



Health Care and the Presidential Election: Some Considerations

Issues and Politics in Patient Privacy

*John Hazewinkel, M.P.A., J.D.
Institute for Health Care Studies*

Both major party presidential candidates cite the expanded use of information technology in health care as key reforms in their political platforms. The vision of comprehensive health information availability within a few keystrokes attracts clinicians and reformers who are frustrated with the current fragmented state of the industry, but repels some advocates concerned about privacy and libertarian rights. While it is tempting to frame the debate as a utilitarian battle between greater goods and individual rights, the underlying issues are more reflective of the health care culture and industry than the struggle for personal liberty. The next Administration will be unable to fully address IT/ privacy debates without understanding the fundamental nature of information relationships between patients, providers and payers as well as the opportunities that health IT promises for enhanced medical care and security.

The information technology revolution that has swept through most industries is only starting to make inroads into the clinical setting. The fragmented system of health care delivery in the United States is reflected in a disjointed system of information storage and exchange. Many clinicians still primarily depend on paper records and handwritten notes. While hospitals, health systems, service providers and a few practices have invested in IT systems (including electronic medical records), their systems rarely communicate outside of organizational boundaries. Rarer still is a single place where all patient records may be centrally accessed. Patients and caregivers often lug cartons of records and pill boxes from place to place and are expected to recount details about their treatment histories from memory. Since much health care activity revolves around patients with chronic conditions who typically access multiple health care providers and services, this lack of coordination is costly, burdensome and too frequently injurious. Intensive users of health care and people with scattered or lost records (whether by frequent moves or hurricanes) have the most to gain by systems that aggregate their health data.

The cost savings, quality and patient safety benefits enabled by electronic health information exchange are sometimes overshadowed by concern over security

breaches and dispersion of private information into cyberspace. Periodic news articles about lost flash drives and stolen computers with patient information feed the anxiety, such as the stolen laptop from University Healthcare in Utah that contained information about 4,800 patients. Paper records can also disappear, however, as a courier from the same hospital system discovered when a box containing information on over 2 million patients was stolen from his car. While it is true that electronic compilation and transmission of data can increase the volume of misplaced information, the number of actual damages from security breaches does not necessarily increase in proportion. Thieves of laptops and flash drives generally desire the value of the devices themselves more than the medical content.

Information technology may allow unauthorized parties to access private information more readily. It also enables automated tracking of such access. A Michigan hospital recently disciplined employees who improperly accessed the electronic medical records of Governor Jennifer Granholm. The employees were discovered via a user authentication system. Had the employees merely snooped around her paper records, they would not have been discovered as easily. The contrasting problem under the current fragmented system is that data does not frequently get into the *right* hands—where it is needed. Treatment decisions may have injurious consequences when medications, allergies, and underlying conditions are unknown.

Some of the anxiety expressed by privacy advocates reflects misunderstanding about the current flow of protected health information. A nationally distributed editorial titled “Who’s Reading Your Medical Files Today?” recently posed the question: “How would you feel about your personal health information flowing freely over the Internet between public

(Continued on page 2)

In This Issue:

Issues and Politics in Patient Privacy	1
The Center Welcomes	2
Paying for the Possibility of Disease	3
Globalization, Employment Insecurity and Quality of Life	4
InkLinks	5
Job Announcement	6
Study Abroad Opportunities	6
News & Announcements	7

(Continued from page 1)

health officials, healthcare providers, insurance and data clearinghouse companies, and others – without your permission?” implying that somehow information technology created new rights to access instead of just new means. Consumers have existing contractual, treatment and legal relationships with these groups that require information release. Not only do these entities need such information to perform their functions, consumers experience direct and indirect benefits when these entities have appropriate information. Medical research becomes more robust, public health warnings about disease outbreaks can be issued within minutes as opposed to days, and patterns of improper care can be detected and remedied much more easily. Private health information has been routinely collected, stored, and used (much of it electronically) by disparate organizations for decades without much public fanfare. Consumers’ formal relationships with the health care industry have altered by the economic and legal atmosphere of the industry itself far more than by increased electronic communication.

