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“OUR BODY: THE UNIVERSE WITHIN is a fascinating, artful and educational exhibit consisting of actual human bodies and organs. Appropriate for all ages, this exhibit literally goes “under the skin”, revealing the mysteries of the human anatomy. The bodies, specimens and organs have been preserved using a process known as polymer impregnation. OUR BODY: THE UNIVERSE WITHIN allows you the insight to the inside: giving one a true look at the inner workings of the extraordinary human body.”

Observations of an Anthropologist on Plastinated Bodies Exhibits

by Lynne Goldstein, Ph.D.

My perspective comes as an anthropologist/archaeologist who studies past mortuary practices, as well as present treatment of the dead, in the US, and world-wide. I have also spent a significant amount of time working in museums, examining what makes a good (or bad) museum exhibit.

I visited both versions of the plastinated bodies exhibits--the version that on display in Detroit, and the other version, one of which was shown in Phoenix. In each case, I spent as much time studying the exhibit goes as I did the exhibit itself. I wanted to see how people perceived these exhibits and how they reacted to them.

I was impressed with the fact that everyone read every label and looked at every exhibit carefully. That is unusual and pretty much unheard of in the museum world. No one just casually breezed through the exhibit. That was true for everyone from kids to older adults. People were drawn into the exhibit by the subject and the displays. Individuals really wanted to see what body parts looked like.

Death is a disturbance of the social order, and a break in social and family networks. On a more pragmatic level, death creates an immediate problem. People have to dispose of the dead body--it smells, it can carry diseases, it can be unpleasant to be around. There is no inherently right or wrong way to treat a dead body, except within a particular cultural setting. Mortuary treatment and mortuary practices are totally culturally determined. Cultures decide what is right.

That said, dead people can be said to “belong” to living people who may claim them in various ways. What is it about a corpse that seems to invite its use as a symbol? Why are we so interested?

Corpses and bones are material objects that can be displayed, seen, touched, moved, etc. They are concrete and can make the past immediately present--monasteries have counted on this for centuries. But, it is not the actual bones that count; it is people’s belief in the bones. It is not the

dead body itself that is meaningful, but culturally established relations to death and the way a dead person's importance is construed.

Bodies are complex and can stand for many things. It therefore depends on the particular story one chooses to tell. Further, even though bodies rarely talk back, they often appear to be saying only one thing. Bodies' materiality makes them seem grounded. Different people invoke corpses as symbols, and they can mean different things to each person. In this sense, they have both materiality and ambiguity. They also invoke awe, uncertainty, and fear of things such as life and death.

Bodies are "heavy" symbols because people once cared about them and because identify with them. Since all people have bodies, any manipulation of a corpse directly enables one's identification with it through one's own body.

In the U.S., we have added to the mystery of death because we have removed ourselves from the process of death and dying to a great extent. People do not generally see death, and we have little to no chance to see dead bodies up close, dissected, or in pieces. When an entrepreneur comes up with plastination and promotes it as "science," it sounds like something that is hard to resist. Plus, it provides a stamp of approval to see.

I thought the exhibits were interesting, and I thought the process was interesting, but I would have loved to learn more about how it was done. In that regard, the Phoenix exhibit was more educational than the Detroit exhibit. The Phoenix exhibit had a short film on how plastination was done and how the bodies were prepared.

It is clear that the promoters/exhibitors have tried to address various ethical concerns that have come up since this kind of exhibit first opened several years ago, and while these attempts are not totally satisfactory, they are interesting in themselves. In the Phoenix case, for example, it appears that all of the individuals now on exhibit have expressly agreed to donate their bodies to be plastinated and on exhibit.

While interesting in many ways, the exhibits leave me with many unanswered questions. As an anthropologist, here is some of what I *really* want to know:

- Why idealize? Why were all the total bodies so young and fit? What happened to old and fit people? Or young and not so fit?
- Why couldn't we see more than a slice or two of someone who was ill? Wouldn't it have been educational to see what more than one slice of someone with a disease looked like?
- Tell me about the folks who donated their bodies--how old were they, what did they do for a living, why did they donate, how did they die? The anonymity of the people bothers me--I would at least like to know what they did for a living. Is the pose representative of what they did?
- Now that these people are in the exhibits, what do their families think? Do they ever come to visit? Have they asked for pictures?
- What do you do with all of the comments you collect and receive?
- How many people have willed their bodies to you?

