

MEDICAL HUMANITIES REPORT

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Autonomous Contraception: Science, Sociology, and the Potential of a Male Pill

by Lisa Campo-Engelstein, Ph.D.

Researchers at Oxford University recently discovered that a genetic defect with the PLC zeta protein in sperm leads to infertility in men because proper functioning of this protein is needed to allow fertilization. This discovery is not only important to men suffering from this type of infertility; it also presents the possibility that researchers could develop a male contraceptive that would inactivate the PLC zeta protein, and that would probably have fewer unpalatable side effects than other male contraceptives under research.

Before comparing this potential male contraceptive to others, it is first important to justify the need for male contraception. The dearth of male contraceptives, especially long-acting, reversible contraceptives, referred to as LARCs, contributes to an unjust arrangement in which women bear the majority of the social, economic, and health-related burdens associated with contraception. Today, there are eleven female contraceptive methods but only two male methods: condoms and vasectomy.¹ Women alone contracept 67.3 percent of the time. If we include shared methods as well as male condom use, which women often negotiate, then women are involved in almost 91 percent of all contraceptive use. Men, in contrast, only participate in contraceptive use one third of the time.² Moreover, men's involvement with contraception is usually limited to casual sex, not long-term monogamous relationships where couples tend to prefer LARCs. In short, men's autonomy is enhanced by their freedom from contraceptive responsibility.

The high cost of contraception can affect women's ability to use contracep-

tion, their choice of contraception, and their overall economic situation. The one in five women of reproductive potential who are uninsured have to pay out of pocket for contraception, and, not surprisingly, they are 30 percent less likely to report using prescription contraceptives than women with health insurance. Even having insurance does not obviate financial concerns. Copayments can be high and often add up quickly. Additionally, many insurance companies do not cover contraception. As a result, women pay 68 percent more out of pocket for their routine reproductive health care than men of the same age.³

In addition to the economic burdens of contraception, women also suffer from the negative side effects associated with contraception. The side effects of female contraceptives are generally more serious than for male contraceptives in part because there are no hormonal methods for men, and such methods typically carry more risks. Specifically, the side effects of female hormonal contraceptives can include cardiovascular complications, depression, hepatic adenomas, pathologic weight gain, and possible bone loss.⁴ The two available male forms of contraception also carry fewer risks than their corresponding female contraceptives, female barrier methods and tubal ligation, respectively. Some dismiss women's side effects as "minor;" however, to the women who experience them, they often are far from benign. Women most commonly discontinue contraceptives due to side effects⁵ and most forms of contraception have discontinuation rates approaching 50 percent after one year of use.⁶

Not being responsible for some or

all of these economic, health-related, and other burdens is a significant boon for men. Men typically do not have to dedicate time and energy to contraceptive care, pay out of pocket for the usually expensive and sometimes frequent (often monthly, or at least four times a year) supply of contraceptives, acquire the knowledge about contraception and reproduction needed to effectively contracept, deal with the medicalization of one's reproductive health, endure the bodily invasion of contraception, suffer the health-related side effects and the mental stress of being responsible for contraception, and face the social repercussions of their contraceptive decisions (such as whether to use a particular contraceptive or to switch contraceptives), and the moral reproach for contraceptive failures. Women who contracept have to devote and sacrifice many aspects of themselves and what they value: their body, health (physical and mental), time, money, etc. These contraceptive burdens and sacrifices limit people's freedoms. Since men are frequently not responsible for contraception, they are absolved from these burdens and thus their freedom is not infringed upon. In short, men's

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autonomy is enhanced by their freedom from contraceptive responsibility.

