College of Arts and Letters Establishes Interdisciplinary Programs in Health and Humanities

The notion that practitioners of science and the humanities in the western world represent two distinct cultures, separated by a chasm of mutual perplexity and miscommunication, has surfaced periodically since C.P. Snow's formulation in 1959. Such polarization is particularly troubling for professions whose intellectual vitality, historical traditions, and service ethic are rooted in both "cultures." Most U.S. health professional educators, for example, envision few gains from the internecine debate about whether medicine is art or science; the public wants healers who are empathetic listeners and skilled technicians in equal measure. But an imbalance has favored the latter for more than a half-century. Consequently, medical reformers, particularly since the mid-1960s, have proposed a variety of measures to humanize modern scientific medicine, often including a modest involvement by humanists and social scientists at various stages in the training of future practitioners. Nationally, the assessments of such ventures are decidedly mixed; there is general agreement, however, that there simply isn't room in the medical school curriculum for an extensive infusion of the humanities.

Many of us affiliated with the Medical Humanities Program at MSU, therefore, believe that the humanistic disciplines, broadly conceived, ought to provide a variety of supplemental programs of instruction and research opportunities to help reduce "cultural polarization," both within the health professions and between health professionals and the public. In order to facilitate such programmatic development, the Dean of the College of Arts & Letters at MSU, in consultation with the Medical Humanities Program, established a new administrative unit, Interdisciplinary Programs in Health and Humanities (IPHH), with Peter Vinten-Johansen (Associate Professor of History and Medical Humanities) as its first Director, responsible for the initial development and implementation of four programs that may, from a student's perspective, be viewed as either distinct or interrelated.

First, several years of work on an undergraduate concentration in medical humanities (discussed in two prior editions of MHR) is near fruition; a proposed Specialization in Health and Humanities is now under-going review by educational policy committees within the academic governance system at MSU. The specialization is available to all undergraduates who wish to complement their majors with a program of required and elective disciplinary courses (totaling 24 credits) that introduce them to basic vocabulary and fundamental concepts in philosophy, history, economics, literature, sociology, anthropology, geography, and technology necessary for an informed analysis of humanistic and behavioral issues in human health and healing. In addition, several faculty who teach courses in the specialization will work jointly with the Center for Literacy and Learning (College of Arts and Letters) to teach writing and analytical problem-solving skills in their disciplinary subjects. At present, we are primarily interested in the specialization as a vehicle for providing access to discrete disciplinary dimensions of health and healing.
issues, less concerned with interdisciplinary integration at the undergraduate level of instruction. After several years of operation, however, we should know whether it is both appropriate and feasible to add a capstone, interdisciplinary seminar to the specialization. The Director of IPHH will work closely with the Office of Admissions and the undergraduate advisors in various Colleges and Schools at MSU to recruit students and monitor their progress.

Second, the need exists for an interdisciplinary program of courses in health and humanities at the Master's level. Some individuals, for example, would prefer to enroll in a Master's program composed of several disciplines before making a choice to specialize in one discipline for further graduate work; others, such as hospital administrators, seek a terminal Master's program that has broad (as distinct from a single) disciplinary relevance to ongoing careers in health fields. Precisely how the College of Arts and Letters, in conjunction with other Colleges at MSU, may reorganize some of its resources to meet these needs is still unclear. One possibility is a series of interdisciplinary pairings—for example, history/philosophy, history/literature, philosophy/religious study, literature/anthropology, history/sociology, etc.—or even triads, with candidates for the Master's required to choose two pairings or one triad, or something along those lines. Such rubrics would also be available to Ph.D. candidates from any department in the university who sought an interdisciplinary minor field. The goal of the curriculum that emerges, regardless of format, would be to prepare students to reason within an interdisciplinary context and with interdisciplinary methodologies. The interdisciplinary Master's program would also require at least one practicum experience in health and humanities. Students would, however, be able to choose whether or not to write a thesis as part of the requirements for a Master's degree. In short, I believe that a multiplicity of options within a tightly constructed interdisciplinary Master's program is the most effective manner to address the interests of a new, diverse constituency.