These are heavy symbols being used flamboyantly, but in an unusual cultural way. They are being used to promote a particular approach--plastination. The promoters compare themselves to the ancient Egyptians, Peruvians, and others, but these ancient peoples did what they did for religious and spiritual reasons, and they maintained these bodies *because* they were symbols. In the present case, we never really know *why* the promoters want to plastinate the bodies--what is the purpose of having all of these bodies? Why do we need them? The answers to these questions are never addressed.

Most people I talked to or overheard enjoyed the exhibit or thought they learned a lot. Many people told me that they were glad they saw it but would not see it again. Others said that it was fabulous and a wonderful way to learn about the body (these people tended to poke themselves as they stood in front of exhibits), Some said that they felt that there was no other way that this information was available to them--that books and charts were simply not the same. Some people who were familiar with anatomy said that they thought the exhibit was too sterile and did not look real, and they thought it had been a waste of their money--they wanted more substance or more art. In sum, I think it was a successful exhibit, but it was not truly art or science.



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The Ambivalence of the Viewer: Interrogating Motivations by Anne Mongoven, Ph.D.

I address ethical questions that pertain to the viewer’s interest in, and experience of, the exhibit. I speak personally but hopefully in ways that resonate with other viewers’ experience. My emotional reaction to this exhibit can be summed up in one word: Ambivalence. With trepidation, I am going to interrogate myself publicly about my ambivalence.

Ambivalence #1: Informed Consent and My Consent to View the Exhibit

Why did I go to this exhibit? In particular, why did I go to this exhibit despite my lingering suspicions about how the bodies were obtained and the nature of any related informed consent process?

I am not claiming that the bodies were obtained unethically. But I am uncertain *how* they were obtained, and I was dissatisfied with the information included in the exhibit and with the response to my request for more information. In the panel presentation at the Detroit Science Center from which these remarks are drawn, the exhibit organizers stunningly admitted that they had no idea how the bodies were obtained in China. The exhibitors claimed they got “informed consent” to use the bodies from the Chinese medical institutions that donated them to the exhibit, but acknowledged they have no idea how those institutions got the bodies and what, if any, ethical safeguards governed their original acquisition. Then the exhibitors continually deflected questions about the social context of the acquisitions--questions about whether poor people, migrants, ethnic minorities, or unclaimed dead might be more likely to have their bodies “donated” than others in contemporary China. Moreover, it seems questionable whether even the minimalistic institutional consent was genuinely informed. Donators were said to have given permission for the bodies to be used for “scientific research.” But putting preserved, recognizable, and partially-dissected Grandma Lee on world tour might not be the first thing that comes to mind for many who hear the words “scientific research.”

Given the uncertainty about how bodies were obtained, why did I go to the exhibit anyway? This is a particularly acute question for me because of my role as a bioethicist. One of my

primary professional responsibilities is to support administrative processes aimed at insuring informed consent and genuine voluntariness for any bodily giving.

So why did I go anyway? I can only tell you what I told myself. I thought: “I must go to the exhibit because I have been asked to be on two panels about it. If I don’t go, I won’t be able to do what I am trained to do for the benefit of others. I am not an ordinary lay museum viewer. No, I am a *panelist*. As a *panelist*, I must go there in order to share the fruits of my education and training with the general public.”

But isn’t that the process of rationalization that goes on in every notorious case where a scientist transgresses bioethical norms? Here I was, engaging in the same rationalization that it is my job to constrain.