At the same time, however, men's autonomy is also diminished by the fact that they are usually not responsible for contraception. For many men, neither of the two currently available male contraceptives is well-suited for their contraceptive needs: they want a long-acting, reversible contraceptive. The lack of such options forces many men in monogamous relationships to rely on their partners to contracept. Even when men choose to use condoms, given its high failure rate of 16 percent for typical use, they are still not able to regulate their reproduction as effectively as women; many female hormonal methods and IUDs have failure rates under three percent.⁷ To further decrease the probability of pregnancy, some couples use both the male condom and a female method. But even if men contracept, they are often dependent on women to also use contraception if they want to use a method with a high success rate (and they are not yet ready for sterilization).

This dependence on women reduces men's reproductive autonomy. Men have to trust that their partners are correctly and consistently using contraception. If a pregnancy does occur—either unintended by both partners or when the woman decides to stop contracepting without telling her partner—men have no recourse. Men cannot mandate that women get an abortion. Regardless of the circumstances under which the conception transpired, men are still held socially and financially responsible for any children they father. In some ways it seems unfair to hold men responsible for children they did not want when they are ill equipped to prevent pregnancy.

What men need in order to successfully control their reproduction is the one type of contraceptive they are missing (and that women currently have), LARCs. Indeed, the development of male LARCs would enhance men's reproductive autonomy by enabling them

to do what women have been doing since the advent of the female pill: effectively regulate their fertility outside of all sexual activity and without their partner's participation or knowledge. Scientists have been working on developing male contraception for the last 40 years and keep saying that these contraceptives are just around the corner. So why are there still no male LARCs?

First, dominant understandings of women's and men's bodies have played a role. Some scientists claim that it is more difficult to create male contraceptives because men's bodies are more complex than women's: women release one egg a month, while men produce millions of sperm a day; women's fertility is limited to a handful of days each month, whereas men are consistently fertile.⁸ At play in these comparisons are implicit and sexist assumptions about the mind/body dichotomy: women's bodies are more simplistic and closer to nature, while men's bodies are more advanced and farther from nature. While some scientists still insist that women's bodies are more controllable and better suited for medical intervention, especially reproductive intervention, other scientists assert that men's bodies are more easily manipulated and that "if scientists had simply followed nature, they would have developed male contraceptives rather than female methods."⁹ Regardless of the relative ease of developing female or male contraceptives, other factors have contributed to the dearth of male contraceptives. Notably, it was not until the 1970s—50 years after scientists starting researching "modern" female contraceptives—that scientists began researching new types of male contraceptives.¹⁰ Previously, scientists' work on male contraceptives was limited to improving the condom.¹¹ Because the female reproductive system has been studied for so much longer, more is known about it and consequently there are more female contraceptives and developing female contraceptives is not as difficult.

Second, much more money is allo-

cated to female contraceptive research. The distribution of research and development money in the 1990s was as follows: 60 percent to high-tech female methods, 3 percent to female barrier methods, spermicides, and natural fertility control methods, 7 percent to male methods, and 30 percent to multiple methods, though mostly for women.¹² Researchers who would like to study male contraception often cannot due to a lack of funding. For example, Richard Anderson, a professor of clinical reproductive science at Edinburgh University, says that "most of the work [on male contraception] has been initiated by university investigators and the World Health Organization. There has so far not been a lot of money from corporate companies."¹³ Despite positive findings on a male contraceptive pill, Anderson has not been able to conduct trials

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because no pharmaceutical company will financially support them.¹⁴ The main reason pharmaceutical companies decline to fund male contraceptive research is that they do not think male contraceptives will be lucrative. While nonprofit organizations also research contraception, they typically lack the resources to do so on a large scale. The World Health Organization had been one of the more visible and active nonprofit organizations working on male contraceptives, but today they focus entirely on female contraception because they see it as the key to helping women in developing countries.¹⁵

Third, many do not think there is a market for male contraception because they doubt both that women will trust men to contracept and that men will be interested in using contraception. Yet this reasoning is based on gender ideologies, not fact, and so it is not surprising that empirical evidence shows the opposite conclusions. For example, while mass media articles in the English-speaking world assert women will not trust men (including their partners) with contraception,¹⁶ an international study reveals that only two percent of women would not trust their partner to contracept. A gender ideology relating to why men would not be interested in male contraception is that men do not want to participate in private-realm responsibilities like reproduction because they are women's work. However, empirical studies show that 55 percent of men would be willing to use contraception.¹⁷ Therefore, the data suggest that if those men had access to a long-lasting contraceptive, their female partners would have reason to trust they were using it.

