



Community Health Groups and the Changing Terms of Health Care in Mexico

by Suzanne D. Schneider

Unequal access to and rising costs of health care are among the most pressing global problems of the 21st century. As the cost of treatment soars, millions of people throughout the world are denied access to basic medical care, not to mention advanced medical technology. While the clamor for biomedicine increases, particularly among those who have little access, a growing critique of modern medicine and the institutions that deliver it has propelled a global movement for medical alternatives and new modes of health care delivery.

One local expression of this global movement can be seen in central Mexico where grassroots health organizations are sprouting up throughout the region. Local community groups, searching for new ways of “doing” and delivering health care, have organized around the study and diffusion of alternative medicine. The health groups I observed in the state of Morelos share the following similar set of characteristics. They all express a critique of the dominance of biomedicine; they advocate a counterpoint to biomedicine’s curative approach by embracing holistic health practices with roots in both Eastern and Western traditions; they run community clinics, natural pharmacies, and training programs in order to make the alternatives they propose accessible and affordable for all residents; and finally they advocate community service as a means to distribute their resources. The discourses they advocate and the work they do help shed light on the shifting terms of health care in Mexico.

Such community health groups emerge in the context of persistent health disparities, the rising cost of medical treatment, and the deterioration of an underfunded national health system. Neoliberal health reforms implemented by the Mexican government over the last two decades have emphasized less government intervention in public health, which in return has accelerated the decrease in health care protection. As a result of neoliberal reforms patients are now expected to pay fees for public services that historically were available free of charge. Meanwhile the private sector’s participation in health care expands. As the divide between the retracting state and the inaccessible market grows, citizens and local communities are increasingly expected to step in and fill in the gaps of a declining public health system.

The health groups I studied attempt to bridge this divide by making their health services and education accessible and affordable for all residents. Members are largely low-income women who share an interest in health care and alternative medicine. These women seek education and professional options in a country that grants poor women few opportunities for either. In programs that last eight months to three years, health group members train in Chinese medical philosophy, nutrition, acupuncture, herbalism, and naturopathy, among other diagnostic and healing modalities. Students may apprentice or shadow more advanced practitioners in community clinics where a range of therapeutic services including nutrition therapy, massage, acupuncture, Reiki, polarity therapy, homeopathy, and traditional Mexican herbalism are offered on a sliding scale. Patients that utilize clinics services are sometimes invited to become students;

joining the training program is viewed by members as an extension of the healing process. Work offered by health group members is mostly voluntary and the majority of the groups' operating budget is largely generated through clinical consultations, natural remedy sales, and donations.

These clinics draw a demographically diverse group of patients including poor farmers who come from the rural countryside, middle-class women who come from the cities, and the working poor who live in the towns in which these clinics operate. The most common problems that patients present are those that "traditional" biomedicine can not easily remedy—chronic aches and pains largely resulting from occupational stress and chronic illnesses that have no known biomedical "cure." Sometimes "alternative" medicine can help with problems that traditional biomedicine cannot easily resolve. Moreover, alternative medicine is arguably better suited for certain problems: for example, herbal remedies can mitigate intestinal and respiratory problems and holistic therapies often more adequately address emotional or psychological problems.

While health groups incorporate an array of global health practices with roots as far away as China, India, and Europe, they also emphasize the goal of "rescuing" traditional Mexican medicine as a central component of their practice. Participants are *mestizo* Mexicans (people of mixed Spanish and Indian descent) who share a concern that as a result of the influence of Westernization their native traditions and values are rapidly disappearing. Traditional medicine (particularly herbalism) is viewed as one aspect of culture that can and should be rescued and diffused particularly in light of the expense of synthetic medicines and their potential side effects. The emergence of these health groups therefore relates as much to social critiques of Westernization as to local critiques of biomedicine and government health care delivery.