Some concerns are primarily symptoms of other problems with the American health system. Consumers may fear that public disclosure of their pre-existing health conditions will result in job discrimination or denial of health insurance coverage. The underlying problem is a dysfunctional system that enables such coverage gaps. A relatively new phenomenon – medical identity theft – is motivated by the same lack of universal coverage. Involuntary disclosure of some conditions can create embarrassment or social stigma. Changing cultural attitudes over time make it hard to legislate against these potential exposures, however. Attitudes toward smoking and HIV status have changed over the past decade for example. Some generations have highly valued secrecy; others are unafraid to post intimate details on their Facebook accounts. With the emerging frontier of genetic-based medicine, information about even the minutest details – individual genomic sequences – may make their way into electronic records. Dangers do exist when such information is improperly exposed. Forgotten in the concern is that equal dangers exist in the blank fields. The files of too many Americans lack information about immunizations, medications, preventative care and other subjects because such care was never received. The value of information technology in the battle to improve access, quality and affordability must be considered along with the pitfalls.

Electronic privacy debates are misplaced when they attempt to impede technological developments and keep the health care industry stuck in the past in order to prevent future abuses. The discussion should center on what technical and policy innovations are still needed to enhance privacy protections while simultaneously promoting systemic improvements. Refined role-based security processes will help ensure that appropriate parties receive the appropriate level of information. (Podiatrists do not need to see the same information as oncologists, for example.) Reasonable access controls that maintain the privileges of all parties in

the health care relationship will build confidence. Clear legal standards that articulate the rights and responsibilities of various stakeholders, plus penalties for abuse, will help to clear the foggy atmosphere created by HIPAA and other related laws. The most important innovations will use information technology tools to join the fight to solve the American health care crisis instead of adding to it.

For references, visit <http://bioethics.msu.edu/mhr/contents.html>

The Center Welcomes...

The *MHR* would like to welcome Karen Meagher, who recently joined the Program in Bioethics, Humanities, and Society as the undergraduate specialization advisor. She is a doctoral student in the philosophy department at Michigan State University. Karen is specializing in medical ethics. Her research interests include notions of ontology and their relation to public health, health disparities, and development issues. Karen is beginning dissertation research on ethics of public health.

The *MHR* would also like to welcome its new editor, Emily L. Altimare. She is a graduate student in the department of anthropology with interests in organizational culture, medical anthropology, health care, disease management, and corporate health initiatives. Emily received her Masters in Applied Anthropology from Northern Arizona University in May 2007.



Editor

Emily Altimare, M.A.

Director

Tom Tomlinson, Ph.D.

Assistant Director

Libby Bogdan-Lovis, M.A.

CEHLS Faculty

Judy Andre, Ph.D.

Leonard Fleck, Ph.D.

Margaret Holmes-Rovner, Ph.D.

Linda Hunt, Ph.D.

David M. Kozishek, M.A., B.C.C.

Ann Mongoven, Ph.D., M.P.H.

Gerald Schatz, J.D.

Misha Strauss, Ph.D.

CEHLS Staff

Peggy Anderson

Jan Holmes

Karen Meagher

The Medical Humanities is published three times a year by the Center for Ethics and Humanities in the Life Sciences (CEHLS) at Michigan State University. The Center is an academic unit whose faculty teach in the medical, nursing, and veterinary colleges, as well as in Arts and Letters and Social Sciences.

Phone: 517.355.7550

E-mail: center@msu.edu

Reprint permission granted with MSU and CEHLS citation.

Available online at <http://bioethics.msu.edu/mhr/contents.html>

Paying for the Possibility of Disease: How Medicalization of Risk Conditions Affects Health Policy

Alison Reibeld, Ph.D. Candidate, Lyman Briggs College

“This week, in clinics and hospitals across the country, thousands of perfectly healthy-feeling adults will receive a diagnosis for a disorder that they did not know they had . . . diseases that bear no immediate relation to symptoms but rather are connected to a statistical likelihood of developing symptoms in the future, pathologies—such as high blood pressure, mild diabetes, or elevated cholesterol—that are measurable only with the aid of intervening diagnostic technology . . . [F]or most people these diagnoses lead directly to the prescription of a drug they will take every day for an indefinite period, if not for the rest of their lives.”