Another gender ideology that has inhibited the development of male contraception is that men are not willing to suffer side effects that "minimize" their masculinity. Many of the hormonal male contraceptives currently under research, such as gels, patches, implants, and injections, depend upon testosterone to induce sterility. While most men do not mind increased muscle weight gain,

many are troubled by other side effects of testosterone like acne, mood swings, and temporary shrinking of the testes.¹⁸ Additionally, some men are concerned about the effect hormones will have on their libido and their future fertility.¹⁹ A non-hormonal male contraceptive pill currently under research avoids these unpalatable side effects and works by preventing ejaculation. Although the lack of an ejaculation does not affect the quality of orgasm, urologist Harry Fisch claims this side effect will preclude many men from considering this contraceptive: "I don't think a lot of men are going to take this.... The ejaculate coming forward is a significant part of a man's sexuality."²⁰

A potential male contraceptive based on a genetic defect with the PLC zeta protein would sidestep the aforementioned negative side effects, thereby making it more acceptable to men. This is not to say, however, that this potential contraceptive would not also have problematic side effects. Moreover, a contraceptive that mimics this defect is still in its infancy. Although developing more male contraceptives will make it easier for men to contracept, it is unlikely that men will start contracepting at the same rates women do without any changes in dominant ideas about contraceptive responsibility. The mere existence of a particular technology is not enough to change our current contraceptive arrangement. Permanent contraceptives provide a strong example of this fact.

Unlike the case of reversible contraceptives, permanent contraceptives are equally available for women and men. Both have one option available to them: tubal ligation for women and vasectomy for men. This equality of options might lead one to expect similar rates of tubal ligation and vasectomy. Yet, tubal ligation is practically three times more common in the United States. Worldwide, the same pattern stands. In fact, only two countries, Britain and the Netherlands, have vasectomy rates that are equivalent to tubal ligation rates.²¹ These differing rates cannot be attrib-

uted to availability of technology nor to the procedures themselves, as vasectomies are quicker, easier, safer, and cheaper than tubal ligations. The alignment of femininity with contraceptive responsibility explains, at least in part, why tubal ligation is much more popular. Before we can expect any male contraceptive to be widely accepted—no matter how objectively attractive it may be—we must first work on changing social norms so that men, as well as women, are expected to assume reproductive responsibility.

For references:

http://www.bioethics.msu.edu/images/stories/file/MHR/10S_MHR/s10_campo.pdf

The Center Welcomes

In mid-April, the Center, the Department of Philosophy, and the Asian Studies Center will host a delegation from Southeast University, in Nanjing, PRC. Visitors will include Dr. Fan Heping, a well-known leader in Confucian ethics scholarship. Dr. Fan is the Dean of the Humanities College at Southeast, and Director of the Ethics Studies Center there. Our center is especially interested in developing collaborative research projects in comparative bioethics, as well as faculty and student exchanges.

During the last week in April, the Center will host Dr. Nariman Safarli, an ophthalmic surgeon and the President of the Azerbaijan Medical Association. During his visit Dr. Safarli will meet with Center faculty, faculty from the Russian and Eurasian Studies Center, officials in the Michigan State Medical Society, and others, to discuss the difficult ethical challenges facing the health system and the medical profession in Azerbaijan. This visit will launch an ongoing collaboration designed to help Dr. Safarli and his colleagues develop effective responses to these challenges.

Variations on a Theme: The Clinton and Obama Health Care Reforms Compared

by Rodger Jackson, Ph.D.