As health care increasingly becomes a commodity to be bought and sold, health groups also articulate a concern regarding the decline of health care as a social right. Their work is therefore conceived of in communitarian terms—helping the poor and empowering the community in health matters. To achieve those ends, groups charge for their services on a sliding scale, seek to attend to the poor members of society, and offer "scholarships" and affordable membership for those who join the health training program. While offering a communitarian approach to health service delivery members sometimes also participate in the commodification of health care. For example, after volunteering their time and labor in the community clinics members may hold private consultations either in their homes or in the community and charge a relatively considerable fee for their services. Moreover, health groups are increasingly involved in developing herbal medicine cooperatives with the goal of generating income. The most successful groups market their products on the internet to an international clientele.

Paradoxically, although market-based approaches to health care are contrary to health groups' mission of community service, capitalizing on the economic benefits of alternative medicine may provide the only option for such groups to remain viable. In fact, health groups largely choose to work independent of government funding since such funding is notoriously linked to "a lot of work for a little money." On an individual level, charging a fee for private consultations and selling herbal products offer some women a unique opportunity to gain a semblance of economic independence from their husbands. Indeed, such conflicting interests create tensions both within and between groups. For example, I documented numerous occasions in which either individual members or those groups experiencing entrepreneurial success were perceived by others as "robbing" the community since they were not adhering to communitarian values.

Not unlike the domain of formal health care, the tension between capitalist and communitarian values marks the work of community health groups. Like any other service or commodity, to remain competitive and viable alternative medicine (and its providers) must adapt to the market in order. In becoming too market oriented however, health groups risk contributing

to what Baer (2001) calls “a marketed social movement.” Many argue that movements in the United States such as holistic health and organic agriculture exemplify this pitfall and run the risk of representing a consumer lifestyle rather than a civic responsibility (DeLind 2000). Health groups in Mexico thus confront certain of the same dilemmas that they themselves critique in formal medicine. Rather than existing outside of those social forces that are changing the terms of health care, they appear instead to be bound within them.

Immersed within these social forces, health groups struggle to fulfill their mission of community service and while simultaneously maintaining authenticity in practice. These members attempt to bridge the health care divide by attending to the poor, the aged, and to those who feel marginalized in public clinics. They utilize global and local resources to contribute to and redefine the health care process as one that centers on the patient as participant.

The members I interviewed view their work as urgent, particularly as biomedicine becomes increasingly costly, impersonal, and technologically-oriented. They strive to revive some of the “humanity” they feel has been lost in modern medicine. In essence, their work reflects the spirit of the modern Hippocratic Oath that reminds health practitioners that “there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.”¹ While contributing to the dialogue concerning what constitutes just and compassionate care, these groups provide health services to individuals who would otherwise not receive treatment, offer health education to those with little access, and empower patients to participate in their health.

Although they play an active role in providing community health care intended to be complementary to available biomedical options, the groups I studied are largely ignored by the local government and health officials. In fact, health group participants are often viewed as “women practicing what they have always practiced—traditional medicine” to quote one health official I interviewed. This assumption not only stereotypes the participants, but it also overlooks the diversity of the groups’ global and pluralistic health care approaches. Additionally, officials’ inattention to the local health system reinforces a message that has been communicated in public health efforts for decades—that there is only one avenue to improve community health and that route is through biomedicine.

As health groups are overlooked, public officials and health administrators speak of their growing concern regarding chronic health resource shortages, increasing population demands on public clinics, and the strain that chronic illnesses are having on the local health system. The irony here is that while community groups offer creative solutions to address the limitations of curative-based health care, their efforts are viewed pejoratively as “traditional” (that is, backwards) and thus ineffective. Moreover, the strategies they advocate—prevention and participation—are hailed as the panacea by global health reformers to address the inefficiencies and inadequacies of Mexico’s health system. Yet on the ground, those strategies are viewed as irrelevant by those in charge of instituting health reforms.

As local groups and their medical alternatives are rendered invisible by adherents to the dominant medical paradigm, this case raises important questions regarding the role of civil society in the context of state decline. For example, who controls a health care process that requires the participation of multiple sectors of society? Who determines which groups are equipped to deliver health care services? What is the role of the market in determining the value and viability of community health services? Immersed in many complex and contradictory social forces, health groups in Morelos appear to be both products and producers of social change. They express the many challenges inherent in health care today and the possibilities for health care tomorrow.