— Jeremy A. Greene, M.D.

Health policy in America is a major political issue, and rightly so, given the 45.7 million Americans—15% of the population—who lack health insurance (Vietz). The issue is being addressed bipartisanly by attempting to broaden access to private insurance, an obvious solution to a lack of health insurance. President George W. Bush’s 2008 state of the union address proposed to resolve the problem by trusting “patients and doctors to make medical decisions” and “expanding consumer choice” by removing tax penalties for those who purchase individual private insurance. In addition, the Bush Administration proposed expanding Health Savings Accounts. Both solutions fail to address the underlying problems: the rising cost of health insurance for individuals and groups, and the rising cost of healthcare in general (8.8% of U.S. GDP was spent on healthcare in 1980, and 15.2% in 2003, according to the Kaiser Family Foundation). Neither of the current candidates for president, Senators McCain and Obama, address these problems directly. As with the Bush plan, they focus on getting people insured, not on how much it will cost to do so or why it costs so much.

These measures fail, in a bipartisan way, to consider *what gets covered* by private insurance or the conceptual underpinnings of *how we determine what gets covered*. Medicalization is a key component of these underpinnings, for it governs which diagnostics and treatments for which conditions would be considered legitimate medical expenditures. I will demonstrate the direct connection between medicalization and health policy by considering the way that medicalization of risk conditions has impacted healthcare expenditures in the United States and contributed to the rising healthcare costs which make access to care a much bigger problem than policy has so far acknowledged.

Let us begin with a recent policy statement issued by the American Academy of Pediatrics. The statement recommends, “cholesterol screening of children and adolescents with a *family history of high cholesterol* or heart disease . . . [or] whose *family history is unknown* or those *who have other factors for heart disease including obesity*, high blood pressure or diabetes. Screening should take place after age two, but no

later than age 10 . . . If a child has *values within the normal range, testing should be repeated* in three to five years. For children who are more than eight years old and who have high LDL concentrations, *cholesterol-reducing medications* should be considered. Younger patients with elevated cholesterol readings should focus on weight reduction and increased activity while receiving nutritional counseling.” (American Academy of Pediatrics, my italics). The goal is to catch patients early who have risk factors for long-term illness, and to prevent that illness by treating the risk factor for a disease. Ideally, this obviates the need to treat the disease. The risk condition in question—abnormal cholesterol levels—is dyslipidemia in children, especially hypercholesterolemia; the condition to be prevented is cardiovascular disease (Daniels). Such screening thus falls under the appealing policy rubric of preventive care. If effective, screening will result in increased treatment of dyslipidemia in children, either by lifestyle changes or by long-term use of cholesterol-reducing medications including statins. Even if it is ineffective, the screening program will result in increased costs for the repeated diagnostics involved. Note that the selection criteria for inclusion in the screen, especially those italicized, apply to a large proportion of the American pediatric population.

But what constitutes the “high cholesterol” for which the guidelines screen? When is this risk condition pathological in its own right, or even truly risky for cardiovascular disease? As Jeremy A. Greene persuasively documents, the threshold for “normal” and “abnormal” cholesterol levels has shifted since cholesterol was first considered to be involved in the etiology of atherosclerosis in the 1930s. In 1963, diagnostic guidelines for hypercholesterolemia required *both* elevated serum cholesterol and a blood relative with both hypercholesterolemia and xanthomatosis, a condition characterized by small fatty cholesterol-based tumors on the skin and elsewhere in the body. At the time, elevated serum cholesterol was insufficient to diagnose hypercholesterolemia; an abnormal cholesterol level was just a marker, not a medical condition in and of itself (Greene, 155). In fact, in 1980, the National Academy of Sciences judged claims about the efficacy of cholesterol control programs to “lack justification in the clinical and scientific literature” (Greene, 152). In 1987, the first of the cholesterol-lowering statins, Mevacor, was launched one month before the National Cholesterol Education Program released the first national guidelines for the detection and treatment of high blood cholesterol. Mevacor was approved for patients with severe hypercholesterolemia, but as with many treatments, new uses were quickly found. By 1990, Mevacor and its sister statins, Zocor and Pravachol, were being clinically tested for long-term prevention, helping to validate asymptomatic hypercholesterolemia.