If I have my chronology correct, I was the second editor of the MHR, my tenure extending from 1989-1994. It coincided with one of our country's periodic attempts to confront the problem of access to health care, an event that dominated the political landscape this past year. As I've watched the events of the past year, it is hard for me not to feel as though this is a case of variations on a theme. The following constitutes my reflections on the similarities and the differences between the two adventures and my personal reasons as to why I believe the eventual failure of the project again this year will be a tragedy.

In my early days at the Center, there was a sense of a growing political consensus that we, as a nation, were finally going to rectify the massive disparities present throughout the health care system. The recession of the early 1990s highlighted the fact that tying health care to one's job meant that being a member of the middle class was no guarantee of health care security. In 1991 Harris Wofford had won a special election in Pennsylvania against the heavily favored Dick Thornburgh, largely on the issue of health care reform. Finally, there was Bill Clinton's successful presidential election campaign with one of its centerpieces being the securing of access to health care for all Americans. Although no one thought it would be easy, there was a general sense of optimism that now was the time.

Many of the background conditions between then and last year are conspicuously similar. Both Obama and Clinton won in large part because of difficult economic times. Health care figured prominently in both their campaigns. Both had developed reputations as inspirational speakers. Both had Democratic majorities in the House and Senate. They also faced similar challenges. In both cases the very same depressed economic climate that provided the candidates with a powerful election issue,

forced them as presidents to use up political and fiscal resources that might have been employed in furthering the cause of health care reform. Those very same Democratic majorities in the House and Senate represented a wide range of the political spectrum and then as now are infamous for being fractious and not unified. There was also the concern that neither President had much experience in dealing with the "Washington culture" in terms of passing major legislation.

While all of these similarities were certainly striking, what I found most fascinating this past year was observing the differences in how the two administrations tried to craft their legislation. The general idea behind then First Lady Hilary Clinton's plan was to bring together the leading thinkers on health care, put them into various working groups, sift through their recommendations, synthesize their findings into a reasonable, practical system and then present the final product to the Congress to vote on. The goal was to try to avoid a piecemeal process that would be plagued by irrational factors and which could be picked to death by special interests.

The mood around the Center for Ethics and Humanities in the Life Sciences at MSU was one of excitement about the extraordinary possibilities inherent in this project. Center members who had researched and written on this subject for years were being asked to put their theories into practice. I recall Len Fleck explaining how there was real give and take among the members of the working group and that reasoned debate over what would be the most just and effective approach was the norm, not the exception. At the time this seemed the sensible way to handle this enormous task.

Numerous scholars have analyzed and written about the subsequent derailing of what became known as the Clinton health care plan. At least one of

the factors cited as contributing to the failure was that the process itself was flawed. Critics claimed that the Clinton Task Force had engaged in a secretive, imperious process which ignored the realities of politics, and excluded legitimate interests from making useful contributions. One frequent protest was that this plan was being imposed from the top down. Detractors argued that if only the administration had been more inclusive, if only it had allowed the congressmen and senators to be in on it from the start, the legislators would have had a stake in its success and been better able to defend it.

As I thought about these criticisms in the ensuing years, they certainly seemed plausible. I wondered what would have happened if the Clinton administration had taken a different approach. Perhaps the critics were right; perhaps it was a lack of transparency, a lack of commitment to the political process that had doomed health care reform back in the 90s. In sorting through these issues, I realized I was actually trying to disentangle two separate questions: a) Was the Clinton Task Force (or its critics) the most ethically correct method for crafting health care reform? and b) What method was most likely to succeed?

Then almost 18 years later, the opportunity for significant health care reform seemed to be here again. While there were clearly differences between the health care plan of 1993 and whatever the final document was going to look like last year, an equally significant distinction was in the way last year's plan was put together. This time there were to be no working groups, no closed door meetings, no plan worked out in detail and then presented to Congress. Although there were elements that President Obama wanted in a final plan, he left the process of constructing it largely in the hands of Congress.