Notes

1. Retrieved from http://www.pbs.org/wgbh/nova/doctors/oath_modern.html, June 21, 2006.

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DeLind, Laura. 2000. Transforming Organic Agriculture into Industrial Organic Products: Reconsidering National Organic Standards. *Human Organization* 59(2) 198-208.



Research Report from Haiti Beyond Human Rights Ideals: Physicians Confront Rationing Decisions

by David Ubogy

Ivens Saint-Jean (a pseudonym) a 12 year old boy from the mountains of rural Haiti, has grown increasingly fatigued and he's developed marked swelling of his abdomen. After an attempted cure by the local Vodou practitioner is unsuccessful, he is carried to the hospital by his father, and attended to by a pediatrician from the United States. Ivens is significantly jaundiced, and has a large amount of ascites (free fluid surrounding the abdominal organs), which has begun to affect his ability to breathe. The physician soon completes those limited diagnostic tests available at the hospital (far less than he knows is available in the developed world), which prove unrevealing. Because therapy for tuberculosis (TB) is one of the few treatments available, in desperation, TB therapy is begun, despite initial indications that Ivens is not experiencing an unusual form of abdominal TB. With a needle, fluid is drawn off from his abdomen with a needle, and his breathing is temporarily eased. Initially he appears to respond to therapy with more energy. Despite the language barrier, over several weeks, Ivens and his doctor develop a friendship, with the boy walking around the hospital grasping the doctor's hand, speaking continuously in Kreyol, and repeatedly demanding "un Coka." Ivens smiles as he makes the request, because he knows from many refusals, that the drink will not be forthcoming.

But after a month, Ivens' TB tests are definitively negative, and the initial improvement in his fatigue, in retrospect likely due to nutritious hospital food, has ended. With nothing further to offer medically, the pediatrician takes Ivens' father aside and offers him money to either pay for an abdominal CT scan in the capital (which would likely establish the feared diagnosis of malignancy, for which any therapy would be unavailable), or that same amount of money could instead be used for food and pain medication after Ivens' father takes his son home to die. The choice is easy to make. Father and son leave the hospital, Ivens with a new yarn bracelet as a farewell gift and triumphantly carrying a bottle of "Coka," having at long last worn down the defenses of his doctor.

Two months later, another patient visiting from Ivens' village informs the pediatrician that Ivens has died. He seemed to have been in pain and to have had difficulty breathing before he passed.

This true story is all too common in the setting of Haiti. Founded by former French slaves after a bloody war 200 years ago, Haiti is by most accounts the poorest country in the Western hemisphere, with a per capita income of \$425, a life expectancy of 49 years, an infant mortality rate of 79/1000 (U.S. Department of State, 2005) and a severe burden of disease including AIDS, TB, malaria, diarrheal diseases, and malnutrition (Farmer, 1999). Both general and as well as medical infrastructure are severely underdeveloped, with large percentages of the population suffering from chronic food insecurity, lack of access to potable water, and no access to healthcare (The United Nations World Food Programme, 2005). When we speak of lack of healthcare access in the United States, we generally mean the uninsured who lack a primary

physician, who may be unable to afford medications for chronic conditions, and who obtain sub-standard care in the emergency room. The Haitian government estimates that 40% of the population has absolutely no access to healthcare professionals, medications, or facilities (Pan American Health Organization, 2006).

At the rural NGO Hôpital Albert Schweitzer (HAS), physicians are faced with a triple dilemma of desperately ill patients, grossly inadequate resources, and a financially insolvent institution that severely curtails services. Traditionally focused on the doctor-patient dyad, physicians at HAS find themselves balancing medical needs of the patient in front of them against the financial survival of their institution.

Paul Farmer, a physician-anthropologist who himself practices in Haiti, has called for healthcare to be treated as a human right (Farmer, 1999). No less than the United Nations has called for the same, with article 25 of the Universal Declaration of Humans Rights stating:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (United Nations, 1948)

Implicit in these exhortations is that rationing decisions be made only after resources have been distributed so as to meet equally the needs of all. At HAS, real-world rationing decisions are regularly made in ways that trump laudable but unattainable human rights ideals.

