attorney, dentist or physician by trade would I be considered a bioethicist?" There is no simple answer to these questions; scholars grapple with them on a daily basis. I think Dr. Judith Andre says it best in *Bioethics as a Practice*: "The practice called bioethics is more than an intellectual discipline. It helps attract and focus public attention; it helps society think more deeply about matters of health. For these reasons we need to ask whether we are making the world better or dazzling it further into blindness. In contrast with the fora ordinarily available to scholars and clinicians, bioethics supplies a bully pulpit, one that we should use thoughtfully"(77). Perhaps categorizing, defining, or identifying bioethicists or bioethics should not be the major concern and exchanging bioethical jargon should not be the focus. Instead, those in the field should use their talents and gifts collectively to promote a more just society as well as encouraging others to do the same.

On day two of the conference, Dr. Rueben Warren, Associate Director of Institute for Faith-Health Leadership Interdenominational Theological Center and Associate Director of Environmental Justice at Centers for Disease Control and Prevention (CDC), reflected on his experience orchestrating, along with Gamble and others, the nationally known apology from the United States government for the US Public Health Syphilis Study. He explained that although some felt the apology should ideally come from the CDC, problematically, the director of the CDC at the time was Black. (Many audience members chuckled—imagine the reaction that would have taken place if a Black man had apologized for the abuses that occurred in the study.) Instead, they pushed for, and received, an apology from the president of the United States.

In her closing remarks on the final day, Roberts listed some of the many issues that emerged from the conference: activism, service, and community involvement. In addressing the question of a distinctive Black bioethics she contended that "traditional bioethics has failed to highlight issues of particular concern to Black community. It is more than applying traditional bioethics to racial issues." She elaborated: "Race is relevant to *all* bioethics issues." According to Roberts, the methodology one should use to transform bioethics is through narrative/storytelling and community involvement through a multidisciplinary approach. Roberts challenged everyone not

only to include race in the bioethics agenda, but also to transform bioethics to aid in the struggle against racism. She said the agenda is among us, in our professions, and in our communities. Finally she concluded by saying those who practice bioethics should be about giving life and saving lives.



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## The Author: Ethical Lapses All Around

by **Gerald S. Schatz, J.D.**

*Center for Ethics and Humanities in the Life Sciences*

The Categorical Imperative (“Act in a way that you would be willing to have everyone act”) does not restrain sociopaths and zealots; they agree to its terms. It is irrelevant to cynics. It should counsel restraint and at least some prayerful weighing for those good people who wish not to be complicit in what they deem terribly wrong, but that reflection was lacking in most of the Schiavo controversy, which was outcome-centered. To my mind, those good people, whether knowingly or not, tried to set a precedent for mob rule over law when concerns run high. For me the Schiavo controversy reflects ethical lapses in:

- Discourse by ethicists on ethics.
- Discourse by physicians on individual cases.
- Exercise of public office.

None of this is to suggest that vigorous public discussion of public issues is not desirable. However:

Many ethicists chose up sides, depending on which outcome they favored, and thus impliedly joined in trying to decide an individual bedside medical ethics problem by a swearing contest.

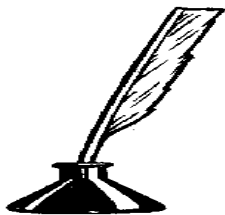
State and federal legislative and executive branches ignored state and federal constitutions and sought to nullify not only an already decided case but also basic constitutional separation of powers. They violated their constitutional responsibilities.

Most of the ethicists, public officials, and physicians who spoke and prognosticated prominently in this controversy did so without knowledge of the specific medical facts or the facts of guardianship. They did not base their comments on evidence neutrally screened for reliability, credibility, and relevance.

Attempts to thwart the Constitution are dangerous. They go beyond protest and specifically threaten our established means for managing societal controversy. They threaten the rights of individuals whose rights have been upheld by the courts. Furthermore, the willingness of public officials to demagogue an individual case may frighten healthcare providers into failure to respect the rights of patients

How an issue is decided is important, sometimes more important than outcome in a particular controversy.





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## An Attorney: A Tug of War Between State and Federal Governments

Paul Arshagouni, M.D., MPH, J.D.  
College of Law

Gerald Schatz's essay on the legal posture surrounding the Terry Schiavo case raises a fundamentally important question as to the role of governments and governmental officials. He is quite correct when he says that the *Schiavo* case raised nothing new in medicine or medical ethics. The issue it raised was that of the proper distribution of governmental power. While he focused primarily on the division of powers amongst the three branches of government and expressed concerns about executive and legislative branch interference in judicial functions, the *Schiavo* case also highlights another important separation of powers, that of federalism. When proponents of maintaining Terry Schiavo failed to achieve a Florida remedy, congressional leaders stepped into the fray.