(Continue on page 4)

Globalization, Employment Insecurity and Quality of Life

Mike Polzin, Ph.D., School of Labor and Industrial Relations

Globalization is a term that carries with it connotations of both opportunity and threat. The prospect of getting to know more about people and cultures in far-off lands presents inviting opportunities. Students are encouraged to take part in international study, made easier by advances in communications and transportation. Businesses enjoy greater and quicker access to market and production capabilities in developing countries where needs are great, labor costs are low and constraints are few. For many working people, however, hearing mention of *globalization* can trigger a surge of panic as they envision their employer sending their jobs or their whole business operation to one of those aforementioned countries, leaving their lives, their families and their communities devastated as a result.

The promise of globalization is improved standard of living and quality of life for all. The benefits of globalization, however, are not shared equally. In his book, *The World Is Flat* (2005), Thomas Friedman describes globalization as the inevitable consequence of the convergence of a number of factors, including technology, and optimistically claims that it has the potential to improve the well-being of people around the world. Working people often have their own opinion, however, that is not so optimistic. They typically view globalization as encompassing several elements that give an advantage to businesses over working people: an increase in international exchange and interdependence; the reduction of government-imposed restrictions that inhibit creation of a borderless world economy (Scholte, 2000); and a major shift in the organization of social relations and transactions—assessed in terms of their extensity, intensity, velocity and impact (Held et al., 1999). Fueling the process of globalization are advocates of a “free market” economy, both Republican and Democrat, who have been in positions of power and influence in the United States over the past three decades. The concepts that they actively promote give priority to the needs of business, with the justification that the needs of working people will be addressed as a result: aggressively negotiate free trade agreements; reduce government regulations affecting business; increase privatizations of public services; promote labor market dynamics that include fewer regulations and serve to weaken an already declining union base; and implement a monetary policy that focuses on inflation and not employment (Baugh, 2008).

The result is that working people become painfully aware of what becomes *their* promise of globalization: a working environment consumed by intense competition, lower costs, and a constant need to change quickly. Several assumptions become woven into the fabric of their outlook on life: the process of globalization is unavoidable and here to stay; the pace of globalization is relentless and the pace of change will only intensify; and the process of globalization is unforgiving and one needs to prepare effectively or be left behind. In addition, many doubt the ability of the political

or electoral process to provide relief, as they witness how borderless corporations make decisions beyond the influence of national governments.

The impact of globalization on working people has been severe and demoralizing. Results from a recent survey by the Bureau of Labor Statistics speak volumes about the relentless churn of change, challenging working people in the United States. From January 2005 through December 2007, 3.6 million workers were displaced from jobs that they had held for at least 3 years—a number that was about the same as the number of workers reported displaced during the previous 3 years. An additional 4.6 million workers were displaced from jobs they had held for less than 3 years. At the time of the survey, approximately one-third were still unemployed, and 45 percent were re-employed in jobs that paid less than the jobs they lost, with one quarter reporting earnings losses of 20 percent or more (Bureau of Labor Statistics, 2008). Job loss is only part of the problem. Additional families fell into poverty: 3 million more during the period from 2001-2005 and 5 million more people without health insurance (Baugh, 2008). Because health insurance is seen as a competitive disadvantage—perhaps because most other industrialized countries have effective social insurance systems and developing countries have none at all—employer-sponsored health insurance programs have been attacked.

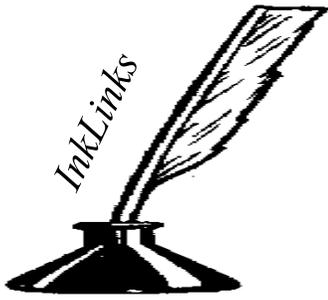
This article is continued online, visit <http://bioethics.msu.edu/mhr/contents.html>

(Continued from page 3)

These trials credited the statins with significant decreases in cardiovascular mortality and events (Greene, 185). Over time, the statins have shifted from being intended for severely affected hypercholesterolemics toward the one in every four American adults estimated to have asymptomatic high cholesterol.