To examine how this dilemma is reconciled at the individual provider level, nineteen physicians were interviewed at HAS. The subjects represented a mix of nationalities (Haitian, American, Indian, Swiss) and specialties (surgery, pediatrics, medicine, OB/GYN, public health). In addition to examining those contradictions inherent in conceptualizing healthcare as a right even as rationing decisions are made, categorical differences between Haitian and expatriate physicians were analyzed.

All of the study subjects believed that healthcare either was or should be treated as a human right; all were therefore caught in an unavoidable ethical dilemma. Several strategies were used to address the dilemma, as illustrated by the following interview excerpts. Some physicians preferred to focus exclusively on the needs of the individual patient, effectively denying the dilemma.

I have a patient [who] needs an operation on the heart. And I know we can't do it here. And I know that it costs lots of energy and lots of money to organize something for him. But, I have seen this patient so many times and I'm trying to do something, knowing that it's crazy. Yeah, he has hope, and why shouldn't I try?

Other physicians acknowledge the conflict, but freely violated institutional policy to favor the individual patient.

Yes, I have done that many times. If they were poor and they needed healthcare, yeah. I did it often. For the blood, there's a lot of patients that come with nobody. They can't give their own blood to get blood. And they don't have the money to pay for the blood, which is an option people with money have. Also, when the really poor people come in, their family members are usually quite poor too and

quite anemic. You can just look at them and know. Do they have shoes? How are they dressed? You can tell someone that's from the mountains. You can tell really just by looking at them, the whole picture.

Such cases of individualized “exception-making” were commonly justified by implicitly invoking justice.

I do have a big problem when the poor come to us and we turn them away. My view on this is well known to the Board. It's well known to [the Medical Director]. It's well known to anyone that has spoken with me, that I have a problem with withholding care to these people that otherwise would not be able to get it.

Justice was alternatively used by another physician to explain rationing.

You have to draw a line, to be able to work within your garden. If you don't do that, those people who are in the garden don't get good care properly anymore. So for example, those who are more wealthy, come from St. Marc, with the cars, with [their] cell phones. Do they have the same right for the treatment as our poor people in the Artibonite Valley? Sometimes it's artificial, but mostly I think richer people coming from areas like St. Marc, even Port-au-Prince, who then have to pay more [should] not be treated equally like the poor people out of the mountains. And I think there it's right. It's just to make a system of justice.

Arguably, this physician had made some sort of peace with rationing decisions. Another informant cited an example of explicit hospital policy that limited her practice.

Somewhere around seven months ago we started the HAART program. The criteria was CD4 count under 200, or an AIDS-defining illness, and in-district. That went on for three months or so. [Laughs] I was enrolling people so fast that we ended up having to close the program. Cause we had some other criteria from the Board of Directors that said 'In your first six months' and then 'In your first year' how many patients maximum they wanted us to have. And we were already skimming over where we should be.

And finally, physicians often resolved the resource scarcity dilemma in very personal, albeit impractical ways—such as by giving gifts to their patients with few resources.

I had one patient who had a very sick heart and lived far away, and had a hard time finding enough money to get transportation to come. And I ended up giving her money for transportation once or twice.

Physician informants therefore used various strategies to resolve the personal dilemma they faced, although when categorized according to specialty or nationality, no definitive patterns were noted. Interestingly, while not originally intended as a main area of study, a striking difference between Haitian and expatriate physicians was noticed upon analysis. Haitian physicians were as a group both subjected to violence and denied professional training opportunities in ways that expatriate physicians were not. There was a roughly ten-fold