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Perspectives on: Health Reform: The Enemies Within

In the last issue of the MHR, Leonard Fleck, Ph.D. wrote about the challenges that threaten the success of health care reform. The contributors to this InkLinks continue this discussion. InkLinks is a regular column in which readers reflect on issues related to the previous lead article. It is meant to tap the rich intellectual resources that this network provides. We welcome your contribution at altimare@msu.edu.

A Historic Challenge

Len Fleck's essay openly combats complacency towards health care reform and identifies the primary challenges to its passage as internal to us all rather than an external group representing the conservative right or liberal left. This concept challenges longstanding and internal ethical conflicts. Most poignantly, how can we claim moral high ground by stating that all human life is priceless while failing to recognize the value of human life among the uninsured when we see the life and death implications of being uninsured?

Ignorance is identified as one of the four horsemen of the apocalypse. I would like to relate this personal consideration to the national discussion on health care reform. How many individuals truly understand their health care coverage and how the system of care in their community is organized? Add the complexities of provider payment systems (public or private), insurance risk management systems, quality assurance mechanisms, public appropriations approval process, and several other critical components of the nation's health care system and it is easier to understand the confusing arguments ongoing between Congress and the White House. The inclusion of special interest groups and individuals seeking to protect their current status or better position their future status further complicates an already complicated situation.

The arguments offered in the essay remind me of a favorite phrase, "We have met the enemy and he is us" (Walt Kelly, 1970, cartoon character Pogo in an Earth Day Poster). The essay implores us to hear the call and to remember the moments in history when Americans were at their most noble and

principled. While the complexity of the health care system complicates reform efforts, we must strive to meet the American embraced standards of equality and decency as we accept this historic challenge.

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The Fifth Horseman: Fear

Leonard Fleck mentioned four motivations for failure to embrace health care reform. I would suggest that a more basic response is at work—fear. Health care reform is an extremely complex undertaking. Even as the legislation being crafted by Congress is becoming more specific, Americans are becoming more uncertain about how reform will affect them and the rest of the country.

The Kaiser Family Foundation's January Health Tracking Poll found that many American voters remain unfamiliar with key provisions in the bills passed by the House and Senate. Less than half are aware of provisions to prohibit gender rating, limit age-adjusted rating, and help close the Medicare doughnut hole, among others. This is despite the fact that the Foundation's December Health Tracking Poll found that nearly 80 percent of voters say they are following the health reform debate at least "somewhat closely."

The long drawn-out process for developing health reform has likely contributed to, rather than ameliorated, this lack of knowledge and understanding of potential reforms and has diminished much of the public's early enthusiasm. President Obama admitted as much in his State of the Union address, saying the process has left Americans

"skeptical" and wondering, "What's in it for me?" As they become less certain of the ins and outs of reform, Americans become more afraid of its ultimate effects. A growing percentage of American voters believe that health reform will leave them worse off.

Most people fear change. Take for example, the reaction to revised screening guidelines for breast and cervical cancer released last fall. The U.S. Preventive Services Task Force recommended that, unless it is contraindicated by their medical history, women should start receiving mammograms at age 50 and biannually after that. This was followed by a revision in cervical cancer screening guidelines issued by the American College of Obstetricians and Gynecologists that also suggests screening start later and occur less frequently than previous guidelines had recommended.

The revised guidelines motivated an angry reaction from doctors, women's groups, and legislators who feared that these changes pointed toward the rationing of health care, and that insurers would use them to justify reduced coverage. Insurers have since indicated that they do not plan to change how either of these procedures is covered, but the lesson has been learned. The new guidelines are likely valid and rational, but fear is not rational. And the prospect of being diagnosed with cancer at a late stage when it could have been detected much earlier is very scary. More than half of American voters say they think their insurance company should pay for an expensive medical treatment that has not been proven more effective than other, less expensive treatments.