Statins are now being used preventively as a result of these shifting diagnostic and treatment guidelines. Alas, they are not cheap now nor were they when they first appeared. Cost-effectiveness studies of cholesterol guidelines from the late 1980s found an average figure of \$150,000 per life-year saved through drug therapy when not targeted at only the most severe cases (Greene, 214). When used for prevention in high cholesterol asymptomatic middle-aged men at current drug costs—lower now because the original formulae are off-patent—the cost per life-year saved ranged from \$14,600 to \$45,250 (converted from Euros to dollars in Peura, et al.).

(Continued on page 6)



Perspectives on: *More than Skin Deep?* Concepts of Racial and Ethnic Difference in the New Genetics

In the last issue of MHR, Linda Hunt discussed the use of racial classifications in biomedical research. The contributors to this InkLinks continue this conversation.

InkLinks is a regular column in which readers reflect on issues related to the lead article. It is meant to tap the rich intellectual resources that this network provides.

We welcome your contribution at altimare@msu.edu.

Race and Genomics: Beyond Skin Color

Two facts about race are well accepted in scientific communities: 1) “races” exist as social constructions and not as biological entities, and 2) racial classifications are used in everyday life in ways that structure and perpetuate social inequalities. Professor Hunt raises the concern that the use of common classifications of races in studying genetic variation may inadvertently and wrongly affirm the existence of biological races. She raises the concern as a matter of questionable science, but given the destructive uses of race-thinking in the past and in contemporary society, the erroneous affirmation of biological races and their association with particular alleles might serve to further stigmatize and oppress particular population segments. Such a possibility motivates Stevens (2003: 1035) to propose that the National Institutes of Health, “issue a regulation prohibiting its staff or grantees from publishing in any form...claims about genetics associated with variables of race, ethnicity, nationality, or any other category of population observed or imagined as heritable, unless statistically significant disparities between groups exist and description of these will yield clear benefits for public health, as deemed by a standing committee to which these claims must be submitted and authorized prior to their circulation in any form beyond the committee.”

The situation presents an interesting paradox. Ideally, we are interested in identifying genetic variation among human groups for the beneficent use of the resulting knowledge, particularly in human health, while at the same time we are situated within racial contexts that provide common racial categories that impact our research studies and potentially may be dangerous to racially and other oppressed groups in society.

The view of races as biological entities continues to have some adherents in the communities of science, including geneticists and medical, social and educational researchers, but they are numeric minorities. As a way of promoting the discussion, the National Human Genome Center at Howard University held a small but critical workshop in 2003 on *Human Genome Variation and ‘Race.’* Presentations given at the workshop were published as articles in a 2004 supplement of *Nature Genetics* titled “Genetics for the human race.” The articles in this supplement address issues regarding race, ethnicity, genetics and health, and a variety of perspectives are provided. In general, however, even those researchers who consider racial and ethnic la-

bels useful in epidemiological and clinical settings understand the need for standards for statements regarding the contributions of genetics to between-group differences. Other useful fora on the topic of race and genetics have occurred since then, including that by the Social Science Research Council (SSRC).

The SSRC created an e-forum entitled *Is Race “Real”?*, as a way of contributing to the discussion, using a series of commissioned short essays focusing on race and genetics by noted scholars and researchers. Here, too, the prevalent view is that race is a social construction, while recognizing that humans vary biologically (both genetically and phenotypically). Interesting views indeed! Which is it, then, are races biological or social constructions? This debate will undoubtedly continue into the future, and rightfully so, as the exchange of ideas is a basic norm within scientific communities.

At this time, what we do know about race and genetics is that human genetic variation is not clustered into phylogenetic groupings called “races.” At the same time, health variation among humans is real and is due to a combination of environmental and genetic variances (some researchers prefer to associate the latter to ancestry rather than race). As the research proceeds, it is important to keep the focus on human genome variation and to find ways to conceptualize population groups without relying on common race taxonomies.

Rubén Martínez, Ph.D.