Ambivalence 2: Humanizing and De-humanizing the Bodies

Once at the exhibit, I found myself paradoxically exhilarated by and repulsed by the realness of the bodies. I alternated between fascination with that reality and the simultaneous need to distance myself from it. Clearly I am not alone here. Consider that the Science Center’s advertising materials for this exhibit boldface “Actual Human Bodies.” However, the pamphlet viewers are given at the exhibit argues that we should refer to the bodies as “specimens”—as opposed to cadavers, corpses, or other such terms. And the term “specimen” is used throughout the exhibit. The label “actual human bodies” embodies our fascination for the real; the label “specimens” our need to distance ourselves from the real.

My point here is not simply to criticize the Science Center. The museum’s paradoxical labeling is iconic of my emotional dance as a viewer. “Wow, this could be Uncle Lou. Oh, this looks more like a store mannequin than Uncle Lou.” I worry that the ambivalent dance allows viewers to shirk the moral weight of the realness. How can I confront that ethical danger? I’ve chosen one small way: to call a spade a spade by calling the bodies bodies.

Ambivalence #3: Science or Art?

Finally, I want to highlight the ambivalence between considering this exhibit as science education or as aesthetic entertainment. Why was I so curious to see those real bodies, anyway? Clearly the “p.c.” answer would be that I wanted to educate myself scientifically. After all, the exhibit is at a science museum, and has been advertised as a scientific learning opportunity. Great answer. Only, it is not true, for me. I did not expect to learn much scientifically. And I didn’t. Indeed, the textual explanations with the bodies are very sparse, so one has to come to the museum with knowledge of bodily function to make connections between form and function. It’s a good thing I came with such low expectations for scientific education.

If I am honest with myself, what I really wanted was to experience the beauty of the body in a new way. Here, my expectations were not only met, they were dramatically exceeded. Wow. What complexity. What delicacy. What patterns. What simultaneous strength and vulnerability. What *beauty*. Wow! After experiencing that, I was not surprised, flipping through the exhibit guestbook, to see how many guests didn’t mention science at all, but articulated religious or quasi-religious expressions of awe.

So I was artfully entertained by the bodies here. And the exhibitors clearly intended me to be artfully entertained, considering the posing and lighting of the bodies. Is there anything wrong with reveling in that aesthetic experience? I don’t think so. But then, why is the exhibit packaged so thickly in the language of science? Indeed, why is the exhibit not at the art museum? I ask those questions not to reify a false dichotomy between science and art. Rather, I wish to highlight how seductively the two are married in the exhibit while only science is invoked rhetorically. Why does the language of science placate us? Why does it make us feel the subject matter is

tamed and justified? And why do we fear acknowledging our electrically sensual interest in this material?

Ambivalence #4. Is It Good or Bad that I Went?

At the end of the day, is it a good thing that I went to this exhibit? I don't know. But here are two goods I hope to take from it. In the first place, I want to hold on to a realization about why processes I work to support as a bioethicist--transparent processes to insure voluntary and informed consent for bodily use--are so important. They are important not because there are a few Frankenstein researchers out there, not because there are a few bad apples, but because there are *many people just like me!* The human drive for new knowledge and experience just comes with a capacity for ethical rationalization and exceptionalism. Secondly, I want to hold on to my feeling of awe at the beauty of the body. I want to ask myself what that beauty means for the care of my body and others.

Is it good that I saw this exhibit? I don't know. But I am more likely to press it to the good if I am willing to interrogate both my motives for going and the profound ambivalence that wracked me as a viewer.



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Procuring Bodies: A Cautionary Note

by John Waller, Ph.D.

In February 2007, the Detroit Science Center hosted a public discussion of *The Universe Within*, its latest, most controversial and overwhelmingly most popular exhibit. Hundreds of human bodies, limbs and organs kept from decomposing by a process called plastination are displayed for public edification, or at least entertainment. The corpses come from China and are leased by an American company based in Florida. It’s one of a clutch of similar exhibitions. Wherever they go controversy follows and money pours into the coffers of the touring companies.