Federalism concerns the relative roles and powers of the federal and state governments. The expanding role of the federal government has long troubled many conservatives, who have argued against it with passion for many years. Conversely, liberals have long pushed for the expansion of federal power as a means of correcting perceived social injustices at the local level. The legal issues within the *Schiavo* case concern the practice of medicine and the right to refuse medical care. These have always been within the province of the states. Yet here, the federal government sought to intrude itself into this traditional state function. This has caused a flip in the usual political roles, with conservatives arguing for federal intervention and liberals arguing for a respecting of state authority.

This importance of this aspect of the *Schiavo* case should not be underestimated. We have seen similar federal involvement in the medical marijuana cases last year and the Oregon Death with Dignity Act, currently before the Supreme Court, both of which involve federal-state conflict over who should decide what constitutes the proper practice of medicine. These cases are just three examples of the federal-state tug-of-war on matters of medical ethics. It is likely that we will see more in the future. Where it will end is anybody's guess.



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## A Physician Ethicist: Oregon, the Supreme Court, and the Next Tug in the War

**Howard Brody, M.D., Ph.D.**

*Center for Ethics and Humanities in the Life Sciences*

The Physician Assisted Suicide (PAS) issue last came before the U.S. Supreme Court in 1997. Two Federal Appeals Courts had ruled that there is a constitutional right to assistance in dying, so that state laws prohibiting PAS were unconstitutional. The Supreme Court did what I think President Bush would like them to—they refused to “legislate from the bench.” They ruled that there is no constitutionally protected right to PAS. Several justices mentioned that this demonstrates a strength of our Federal system. Individual states can pass laws prohibiting or allowing PAS. The “laboratory of the states” should, in the end, allow us to decide on the basis of hard facts whether or not PAS is a good public policy.

The voters of Oregon, in two referendum votes, approved PAS. The Oregon law includes a provision for annual reports on how many and what sorts of patients have made use of the law. These reports have been published in widely read medical journals. Opponents and supporters of PAS naturally read these reports through different lenses. But the bottom line is that there is now a factual record on how PAS can work, for anyone who wants to see.

To my unlegal mind, it would seem most consistent for the Supreme Court now to rule that the Federal government has no business overturning what the voters of Oregon have cast into law. The Federal controlled substances apparatus is designed to deal with drug abuse and drug trafficking. The state of Oregon has declared that PAS, carried out within the appropriate guidelines, is a legitimate medical practice. It is normally left up to the states to regulate medical practice within their boundaries.

In 1997, a number of the justices used the availability of high doses of controlled drugs such as morphine, to treat pain in terminally ill patients, as a reason to deny any “right” to PAS. They reasoned that since suffering patients had the alternative of being given “terminal sedation”—enough pain medications to render them unconscious if that was required to relieve the pain—PAS was not truly needed. Some pain-treatment advocates object that if the Federal government is given the authority today to refuse Oregon physicians the right to prescribe for PAS, tomorrow they could declare that terminal sedation is forbidden, too. Or, more likely, the threat of Federal intervention would deter physicians from prescribing sufficient doses of drugs to achieve terminal sedation, as the physicians would fear that it would look too much like PAS to Federal regulators and so they would be in danger of losing their prescribing privileges.

Some believe that PAS is a very serious ethical wrong, and so virtually any tool that might be used to prevent it is a tool that is being well used. Others believe that using this particular tool to overturn the Oregon law would set too many bad precedents for federal interference in the practice of medicine.

There are therefore quite a number of public policy concerns at stake in how the Supreme Court decides this case. What one thinks about the ethics of PAS is, as it was in Schiavo, only one of many features in judging what ought to be done.



## Innovative Pedagogy

This piece highlights three classes being taught at Michigan State University this semester that deal with issues in medical humanities. The description of each class is presented by its instructor.

### **International Law and Ethics of Human Subjects Research (HM 591-606 & DCL 627-301)**

Gerald S. Schatz

Around the world, researchers in the biomedical and behavioral and social sciences study people in order to understand and counter the world's disease burden, especially in resource-poor countries, and to better understand people's troubles, beliefs, behavior, and hopes. Research on human beings incurs special ethical and legal responsibilities. This fall, the Center for Ethics and Humanities in the Life Sciences, in cooperation with the MSU College of Human Medicine and MSU College of Law, launched a unique joint interdisciplinary seminar in the International Law and Ethics of Human Subjects Research. The seminar brings together graduate students, faculty, and practitioners in medicine, science, law, and social and behavioral sciences to examine the interrelationships of ethics and international law in the protection of persons who are the subjects of transnational research.

The seminar was developed and is taught by Gerald S. Schatz, J.D., assistant professor in the Center and College of Human Medicine and adjunct professor in the College of Law. For further information: 517-355-3499, [schatzg@msu.edu](mailto:schatzg@msu.edu).