Julian Samora Research Institute

For references, visit <http://bioethics.msu.edu/mhr/contents.html>

Broader than Skin Deep

The problem that Linda Hunt points out in, *More than Skin Deep? Concepts of Racial and Ethnic Difference in the New Genetics*, is an important issue that has surfaced anew as a result of the Human Genome Project and the new interest it has generated in the area of genetics. Is race biologically real; and if it is not, why does its use seem to allow us to observe some biological consequences? Hunt answers these questions by indicating that even though race is not biologically real, researchers and clinicians use it because of its imprecise meaning. This imprecision allows researchers to believe that it is tracking something (ancestry in this case) that is helpful in research. Hunt

(Continue on page 6)

(Continue from page 5)

argues however, that the use of imprecise definitions of race and a lack of an adequate classification system of race undermines researchers' conclusions.

I think Hunt is correct, the referents for race are indeed varied and the term is often used to refer to a broad range of human group differences, including differences in cultural, social, linguistic, genetic, geographical, ancestral and other features. However, whether or not race should be used in scientific research and medicine seems to be somewhat of a false dilemma.

While there is biological variation in humans that is connected to ancestral geographic origins, the notion of race, racial categories, and ethnicity can be seen as a social classification system that is able to create biological consequences. Thus, race as a social category is derived from differences in culture, language, social status and other factors. These differences affect such things as income, housing and healthcare, and these, in turn, affect health. As a result, the notion of race can enter into many statistically significant biomedical generalizations even though there may be no biological races.

If the relationship between race or ethnicity and disease is seen as a relationship between several factors that include social/cultural factors, ancestral geographic origins, and various disease genes, then part of what researchers ought to be doing is attempting to ferret out these various relationships as separate variables to aid in determining how they influence health and not just focusing on race as traditionally conceived. The question is not "What affects does race have?" It is the broader question "How can the various factors that influence health be disentangled so that the influence of each is better understood?"

Attempting to understand both the social and biological influences on health will assist researchers in obtaining the ultimate goal, which is individualized medicine.

*Tony Givhan, Ph.D. Candidate
Philosophy Department*

(Continued from page 4)

This seems a fair trade, though it is by no means cheap, and may be quite expensive compared to treating more acute symptomatic pathologies or even with other similarly efficacious preventive methods. Now consider this spread over the lifetime of an asymptomatic 10-year old with high cholesterol. It seems safe to say that widespread screening and treatment for dyslipidemia in children will raise healthcare costs, though perhaps incrementally. Consider that this pattern—a pattern of screening for and treating risk conditions for pathologies which might or might not otherwise develop—is being repeated throughout the healthcare system (see epigraph). That pattern's contribution to cost is much greater. Healthcare policy-makers ought to be asking whether such screening and treatment of risk conditions should occur and be covered. To answer this question, we need to ask whether risk conditions ought to be covered at all, whether they are properly in the realm of the

medical, and whether scarce financial resources should be spent on risk conditions—or which ones they should be spent on—rather than pathologies. We can not continue to spend upwards of 15% of our GDP on healthcare, and the expanded and expensive treatment of risk conditions contributes to our rising healthcare costs. We may decide to screen for and treat risk conditions, but a good health policy is going to have to address these issues of medicalization, coverage, and rationing altogether in order to have real change.

For references, visit <http://bioethics.msu.edu/mhr/contents.html>

Job Announcement

The Department of Anthropology and the Center for Ethics and the Humanities in the Life Sciences, College of Human Medicine (CHM) invite applications for a joint tenure-track position in medical anthropology at the assistant professor level to commence August 16, 2009. This position will be 60% Anthropology, 40% Bioethics. Candidates must be committed to undergraduate, graduate and health professional education, and display evidence of excellence in research. Desired expertise includes but is not limited to: health disparities, critical studies of biomedicine and the health sciences, ethnomedicine, political economies of health and health care ethics. Geographic focus should contribute to current areas of departmental strength, including Africa, Asia, Latin America and North America. The successful candidate will be expected to conduct externally funded research. Those with prior experience on a medical school faculty are especially encouraged to apply. A Ph.D. in anthropology is required by date of appointment. Due December 10, 2008. MSU is an affirmative action, equal opportunity employer. MSU is committed to achieving excellence through cultural diversity. The university actively encourages applications and/or nominations of women, persons of color, veterans and person with disabilities. Please send a letter of application, CV, writing samples and names of three references to: Anthropology-Bioethics Search Committee, Department of Anthropology, Michigan State University, 354 Baker Hall, East Lansing, MI 48824.