difference between the salaries provided at HAS and those received by physicians expatriates when practicing in the developed world. Of the seven Haitian physicians interviewed, two had their residency training shortened significantly by strikes. One was not residency trained. Three had attempted to obtain additional training in the U.S.: one was able to secure a position but then unable to afford the tuition, one was unable to obtain any position due to credentialing barriers, and one was able to secure only a short observer position, in which he was unable to directly examine or care for patients. One subject's position at HAS was felt to be in jeopardy due to funding issues. Two subjects had either been the direct victims of violence (knives and guns) or had had close family members robbed or kidnapped. One subject fled the country after the study was completed for fear of violence, and to date, has been unable to secure employment in the U.S. Three additional Haitian physicians were unavailable for interviews, having previously been forced to leave HAS (two to flee the country), again for reasons of violence. Neither of the two who fled the country has been successful in their attempts to obtain residency positions in the U.S.

It is difficult to reach profound conclusions on the basis of a descriptive study of small size. Seventeen physicians were interviewed for this study, at a specific location and a specific point in time. As such, there are unlikely to be generalizable lessons to be learned. But in the process of this research I obtained insights into physician attitudes in resource-poor settings and discovered strategies used to reconcile certain related ethical dilemmas.

As Ivens Saint-Jean's pediatrician, I offered money to his father to somehow help his son through help the terminal stages of an incurable illness. I did so because I had nothing else to offer. I did so, hoping to keep hunger and pain at bay, and in protest. Had Ivens been diagnosed in the developed world—if medical resources were equitably distributed on an international basis as a universal human right—he might have been cured. Paul Farmer concedes, “it is difficult, perhaps impossible, to meet the highest standards of health care in every situation. But it is an excellent idea to try to do so” (1999a, 1492). The tension between striving for that ideal and falling short is a challenge faced by HAS physicians.

But perhaps as important is the realization that the very conditions that produce such oppressing poverty and widespread illness in Haiti, the very conditions that require an ongoing infusion of expatriate knowledge and skills, are reflected not only in the lives of the poor but also in different ways even among the Haitian educated elite. Providing medical care to the poor may be personally satisfying even as it places physicians in an ethical quandary. But simply providing care may not be enough. It may be that efforts by expatriate physicians should also be directed towards assisting their professional colleagues in Haiti, so that in the future Haitians can help each other, rather than trying to secure individual safety through a continuing spiral of violence.

References

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Informed Consent as an International Norm

by Gerald S. Schatz

Recognition of the ethical and legal requirement of informed consent for medical interventions has expanded again internationally, with a decision in the European Court of Human Rights. The Fourth Section of the European Court of Human Rights held 5-2 in *Evans v. United Kingdom* that in the absence of contrary law the rights of informed consent and withdrawal of consent to medical procedures apply where the consent to assisted human reproduction is withdrawn by either prospective parent prior to implantation of the resulting embryo, even if the withdrawal of consent is against the wishes of one prospective parent and the embryos might be destroyed. The majority and minority differed on criteria for respecting a withdrawal of consent in assisted reproduction cases and noted that national practices differ in such cases but did not question the idea that informed consent is the general legal and ethical norm for health interventions.

The majority opinion cites U.K. law and what it characterizes not as law but as “relevant international texts”: A Council of Europe study of differing assisted reproduction policies in member states; the Council of Europe Convention on Human Rights and Biomedicine, to which the U.K. is not a party and which is in force for very few countries; and the recent Universal Declaration on Bioethics and Human Rights, a nonlaw document proposed by a panel of experts convened by the United Nations Educational, Scientific, and Cultural Organization.

The decision is available at:

<http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=793163&portal=hbkm&source=externalbydocnumber&table=1132746FF1FE2A468ACCB CD1763D4D8179>.



Summer Study Abroad in Costa Rica

Michigan State University will offer an eight week study abroad program, “Ethics and History of Development and Health Care in Costa Rica” next summer, May – July 2007. The 11- credit program includes one integrated course co-taught (in English) by Karen Meagher and Lisa Campo Engelstein, Dept. of Philosophy at MSU, and Patricia Fumero, from the University of Costa Rica, and also 4 credits of Spanish language instruction. Students are housed with Spanish-speaking Costa Rican families within walking distance of classrooms. Field trips include visits to a variety of health care settings, including clinics in rural and poor areas and various regional and national hospitals; students also travel to national parks and eco-tourism sites to explore environmental issues. For further information, contact at Karen Meagher at meagher6@msu.edu or see <http://studyabroad.msu.edu/programs/costaethics.html>.