### **Ethics and Development (PHL 452)**

Judith Andre

PHL 452, "Ethics and Development" is the core course for the new graduate specialization in Ethics and Development. It's essentially interdisciplinary, and attracts a great mixture of graduate and undergraduate students: former Peace Corps, World Bank, United Nations employees, Study Abroad veterans; majors in Philosophy, Crop and Soil Science, Agricultural Economics, and more. Discussions are intense and multifaceted.

The central questions addressed in the course are:

- What do we mean by 'development'? Is it the same as (sustainable) economic growth? democratization? globalization?
- What underlying values justify development? Are they limited to the elimination of hunger

- or poverty, or should they include other values such as autonomy or human well-being?
- Who ought to contribute to development, what ought to be contributed, and how much?
- What moral norms should be used to judge progress toward development? Should they be universal norms applicable to all societies, or should they be tailored to particular societies and cultures?
- What is the relationship between development and the legacy of colonialism, imperialism, militarization, and gender and racial discrimination?

Dealing with these questions requires tackling abstract questions about rights and duties, justice, citizenship and sovereignty, but always in the context of the concrete and particular. We look at the wrenching questions that face humanitarian agencies, at the devastating experiences of the sick and the starving, at the frustrations and confusions of those who try to help. Our ultimate purpose is to arrive at a deeper and more useful framework for thinking about all the various activities in “development.” (Or at least to get beyond the tempting simplicities which hamper good work.)

## **Ethical and Conceptual Issues in Organ Transplantation (PHL 870)**

James Lindemann Nelson

PHL 870 is a philosophy graduate seminar with variable topics; this term, the focus is on ethical and conceptual issues sparked by organ transplantation practice and policy. The folks in the seminar are largely philosophy and BHS students, which is a good thing, as we’re trying to push hard at the deepest problems we can find in the transplant arena.

Class organization is pretty standard for such a topic—we started out examining the concept of death, have moved on to consider various strategies for procuring organs, and will conclude by exploring different ideas about fairness in allocating them. All these areas are very rich in philosophical problems, and we haven’t been shy about pursuing them. We spent a good amount of time and energy early in the term pondering different accounts of what it is about death that constitutes a harm to those who die, and why nonexistence *after* death is so much more dreaded than nonexistence *before* birth. This prepared us to ask whether the real issue in the pertinent organ debate isn’t “when is a person dead”—as is standardly thought to be the case—but rather “when has a person, even if still living, already lost whatever it is of value that death takes from her?”

As we turn our attention to the controversies surrounding whether organs for transplant should remain essentially gifts of individual people, or be transformed into commodities for market distribution, or social goods to be distributed for the commonweal, we’ll be exploring various conceptions of why and in what ways, human bodies matter. How, for example, are our bodies connected to our sense of our own identities? How do our and other’s bodies affect our relationships with others? Can a dead person be harmed or wronged in any sense by transplantation?

Finally, when we move to think about how these scarce, life-prolonging goods should be distributed, we’ll be delving into what it is that we as members of a moral community can expect from each other and from the social organizations in which we find ourselves. Organ allocation essentially is a process of deciding who will die soon who otherwise might have lived longer:



how can that be done in a way that, while sad or even tragic, is not morally outrageous. In the seminar as a whole, we won't only be asking "What does philosophy have to say to these problems?" but "What do these problems have to say to philosophy?" That, in my view, is what makes doing philosophy in ways closely engaged with real world, real time major controversies so rewarding.

The seminar this year is fortunate in a very special way: Professor Robert Veatch of the Kennedy Institute at Georgetown University, the author of our primary text, and one of the leading thinkers on transplantation issues, will be this year's Martin Benjamin Distinguished Guest Lecturer. He'll do an informal session with the seminar over lunch on Friday, November 18, the day of his talk.



## The Center Welcomes

The *Medical Humanities Report* would like to welcome Heidi Connealy, who recently joined the program in Bioethics, Humanities, and Society as the Undergraduate Specialization Advisor. She is a doctoral student in the medical anthropology program at Michigan State University. Heidi's research interests include the use of racial and genetic categories in medicine, asthma management, health disparities, ideals of motherhood, and biomedicine as a cultural system. Heidi is beginning dissertation research on lay and professional understandings of asthma's causes and management in Michigan.

The *MHR* would also like to welcome its new editor, Lisa Campo Engelstein. She is a doctoral student in the department of philosophy with interests in bioethics, feminism, social/political philosophy, and ethics and development. She received her Masters in philosophy from Michigan State University in May 2005, writing a Masters thesis entitled "A Feminist Critique of Rational Democratic Deliberation for Health Care Rationing."