The Science Center is not blithely unconcerned about the ethical issues raised by displaying these bodies. And so, to its credit, it agreed to host a discussion. My brief was to say something about the history of anatomical investigation and the procurement of bodies. I should begin by stressing that I fully recognize the central importance of dissection to medical progress, past, present and future. But the rather cavalier way in which the touring company addresses questions about the origins of its bodies brings to mind the darker side of medicine’s relationship with corpses. Consider for a moment the flagrant disregard for what we’d consider basic ethical values in the vast public hospitals of post-Revolutionary France.

Many of us are familiar with the heroic side to the medical revolution that began in Paris--of how the government set about redefining medical education so that ancient texts were swept away as students learned their medicine at the bedside and in the autopsy room. But there’s a parallel story that deserves to be told. For the bodies dissected were invariably those of poor men and women who died unable to pay their bills. They were so poor and desperate that doctors could take outrageous liberties with their bodies in life and death: matter-of-factly discussing a patient’s impending death by her bedside or scribbling their names on the skin of the dying to claim them for a later autopsy.¹ For all the wonderful advances of the sciences of anatomy and physiology, historians like John Harley Warner and Ruth Richardson have also uncovered cases of the exploitation of the poor and the voiceless.

While we don’t know how the bodies displayed in *The Universe Within* exhibit were procured, there’s enough uncertainty on the matter to provoke reflection.

The early days of human dissection

Around the Detroit exhibit there are a number of panels telling us the history of human anatomical dissection. It's a sanitized story, though it starts accurately enough. We're told that many European states legalized human dissection in the 1500s, but only using the bodies of a handful of executed felons. Dissection was deemed to be a "further Terror and peculiar Mark of Infamy." Even so, the legal supply of bodies was never enough, a fact indicated by William Shakespeare's epitaph in Stratford upon Avon:

Good friend, for Iesus sake forebeare
To digge the dust enclosed heare.
Blest be ye man [that] spares these stones,
And curste be he [that] moves my bones.

By the 1700s gangs of well-organized body snatchers carried out commissions for surgeons who needed more corpses for anatomy instruction and scientific investigation. If a surgeon wanted a certain corpse he could usually get it. As the brilliant English surgeon Sir Astley Cooper boasted, "there is no person, let his situation in life be what it may, whom, if I were disposed to dissect, I could not obtain."² Fresh graves were routinely plundered, sometimes provoking riots. Whose graves were targeted? Those of the poor. The reason is simple: they couldn't afford the triple caskets, the guards or the stone sarcophagi that the rich usually bought in order to keep their graves from being robbed for medical science.

But in 1832, an Anatomy Act was passed in England to give anatomists what an explanatory sign in the Detroit exhibit calls a "legitimate" source of cadavers. This makes it sound as if the surgeons would only henceforth dissect the bodies of those who had voluntarily donated their bodies. On the contrary, the legitimate source comprised paupers who died in workhouses and infirmaries and whose bodies were not collected. The upper- and middle-class who passed the Act asserted that nobody cared about the bodies of the unclaimed. In fact, as Ruth Richardson demonstrated, in the vast majority of cases, their relatives *did* care but they could not afford the expense of a proper funeral. They therefore followed customary practice and didn't claim the bodies but instead mourned at a funeral that had to be paid for by the parish. After 1832, however, poverty acquired a new dimension of degradation. The dying poor knew that they were to come under the anatomist's knife and that their remains would be unlikely ever to be reunited and properly buried. Working class politicians fumed. But they were powerless to oppose or overturn the Act. Ruth Richardson has calculated that in the first 100 years of the 1832 Anatomy Act, almost 57,000 bodies were dissected in London alone and that 99.5% came from places housing the poor. Hardly any of those dissected voluntarily gave up their bodies. Nor did most of their relations in any way approve of or condone what happened to their corpses.

Why does it matter?

This matters because the people who ended up on anatomists slabs in the century after 1832 had intensely dreaded such an outcome. We might be talking here of a Christian society that believed dust returned to dust but the soul ascended to heaven. Even so, most humans do attach profound significance to the integrity of their bodies in death. Hence anatomical dissection was ordered only for executed felons guilty of "the most heinous kind of criminal homicide." This limited number of available bodies lead to widespread fear of the stealing of corpses. The very rich were buried in vaults that were well guarded until the point at which the body had started to liquefy and became valueless to the resurrection men and their surgeon paymasters. Poor

families, who often couldn't even afford a casket, often placed a brick, stone, or stick on the mound of soil. If it had moved by the following day, then in all likelihood grave robbers had been to visit.