News & Announcements

Judith Andre

- Presented “Development Ethics, Environmentalism, and the American Suburban Student” for the international conference “Globalization, Environmental Ethics, and Environmental Justice,” held at Lyman Briggs, MSU (Aug).
- Conducted workshops on confidentiality in health care, with a focus on adolescent medicine, for the College of Osteopathic Medicine Statewide Campus conference, MSU (Sept).
- Participated in the panel “Hearing and Heeding the Challenging Voices: Defining Values for Bioethicists,” American Society for Bioethics and the Humanities, Denver (Oct).

Elizabeth Bogdan-Lovis

- Gave a workshop (with co-presenters Lisa Kane Low, CNM, Ph.D., and Ray DeVries, Ph.D.) titled “Have it Their Way: Constructing Autonomy in Childbirth” and participated in the “Against Health: Future Directions” plenary session, for the “Against Health: Resisting the Invisible Morality” conference, University of Michigan (Oct).

P. Sean Brotherton

- Lectured on “Colonialism, Representation, and the ‘Black Body’: Revisiting the ‘Hottentots Venus’ Controversy” for the Sex and Gender Course, Department of Sociology (Oct).
- Presented a paper, “Emergent Capital, Shifting Ideologies, and Expanding Therapeutic Itineraries in Cuba's Special Period,” for Western Michigan University's Department of Anthropology Speaker Series (Oct).
- Gave a talk “‘We Have to Think Like Capitalists but Continue Being Socialists’: Emergent Capital, Shifting Ideologies, and Cuba’s Changing Health Sector,” for Cornell University's Department of Anthropology Colloquium Series (Nov).
- Chaired a session, titled “Politics and Health Care: Neoliberal Reforms, Shifting Ideologies, and Cuban Dichotomies,” and presented a paper at the American Anthropology Association Meetings in San, Jose, California (Nov.)

Leonard M. Fleck

- Published The Costs of Caring: Who Pays? Who Profits? Who Panders? *Hastings Center Report* 36 (May/June, 2006), 13-17.
- Workshop presentations “Ethical Issues in Withdrawing/ Withholding Life-Sustaining Care from Incompetent Patients,” “Ethical Issues regarding Brain Dead, PVS, and minimally Conscious Patients,” for College of Osteopathic Medicine (core competencies) Ethics Day for medical residents (Sept).
- Paper presentation (with Allison Wolf) “Challenges to Conscience: Quarrels, Quibbles, and Quips” at the Annual meeting of ASBH in Denver (Oct).

Margaret Holmes-Rovner

- Chaired two events at the Society for Medical Decision-Making Annual Meeting, Boston, (Oct): Dinner Symposium and Debate: “Patient Decision Aids Are the Best Way to Improve the Quality of Clinical Decision Making” and a short course on “Standards for Educational Materials to Support Shared Decision-Making: State of the Art.”
- Received the Michigan Cancer Consortium Spirit of Collaboration Honorable Mention Award for her collaborative work in developing the new Prostate Cancer Control Plan for Michigan.

Co-authored presentations:

- Martin, Holmes-Rovner M, et al. “Effectiveness of Disease Modifying Anti-rheumatic Drug Risk Communication in Rheumatoid Arthritis.” American College of Rheumatology, Washington DC (Nov).
- Martin, R, Holmes-Rovner M, et al. “Rheumatoid Arthritis DMARD Knowledge Profile: Development and Validation.” American College of Rheumatology, Washington DC (Nov).
- Martin, R, Holmes-Rovner M, et al. “The Importance of Patient Trust of Physician in Rheumatoid Arthritis Decision Making.” American College of Rheumatology, Washington DC (Nov).
- Dwamena FC, Holmes-Rovner M, Mavis B, Fletcher F, Loyson A, Osuch J, Walsh K. “Teaching Medical interviewing to Patients: The Other Side of the Encounter.” American Academy on Physician and Patient (AAPP) Research and Teaching Forum, Atlanta (Oct).
- Dwamena FC, Smith RC, Fletcher F, Holmes-Rovner M, Mavis B, Osuch J, Walsh K. “Feasibility of Teaching Medical interviewing to African American Women.” American Academy on Physician and Patient (AAPP) Research and Teaching Forum, Atlanta (Oct).