## News & Announcements

### **JUDY ANDRE**

- Gave the inaugural lecture in the First Annual Fairbanks Lecture Series for the Fairbanks Center for Medical Ethics, Indiana University School of Medicine (September 2005).
- Was a discussant for a panel on “Ethical Issues in HIV/AIDS” for the MSU Undergraduate Bioethics Society, Michigan State University (September 2005).
- Presented "Incorporating Ethics Case Studies into Science Courses" at the Lilly Seminar on Teaching Ethics, Michigan State University (September 2005).

### **LIBBY BOGDAN-LOVIS**

- Presented “Bioethics’ Truths?: A Transnational ‘E-Dialogue’ Between Medical Students in the United States and Students in Sub-Saharan African” at American Society of Bioethics and Humanities Annual Meeting in Washington D.C. (October 2005).

### **HOWARD BRODY**

- Gave the keynote address for the Robert M. True Symposium: “Having Difficult Conversations with Patient and Families” and “Ethical Issues in Working with the Pharmaceutical Industry,” Maine Medical Center, Portland (September 2005).
- Presented “Bedside Ethics at the End of Life” for the Josefino Magno Memorial Hospice Symposium at Henry Ford Hospice in Southfield, Michigan (September 2005).
- Was the keynote speaker, 5th Annual Quandaries in Health Care Conference: "The E Word: The Role of Emotions in Health Care," University of Colorado/Given Institute, Aspen, (September 2005).
- Gave the talk “Physicians, Ethical Principles, and the Drug Industry” for Michigan State Medical Society annual Bioethics Conference, Traverse City (October 2005).

### **BARRY DECOSTER**

- Presented “Explanations of Disease as Politics: Why Contextual Explanations of HIV/AIDS in South Africa and the United States Matter” at American Society of Bioethics and Humanities Annual Meeting in Washington D.C. (October 2005).

### **LISA CAMPO ENGELSTEIN**

- Presented “Just Health Care Rationing and Priority-Setting: What Do We Owe the ‘Least Well Off’?” Part of panel session with the same title at American Society of Bioethics and Humanities Annual Meeting in Washington D.C. (October 2005).

### **LEN FLECK**

- Led a workshop titled “Just Caring: Ethical Issues in Health Care Rationing and Priority-Setting” Board and senior management of Priority Health Managed Care in Petoskey, Michigan (September 2005).

- Gave the keynote address, “Shades of Gray: Ethical Issues in Rehabilitative and Restorative Services to Older Persons with Depression and Dementia,” the annual conference “Geriatric Rehabilitation: Strategies for a Changing Environment” in Lansing (September 2005).
- Presented “Just Health Care Rationing and Priority-Setting: What Do We Owe the ‘Least Well Off’?” Part of panel session with the same title at American Society of Bioethics and Humanities Annual Meeting in Washington D.C. (October 2005). This paper was also presented at the International Bioethics Retreat in Amsterdam at Vrije University Medical School (June 2005).

### **MARGARET HOLMES-ROVNER**

- Wrote an editorial, “Consequences of increased patient choice,” that was published in *Health Expectations* 2005, 8 (1):1.
- Published (with co-authors Stableford S, Fagerlin A, Wei JR, Dunn RL, Ohene-Frempong J, Kelly-Blake K, Rovner DR) an article called, “Evidence-based patient choice: a prostate cancer decision aid in plain language” in *BMC Medical Informatics and Decision Making* 2005, 5:16.
- Gave a talk “Is Diabetes Prevention Cost Effective?” as part of a panel on Evidence-Based Updates at the American College of Physicians Regional Meeting, Traverse City, Michigan (September 2005).
- Presented “Resourceful Patient Project: Teaching patient-physician communication to patients” at the research seminar of the MSU Department of Pediatrics and Human Development (October 2005).

### **PAUL NDEBELE**

- Published, with co-author Jens Mielke, “Making research ethics review work in Zimbabwe - the case for investment in local capacity” in the *Central African Journal of Medicine*. 2004; 50(11/12):115-19.
- Gave a talk “The Problem of ‘False Confidence’ in Microbicide Trials in Zimbabwe and Lessons Learned from Microbicide Trails Elsewhere” as part of the Center for Ethics Brown Bag Series at Michigan State University. (October 2005)
- Spoke on “Health Research Oversight in Zimbabwe: Responding to International Developments and Current Challenges in Human Research Including Preparedness for HIV Vaccine Research Trials” as part of the Fogarty International Research Ethics Seminar Series, Michigan State University (October 2005).
- Presented “Reviewing and Conducting Multi-Nation and Industry Sponsored Research: The Challenges for African Institutions and Countries” as part of the Center for African Studies Brown Bag presentation series at Michigan State University (September 2005).