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News & Announcements

JUDITH ANDRE

Presentations

- “Textbooks in Bioethics Education,” for the Fellows Conference of the MacLean Center for Clinical Medical Ethics, University of Chicago (November 2009)

Publications

- “The Virtue of Honoring Oneself,” in *Maternal Thinking: Philosophy, Politics, Practice*, edited by Andrea O’Reilly, Demeter Press, Toronto (October 2009)

Appointments

- Visiting Scholar, Ewha Women’s University in Seoul and Dong-a University in Busan, South Korea (January-February 2009)

LEONARD FLECK

Presentations

- “Sustainable Health Reform: The Liberal Challenges of Individual Mandates and Health Care Rationing” for the American Philosophical Association annual meetings, Philosophy and Medicine Committee program, New York (December 2009)
- “Just Caring: the Challenges of Health Reform in the United States” for the Delegation of Health Care Administrators from China, Michigan State University (October 2009)
- “Just Caring: Health Reform, Health Care Cost Containment and Rational Democratic Deliberation” lecture for the League of Women Voters, Southfield, MI (November 2009)
- “Blood Spot Storage in Michigan: Ethical Challenges” for Michigan Biotrust Conference, East Lansing, MI (November 2009)
- “Health Reform: What should our Health Care System look like in 2015?” for Northern Michigan Hospital Grand Rounds, Petoskey, MI (February 2010)

Publications

- “Just Caring: In Defense of Limited Age-Based Health Care Rationing” in *Cambridge Quarterly of Healthcare Ethics* 19 (2010), 1-11
- “Health Care Reform: When is Compromise Unjust?” *Hastings Center Health Care Cost Monitor* (December 2009) available at: <http://healthcarecostmonitor.thehastingscenter.org/leonardfleck>
- “Just Caring: Health Reform and Physicians” in *MD Magazine* (December 2009)
- “Health Care Reform: The Challenges of ‘Just Caring’” op-ed essay for the *Detroit News* (October 2009)

MARGARET HOLMES-ROVNER

Presentations

- Chair, *Getting Tools Used: Lessons from Inside and Outside Health Care*. “Will patient Decision Aids have a vital role in health care reform? Does Public Reporting of quality matter?” for the Society for Medical Decision Making Annual Meeting (October 2009)

Appointments

- Expert Panelist, for the Agency for Health Care Research and Quality (AHRQ). Reducing Disparities in Healthcare Quality for Priority Populations using HIT. Washington, DC (October 2009)

MONIR MONIRUZZAMAN

Presentations

- “‘Living Cadavers’: The Ethics of Human Organ Commodification” for the Center for Ethics and Humanities in the Life Sciences Brown Bag Series, Michigan State University (December 2009)

MISHA STRAUSS

Appointments

- Member, Chelsea Community Hospital Quality Committee (November 2009)
- Member, Chelsea Community Hospital Audit Committee (January 2010)



**WATCH FOR THE MHR
TO GO PAPERLESS IN
FALL 2010.**

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If you had the time and inclination you could follow the various proposals being debated as they were introduced and then track the changes that were made as the drafts made their way through the committees and onto the floor. In the process of watching all this unfold, I realized that the second question was of much greater significance to me. It wasn't that I was indifferent to the arguments. Those who argued that the Clinton plan gave greater respect to rationality and practicality made sense, as did those who said that the recent approach honored democracy and public discourse. It was what happened to me in the subsequent years that shaped my current perspective, events that exemplify a critical fact in the debate.