We know that medicine can sometimes become blasé about the significance of corpses to the dying and to their friends and relations. There was a huge public outcry when it was revealed in the 1990s that the chief pathologist at Alder Hey hospital in Liverpool, England had stockpiled the organs of 845 deceased children. Most of the children's parents were deeply upset at what they saw as a blatant disregard for the dignity of living *and* dead. It's true that medical advance requires bodies. It's also true that crucial medical advances were made possible by the exploitation of poor people's bodies in the 1800s and early 1900s. But the needs of medicine do not always justify trampling over the wishes of the deceased or their families. The Anatomy Act of 1832 did not, from our moral standpoint, provide a "legitimate" source of cadavers. And with this and other precedents in mind, I think it is important to go on asking about where bodies have come from and whether or not full consent was obtained.

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1. John Harley Warner. *Against the Spirit of the System: The French Impulse in Nineteenth-century American Medicine* (Princeton University Press, 1998).
2. Ruth Richardson. *Death, Dissection and the Destitute* (University of Chicago Press, 2000).



Study Abroad Opportunities

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, June 8 – August 1, 2008. The 11-credit program includes one integrated course co-taught (in English) by Fred Gifford, 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 our 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 Fred Gifford at gifford@msu.edu or see <http://studyabroad.msu.edu/programs/costaethics.html>.

London

Michigan State University will offer a six week study abroad course, “Medical Ethics and the History of Health Care in London” next summer, June 30-August 9, 2008. The 7 credit course will be co-taught by Len Fleck, Ph.D. (Center for Ethics, MSU) and Jessica Reinisch, Ph.D. (History Department, Birkbeck College, University of London). It includes two half day experiences for each student shadowing a health care practitioner. For further information, see <http://studyabroad.msu.edu/programs/ukmed.htm>.

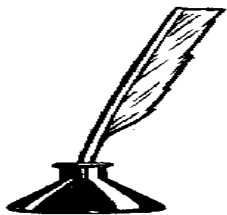


The Center Welcomes David M. Kozishek, MA, BCC

David joins the Department of Family Medicine and The Center for Ethics and Humanities at MSU as an Assistant Professor. He will be responsible for providing leadership in the spirituality and medicine components of medical student and resident training in the College of Human Medicine and will assist with related teaching needs in professionalism and the patient-physician relationship. He will develop and offer training programs in pastoral care for clergy in the areas served by CHM's six community partners, and will develop and engage in scholarship related to the practice and teaching of spirituality in health care. David will also be teaching in the various curricula offered through the Center, and looks forward to pursuing a diversity of teaching, service, and research projects grounded in the medical humanities.

David earned his BA in philosophy, theology, and psychology at St. Ambrose University in Davenport, Iowa, followed by a four-year BA/MA degree in Religious Studies at the University of Louvain in Leuven, Belgium. He is currently a candidate for the PhD degree at The University of Texas Medical Branch's Institute for the Medical Humanities, where he has achieved a double-major in both health care ethics and literature/narrative studies in health care, as well as a minor in the history of medicine. Prior to his doctoral studies David completed a two-year residency in Clinical Pastoral Education at Hennepin County Medical Center in Minneapolis, MN, and is currently a Board Certified Chaplain (BCC) through the Association of Professional Chaplains, endorsed by The Religious Society of Friends (Quakers).

The working title of David's dissertation is "A Hermeneutic Analysis of Clinical Ethics Practice in the Twenty-First Century: Toward a Practice Grounded in the Humanist Tradition." He plans to defend his dissertation and graduate in 2008.



InkLinks is a regular column in which readers reflect on issues related to the previous lead article. In the last issue of MHR, Sarah Goodfellow discussed sex and the elderly, *Gendered Neutral? Medical Representations of Senescent Sexuality*.