Study Abroad Opportunities

London

Michigan State University will offer a six week study abroad course, "Medical Ethics and the History of Health Care in London" next summer, August 14, 2009 (date tentative). For further information, see <http://studyabroad.msu.edu/programs/ukmed.html>.

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 31, 2009 (date tentative). For further information, contact Fred Gifford at Gifford@msu.edu or see <http://studyabroad.msu.edu/programs/costaethics.html>.

News & Announcements

JUDY ANDRE

Publications

- A review of Mike Martin's *From Morality to Mental Health*, in Notre Dame Philosophical Reviews, online. <http://ndpr.nd.edu/review.cfm?id=11503>
- A review of Burdened Virtues, Lisa Tessman. *Hypatia*, Vol. 23, No. 2 (Apr-June 2008) 193-196.

Presentations

- "Cosmopolitan Virtue: On Becoming Citizens of the World," for the Society for Value Inquiry, meeting in conjunction with the Central Division American Philosophical Association, Chicago (Apr 2008).
- Conducted a workshop, "Responding to \$Change\$," at the annual meeting of the Michigan Home Health Association, Traverse City (May 2008).

ELIZABETH (LIBBY) BOGDAN-LOVIS

Publications

- Kozishek, D. and Bogdan-Lovis L. "Beliefs, Boundaries, and Self-Knowledge in Professional Practice." *The Journal of Clinical Ethics*, Spring 2008, 19(1): 26-30.

Presentations

- "Childbirth Choice (NOT): A Paradox of Informed Consent and Best Evidence" at the Costa Rican Bioethics Conference and the second Central American Cochrane Annual Meeting on the Omar Dengo National University Campus in Heredia, Costa Rica (June 2008).

LEN FLECK

Publications

- Has a book forthcoming, *Just Caring: The Ethical Challenges of Health Care Rationing and Democratic Deliberation*, expected out by Oxford University Press winter 2009.
- *Stored Bloodspots in Michigan: Ethical and Policy Challenges*. Outcome Paper Deliberative Jury Process (June 2008).

Grants

- Funded by Institute for Public Policy and Social Research in the amount of \$20,000 for a 1.5 year study titled: Neonatal dried bloodspots: Ethical and Policy Challenges. Dr. Fleck is PI of this study, and Ann Mongoven is co-PI.

Presentations

- "Shock and Awe/Awe and Shock: Addressing the Failures of a Post-Ethical Health Care System" at the International Bioethics Retreat Conference, Paris (June 2008).

Appointments

- Appointed to the American Board of Pediatrics Ethics Committee, a committee that writes and reviews questions on ethics and develops methods for assessing ethical qualities of candidates (2009).

LINDA HUNT

Publications

- Hunt, L.M, and M.S. Megyesi. The Ambiguous Meanings of the Racial/Ethnic Categories Routinely in Human Genetics Research. *Social Science and Medicine*. 66(2): 349-361. 2008
- Hunt, L.M, and M.S. Megyesi. Genes, Race and

Research Ethics: Who's Minding the Store? *Journal of Medical Ethics* 34: 495-500. 2008.

Grants

- Funded by NIH in the amount of \$1,671,735 for a three year study titled: Clinicians' Concepts of Racial/Ethnic Differences in the Management of Chronic Illness. Dr. Hunt is PI of this study, and Margaret Holmes-Rovner is co-PI.

Presentations

- Prenatal Genetics Testing: Do Notions of Risk Inform Patient Choice? Ethics Seminar in Perinatal Medicine, Division of Neonatology, Sparrow Medical Center, Lansing, MI. April 29, 2008.
- Race as a Variable in Genetic Research: A Question of Scientific Integrity. Paper presented at the Society for Applied Anthropology national meetings. Memphis, TN. March 29, 2008.