The number of Americans who die because of a lack of access to health care is either somewhere between 18,000-45,000 depending upon whether you rely on the Harvard-Cambridge study released in September 2009 or the Institute of Medicine report published in 2002. The problem with such a statistic is that, like all statistics, it can be nothing more than a number on a page. It doesn't articulate what the following stories will. I knew a graduate student at Michigan State who was just finishing up her doctorate around the time of the Clinton Task Force. She left the state and moved to California where she was helping one of her adult children who was going through a difficult time. She took a job as a maid to leave herself enough free time to help her child and complete her dissertation. She became sick and, of course, her job carried no health care benefits with it. She thought she had the flu and didn't have enough money to go see a physician, even a "Doc in a Box," so she decided to ride it out. It turned out she had meningitis and she died. Not long after this my wife and I left Michigan State where we had both been Ph.D. candidates in philosophy and moved to Buffalo NY. We had no health care; we had two small children (ages 3 and 5) and I was working five different adjunct positions at an

average salary of about 2,500 per position. My annual income was something like 14,000 dollars and my wife did not have a job. The whole time I was searching for work, finishing my dissertation, and so on, I was in fear of what would have happened to either of the boys, my wife or me if we suffered a similar fate to our friend. Fortunately, I obtained my position at Stockton College with health care benefits. Not long after, one of my sons was diagnosed with a condition that required physical therapy and several visits to a specialist. He's fine now, but we only got this diagnosis and treatment because health care came with my job.

This is not meant to be an argument from anecdote. I do not claim that the most significant question is what strategy will get us to universal access merely because those I care for have been vulnerable. Yet, these two personal scenarios are always in my mind when I think of this issue and hence why I become angry when I see us going down the same road as back in the early 90s. There are thousands of people out there like my family, and our friend, in which it's largely a matter of luck as to whether those stories end badly or not. The tragedy of course is that luck need not have anything to do with it.

*Rodger Jackson, Ph.D.
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(TFH from page 5)

and so it goes. People want protection against the unknown, no matter the cost. While half of American voters think that a major problem with the U.S. health care system is that too many patients are getting tests and treatments they don't really need, two-thirds of voters think that a major problem with the current health care system is that too many patients are not getting tests and treatment that they really do need. These may appear to be contradictory statements, but too much and not enough is the paradox of the U.S. health care system. Those with coverage and/or the resources to pay for care are quite likely to get the care they need (and then some). Those who are uninsured and have low incomes very often go without necessary care.

Fixing this paradox will require a major overhaul of the U.S. health care system. But, while people are aware of the problems that exist in the current system, most are not experiencing them. Only one in ten voters say they have not received medical care that they really needed, and one in six believe that they have received unnecessary tests or treatments.

Without a clear distillation of the legislation and honest, informed dialogue about what reform will and will not do, the public is likely to let fear of change rule their opinions of reform. Some of this dialogue and education is occurring, but not so much in the popular media. The Kaiser Family Foundation and Families USA, among others, have a wealth of information describing the facts about reform. But the general public is unfamiliar with these resources. Thus, it is up to the well-informed to do their part in talking with friends, relatives, co-workers, and acquaintances.

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Upcoming Brown Bags/ Events

March 24, 2010

12-1:00 p.m.

C-102 East Fee Hall

John A. Mulder, M.D.

“Integration of Palliative Medicine into Mainstream
Health Care”

May 7, 2010

MERN Annual Meeting

“The Future of Ethics: Just Caring and Health Reform”

The Johnson Center

Cleary University, Howell, Michigan

ABOUT THE AUTHORS

This issue’s articles were contributed by former editors of the Medical Humanities Report (MHR). Rodger Jackson was editor from 1989-1994, while completing a Ph.D. in Philosophy at MSU. Rodger is presently an Associate Professor of Philosophy and Religion at the Richard Stockton College of New Jersey teaching ethical theory, pragmatism and the history of philosophy. Lisa Campo-Engelstein was the MHR editor between 2005-2008. After completing her Ph.D. in Philosophy at MSU, Lisa moved to Northwestern University as a Senior Research Fellow in Medical Humanities. She is examining ethical issues surrounding oncofertility, especially as they relate to gender and sexuality, justice and allocation, and philosophical understandings of disease. We wish to express our sincere thanks to Rodger and Lisa both for their years of service to the MHR and their generous contribution to this issue.