Fun, Sex Toys, and the Elderly

by Aron Sousa, M.D.
College of Human Medicine

No one expects their elderly patient to ask how to buy a dildo. But about three months ago that was the question I got from T. Because of certain plumbing issues, he and I had discussed sex a couple of times, and by his report, he and his wife were into it. By which I mean that the conversation was not about how sex “was important” or “meaningful,” but rather how sex was fun and they wanted to have sex for that reason.

In her piece “Gendered Neutral? Medical Representation of Senescent Sexuality,” Sarah Goodfellow asks a concluding question, “What would constitute age-appropriate sexual behavior for the elderly?” And I guess my question in return is “Why focus on age?”

I started innocently enough. “So T, given that the meds haven’t worked, what do you want to do?”

“Well,” he answered a bit sheepishly, “what about those.... [awkward hand gesture] those things....”

“You mean a sex toy?!”

“Yeah, I know it would not help me, but my wife would enjoy it and I think she’d be interested.”

“Sounds like a good idea.”

“But, Aron, I am a crippled up 85 year-old guy. I can’t take a walker into some....some sex shop [he chuckles].”

“Oh, but T,” I said, “that is why the government invented the internet.”

“I am not sure how I’d go about that.”

“I’ll bet if you Google dildo or vibrator, you’ll find plenty of options.”

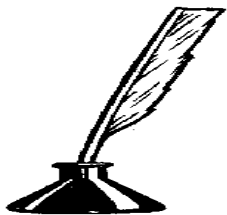
From a clinician’s point of view, I think that sex of the elderly, by the elderly, and for the elderly will not perish from the earth even as elderly do perish. Reading Erasmus Darwin or Ben Franklin makes it pretty clear that the urges of the old are old indeed. Not that doctors have wanted to deal with it. Some of this is surely the hang-ups about age that Goodfellow rightly address – that somehow the elderly are childlike or diminished. But appropriate sexual behavior is not about age; people of all ages make good and bad decisions, get infections, get frustrated, get bored, get laid. What I’ve learned from my patients is that disability is a larger issue for

sexuality than age. Disease and disability completely changes a person's sexual life. And most of us are so afraid of disability, or loathed to deal with the intimate ramifications of disability, that any hint of sexuality or sexual attraction is immediately suppressed.

I vividly remember my own reaction to a home visit to young woman whose car accident had left her disfigured and slightly mentally diminished. This was a long time ago, but I can still see the pictures of her before the accident. In them she was beautiful and the man she was with was handsome. When our discussion turned to her friends, she said that her former-boyfriend (not ex) had visited. I murmured something about how nice that must have been, and she said, "it made me horny." I awkwardly moved on, but I should not have.

Goodfellow claims that "the elderly continue to inhabit an ambiguous sexual space." I am not sure where that space is but I doubt it is between their legs. More likely the ambiguous space is between our ears and is generalizable beyond the elderly to everyone who goes outside of society's approved erogenous zones.

Euro-American society past and present has focused on containing sex. No sex with other races or with the same sex or outside of marriage or between cousins or below your class or with anyone transgressive. For some, even sex just for fun is or has been hedonistic and transgressive. At some point sexy old people must have become transgressive, dirty old women and dirty old men. That's a shame, because they just want to have fun.



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Quality of Life and Sex in the Elderly

by Mark Ensberg, M.D.
College of Human Medicine

Sex is not just for the young. Surveys by the AARP suggest the elderly remain interested in sex and that most elderly want more sexual activity than they have. Satisfaction with personal relationships may increase with age, and sexual activity often remains an important part of these relationships. In general, elderly remain more interested in touching, embracing, and kissing; less interested in masturbation and intercourse.

Unfortunately, myths regarding sexuality in the elderly have been perpetuated because of inadequate study about their sexual behavior. Early studies often examined sexuality in persons “older than 50”—an age considered youthful by geriatricians who define the “young old” as those aged 65 to 74. Most recent studies have been done in healthier, married, mostly white, affluent populations.