Publications:

- Stacey, D., O'Connor, A. M., Llewellyn-Thomas, H., Holmes-Rovner, M., Entwistle, V., Rovner, D. et al. 2006. Outils de prise de décision afin de permettre aux patients de peser les avantages et les désavantages des options associées au dépistage ou au traitement: Une revue systématique de la littérature. In L. Lalonde & F. Légaré (Eds.), *Les choix en matière de santé et la participation du patient: vers une prise de décision partagée* (107 ed., pp. 85-111). Montréal: l'Association francophone pour le savoir (ACFAS).
- Elwyn G, O'Connor A, Stacey D, Volk R, Edwards A, Coulter A, Thomson R, Barratt A, Barry M, Bernstein S, Butow P, Clarke A, Entwistle V, Feldman-Stewart D, Holmes-Rovner M, Llewellyn-Thomas H, Moumjid N, Mulley A, Ruland C, Sepucha K, Sykes A, Whelan T, The International Patient Decision Aids Standards (IPDAS) Collaboration. Developing a Quality Criteria Framework for Patient Decision Aids: Online International Delphi Consensus Process. *BMJ* 2006; 333: 417. Supporting documents are available at <http://www.ipdas.ohri.ca/resources.html>.
- Dunn, S., Corser, W., Stommel, M., Holmes-Rovner, M. Hopelessness and Depression in the Early Recovery Period After Hospitalization for Acute Coronary Syndrome. *J Cardiopul Rehab*, May-Jun 2006 26(3): 152-9
- Holtrop JS, Corser W, Spence-Jones G, Brooks G, Stommel M, Holmes-Rovner M. Health Behavior Goals of Cardiac Patients After Hospitalization. *Amer J of Hlth Behavior*, 2006 (Jul-Aug), 30:387-399.

Linda M. Hunt

- Published, with Castaneda, H. and de Voogd, K. B. 2006. Do Notions of Risk Inform Patient Choice? Lessons from a Study of Prenatal Genetic Counseling. *Medical Anthropology*, 25(3): 193-219.
- Grant Awarded “Helping Low-Income Families Manage Chronic Illness in Lansing: An Ethnographic Study of a Community Outreach Health Program,” (with Heidi Connealy). Family and Communities Together Coalition (FACT), Michigan State University.
- Presented “Race, Ethnicity and Genetic Variation: Origin Myths in the New Genetics” as a CEHLS Brown Bag Talk, MSU (Oct).

Ann Mongoven

- Presented “Terrorism as Ritual: The Hijacking of Public Health?” as a CEHLS Brown Bag Talk, MSU (Sept).

Harry Perlstadt

- Gave a talk on “A Framework for Assessing Risk in Public Health Research,” American Public Health Association Meetings, Boston (Nov).
- Presented “The Ethics of Conducting Clinical Trials in the Midst of an Epidemic: Lessons from Arrowsmith and the Neel-Yanomami Expedition,” 11th World Congress on Public Health and 8th Brazilian Congress on Collective Health, Rio de Janeiro (Aug).

Gerald S. Schatz

- Gave a talk on “A Framework for Assessing Risk in Public Health Research,” American Public Health Association Meetings, Boston (Nov).
- Presented “What’s the Deal with Institutional Review Boards?” at the Cancer Core Conference, MSU Breslin Cancer Center, College of Human Medicine, and Great Lakes Cancer Institute (Sept).

Tom Tomlinson

- Gave a talk on “Bioethics Meets Hospital Administration,” Doctorate of Healthcare Administration program orientation, Central Michigan University (Aug).