MARGARET HOLMES-ROVNER

Publications

- Holmes-Rovner, Margaret. "International collaboration in shared decision-making: The International Shared Decision Making (ISDM) conference history and prospects." *Patient Educ Couns*. 2008 Apr 1. [Epub ahead of print]

Presentations

- Served as a member of the reaction panel for the Spring 2008 MSU Risk Speaker Series, responding to Dr. Paul Slovic, President and founder of Decision Research. The title of his talk was: "If I Look at the Mass I Will Never Act: Psychic Numbing and Genocide", (April 23, 2008).

Consultations

- Served as a consultant to the Center for the Advancement of Health, an NGO in Washington, DC on the project, "Getting Tools Used: Lessons learned from successful decision support tools unrelated to healthcare," (August 11, 2008).

DAVID KOZISHEK

Publications

- Kozishek, D. and Bogdan-Lovis L. "Beliefs, Boundaries, and Self-Knowledge in Professional Practice." *The Journal of Clinical Ethics*, Spring 2008, 19(1): 26-30.

Presentations

- "We're Hoping for a Miracle: Responding to Religious Language in the Clinical Setting" at a CEHLS brown bag, (Apr. 2008).

ANN MONGOVEN

Publications

- Has a book forthcoming, *Just Love: Transforming Civic Virtue*, expected out by Indiana University Press early in 2009.

Grants

- Funded by Institute for Public Policy and Social Research in the amount of \$20,000 for a 1.5 year study titled: Neonatal dried bloodspots: Ethical and Policy Challenges. Dr. Fleck is PI of this study, and Ann Mongoven is co-PI.

(Continued on back page)



Center for Ethics and Humanities
in the Life Sciences
Michigan State University
C-208 East Fee Hall
East Lansing, MI 48824-1316

Upcoming Brown Bag Talks

Friday, November 21, 2008

12:15-1:15 pm

C-102 East Fee Hall

Titus Divala

"The Dream of Medical Rights Watch: 'To Bring Bioethics to Ordinary People in Malawi'"

Wednesday, December 10, 2008

12:00-1:00 pm

C-102 East Fee Hall

Robin Lin Miller, Ph.D.

"Factors Influencing the Viability of Evidence-based Prevention Approaches in Community-based Organizations"

(Continued from page 7)

Consultations

- Worked with Principle Investigator Len Fleck on a public engagement process probing Lansing-area citizens' desired bioethical guidelines for a proposed state research "biobank" of population tissue samples. (IPPSR Funding).
- Visited Zhengzhou University with Tom Tomlinson for talks with bioethics, medicine, genetics and public health faculty toward development of collaborations on projects in medical and public health ethics and policy, China (May 2008).

Awards

- 2008-2009 academic year MSU Lilly Teaching Fellowship to support her fall 08 course, "Election 08 and the Nation's Health."

GERALD S. SCHATZ

Presentations

- "Ethical Lawyering in the Protection of Human Subjects of Biomedical and Behavioral Research," at a Health Law Symposium of the Michigan State University College of Law (Sept. 2008).
- Presented a poster, *International Law and Ethics of Human Subjects Research: Development and Teaching of a Unique Interdisciplinary Seminar for Practitioners, Law Students, Medical Students, Graduate Students, Researchers, Faculty, and International Scholars*, at the Health Law Professors Conference, American Society of Law, Medicine and Ethics (June 2008).
- "Medical Technology, Ethics, and Law in a Not-So-

Brave, Not-So-New World," at a Journal of Medicine and Law symposium, Michigan State University College of Law (Mar. 2008).

Consultations

- Judged in the national and international rounds of the Philip Jessup International Law Moot Court Competitions, on humanitarian law, terrorism, and law of armed conflicts (Apr. 2008).

Appointments

- Appointed to the Advisory Board for Hakimani, a proposed East African Jesuit Center for Social Justice, Human Rights, Legal Advocacy, and Public Values (2008).

TOM TOMLINSON

Publications

- "Caring for Risky Patients: Duty or Virtue?" *Journal of Medical Ethics*, 2008 June; 34(6): 458-62.

Consultations

- Was a member of the Steering Committee, Michigan Department of Community Health Neonatal Bloodspot Biotrust (2008).
- Visited Zhengzhou University with Ann Mongovan for talks with bioethics, medicine, genetics and public health faculty toward development of collaborations on projects in medical and public health ethics and policy, China (May 2008).