Geriatricians do not like to blame age for the consequences of lifestyle or disease. Despite age-related changes in human body, sexual activity can continue to be an important contributor to quality of life in the elderly. The old adage ‘if you don’t use it, you lose it’ applies as much to sexual activity as it does to the preservation of mental function or physical strength. Alcohol may increase desire but dull performance. Studies point to illness, medications, and psychological issues as important reasons for discontinuation of sexual activity.

The most important barrier to sexual activity is the lack of a partner. Two thirds of persons in the United States aged 65 to 74 are married and live with their spouse. Because older women live longer than men, older men are more likely to be married and living with their spouse. More than 50% of women between the ages of 75 to 84, and 80% of women older than 85, are widows. A new friendship, or the reestablishment of an old relationship, by a widow or widower can be very disconcerting to children.

Although the majority of the elderly live in their own homes, older and disabled elderly couples are more likely to live in environments with less privacy, approximately 15% of those older than 85 live with children and 20% live in nursing homes. Assisted living facilities are the fastest growing trend in residential settings for the elderly. Nursing homes are establishing policies and procedures addressing intimacy among their residents, many of whom are cognitively impaired.

Attitudes and behaviors related to sexuality are likely to change rapidly as the baby boomers turn 65. Later-life divorces are increasing. Older lesbians and gay men are more open. Dating services for the elderly are available on-line. Older people are more likely to be involved in

intimate relationships. Sexually transmitted diseases in the elderly, including HIV, are being seen much more frequently. Viagra, Levitra, and Cialis are being heavily marketed. This is a generation with very high expectations.

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News & Announcements

Judy Andre

- Published “Environmental Education in a Course on Ethics and International Development” in *Probing the Boundaries: Environmental Justice and Global Citizenship*. Oxford UK: Interdisciplinary Press, 2007. Pp. 301-306. An e-book: <http://www.interdisciplinary.net/publishing/idp/eBooks/PTBEJGC%201.6b.pdf>
- Published “Learning to Listen: Second Order Moral Perception and the Work of Bioethics” in *The Ethics of Bioethics: Mapping the Moral Landscape*, Lisa Eckenwiler and Felicia Cohn, editors. Baltimore: Johns Hopkins University Press, 2007. Pp. 220-228.

Libby Bogdan-Lovis

- Presented “The Ethics of Informed Consent” for The Center for the Childbearing Year, Ann Arbor (Nov).

P. Sean Brotherton

- Presented “Emergent Capital, Shifting Ideologies, and Cuba’s Changing Health Sector” at XXVII Latin American Studies Association Meetings, Montreal (Sept.).
- Gave the paper “Socialist Entrepreneurs and the Biopolitics of Health in 21st Century Cuba” for the Anthropologie et mondes socialistes et (post-)/socialistes Workshop at the Conference on the Anthropology of Globalized Cultures - Fieldwork in Complex Situations and Disciplinary Issues, Québec City (Nov).
- Presented “Socialist Entrepreneurs, Emergent Capital, and the Biopolitics of Health in Contemporary Cuba” at the American Anthropological Association Meetings, Washington, D.C. (Nov/Dec).

Len Fleck

- Presented “Ethical Challenges for Community Health Centers in the 21st Century” at the annual meeting of Michigan Community Health Centers in Traverse City (Sept).
- Presented “Balance, Judgment and Pluralistic Respect: Keys to Good Ethical Decisions” at the annual bioethics conference of the Michigan State Medical Society in Traverse City (Oct).
- Presented “Embryonic Stem Cell Research: Ethical and Policy Challenges” at annual scientific meeting of the Michigan State Medical Society in Troy (Oct).
- Presented “Just Caring: How Should We Ration Access to Expensive Cancer Drugs?” at the annual meeting of the American Society of Bioethics and Humanities in Washington D.C. (Oct).
- Presented “Medical Ethics: An Introduction” at Ethics Day for Primary Care residents attached to the College of Osteopathic Medicine (Oct). He also did two workshops on ethical

issues in withdrawing life-sustaining care from incompetent patients and ethical issues in the care of PVS and minimally conscious patients.

- Presented “Ethical Challenges of Academic Research: Integrity and Academic Freedom” as part of the annual lecture series on research ethics at the Kellogg Center (Oct).
- Published the chapter, “Just Caring: The Ethical Challenges of Health Care Reform in the USA,” in *Distributing Health Care: Principles, Practices, and Policies*, edited by Niall Maclean. University of St. Andrews Press, 2007. pp. 1-47.

Margaret Holmes-Rovner

Grants

- Began a new grant October 1, 2007 with PI, Angela Fagerlin (UM Research investigator, Internal Medicine & the Program for Improving Health Care Decisions). The grant, entitled, “Impact of a Low Literacy Prostate Cancer Decision Aid on Decision Making,” is a four site study being conducted at VA clinics in Ann Arbor, Pittsburgh, Duke, and San Francisco. It will offer support for informed decision-making about treatment to 480 men newly diagnosed with prostate cancer.

Presentations

- Presented “Use of Beta Blockers, Lipid Lowering Agents, and Angiotensin Converting Enzyme- Inhibitors before Recurrent Acute Myocardial Infarction” with co-authors A.B. Olomu, A. Dhoble, A. Siddiqi, K. Burton, and D. Oluwole at SGIM Midwest Regional meeting, Chicago (Sept).
- Presented “Patient Decision Support Research in Oncology” for Grand Rounds, Cancer Center, Virginia Commonwealth University, Richmond (Nov).
- Presented “Shared Decision-Making in Women’s Health: The View from the Field” at Plenary Opening Symposium, North American Menopause Society (NAMS) in Dallas (Oct).
- Presented poster “Ability to Interpret Statements of Numeric Risk & Patient Satisfaction with Anti-Rheumatic Risk Communication” with co-authors R.W. Martin RW and A.F. Head at the Society for Medical Decision Making, Pittsburgh (Oct).
- Presented poster “Does Depression Modify Patient Appraisal of Anti-Rheumatic Drug Treatment Effects?” with co-authors R.W. Martin and A.F. Head at the Society for Medical Decision Making, Pittsburgh (Oct).
- Presented “Identifying Patients Who Need Low Literacy Materials to Support Anti-Rheumatic Drug Decision Making” with co-authors R. Martin, A. Head, E. Tubergen, and L. Bader at the American College of Rheumatology Annual Scientific Meeting, Boston (Nov).

Publications

- Holmes-Rovner M, Correa-de-Araujo R, Coulter A, Elwyn G, Nelson W, O’Connor A, Pignone M, Rovner D. 2007. Are patient decision aids the best way to improve the quality of clinical decision-making? *Med Decis Making* 27(5): 609-618.
- O’Connor AM, Bennett C, Stacey D, Barry MJ, Col NF, Eden KB, Entwistle V, Fiset V, Holmes-Rovner M, Khangura S, Llewellyn-Thomas H, Rovner D. 2007. Do patient decision aids meet effectiveness criteria of the international patient decision aid standards collaboration? A Systematic Review and Meta-analysis. *Med Decis Making* 27(5):554-574.
- Margaret Holmes-Rovner was a Special Guest Editor of the September-October, 2007 issue of *Medical Decision Making on Shared Decision Making, Decision Aids, and Risk Communication*. The special issue is available free of charge through late November at: http://www.sagepub.com/upm-data/16753_Sep_Oct_Announcement_curissue.pdf.

Gerald S. Schatz

- Was a panelist, on physician ethics, the College of Human Medicine Foglio Conference on Spirituality and Medicine (Nov).
- Presented “International Law on Research Consent,” at the College of Human Medicine Saginaw campus (Nov).

Tom Tomlinson

- Gave two talks, “Ethical Issues in Palliative Sedation” and “Ethical Issues in Limiting Treatment,” at a conference in Flint sponsored by Avalon Hospice (Nov).
- Presented “The Ethics of Futile Resuscitation” at a conference sponsored by the Ethics Institute at Muskegon Community College (Nov).