Increasingly of late, some students enrolled in medical and nursing schools are willing to lengthen their training period to incorporate graduate study in the humanities if it can be arranged. The third program that the Director of IPHH hopes to develop is intended to respond to such willingness. One possibility currently under investigation is the creation of a dual degree, Medical Scholar Training Program to complement the Medical Scientist dual degree programs that already exist in the Colleges of Human and Osteopathic Medicine. Although the second degree in the latter Colleges currently must be the Ph.D., we hope to add an option to use either a Ph.D. or an M.A. program in the humanities, including the interdisciplinary M.A. described above. I would also like to develop a similar dual degree program with the College of Nursing and the College of Veterinary Medicine.

The fourth program under the administrative control of the Director of IPHH is "Medical Humanities in London." Last summer's offering is described elsewhere in this issue. This academic program seeks to overcome a form of cultural polarization somewhat different from what was outlined at the outset of this article—ignorance of how other countries in the western world deal with the humanistic dimensions of health and healing. Team-taught by an historian and a philosopher, the two interdisciplinary courses that constitute the program place current healer-patient relationships and resource allocation policies in the British National Health Service within their appropriate historical and socio-cultural contexts. Offered in five-week terms during the summers, the program has enrolled a very productive mixture of undergraduate, graduate, and professional students from MSU and elsewhere in its first two years. Tasks for the immediate future include regularizing the faculty teaching rotations, further integration of readings and field experiences, consolidation of MSU's institutional partnership with the Academic Department of General Practice and Primary Care in The Medical Colleges of St. Bartholomew's and the London Hospitals (University of London), expansion of enrollments to include British students, and changing the program's name to "History of Medicine and Medical Ethics in London" to reflect the reality that only two disciplines from the medical humanities are involved.

Peter Vinten-Johansen, Ph.D., Director, IPHH
328 Morrill Hall, (517) 353-9417

DEBATE: Will Hospital Executives be the Death of IECs?

Hospital or institutional ethics committees (IECs) show considerable promise, but are at an early and vulnerable stage of development in most hospitals. An excellent way to assure their speedy death before any
of their promise can be realized is well captured in an article, "Clinical Ethics and Management Responses," by a hospital corporate consultant, James W. Summers, Ph.D., writing in volume 2, number 4 of Healthcare Executive (July/August 1987).

Summers accurately notes that hospitals are today being challenged to assure that good ethical decisions are made, and mentions both IECs and ethics consultants as possible mechanisms to assist in the process. From that point on, he illustrates the worst excesses of the "bottom line thinking" stereotype—a stereotype which is often unfairly applied to health care executives, but which seems to fit the thinking of Dr. Summers to a T.

First Summers waxes hopeful on getting third party coverage to pay for ethical consultations, based on the idea that "respecting patient's rights saves money." He cites lower lengths of stay, less need for pain medicine (?!), less malpractice exposure, and lowered rates of complications in surgery. He seems to take for granted that the outcome of every ethical reflection is the discontinuation of therapy. He totally ignores the possibility that an IEC will decide that a patient has a right to request more aggressive therapy, perhaps even over the objection of one or more physicians. The idea that the ethics committee is automatically on the side of cost containment is one sure way to label that committee as representing only the interest of the hospital, and not the interest of the patient or family.

Summers next gets excited about the PR possibilities, saying, "You can go to the marketplace with advertising and public relations programs that talk about specific programs, specific people with specific stories," all by way of showing that your hospital is more ethical than its competitors. Once again, the hard reality, that tough ethical cases are often made of clashes of interest between one or more individuals within the hospital community, or the interest of the patient and the interest of the organization, seems totally foreign to his way of thinking. Moreover, he doesn't seem to question whether confidentiality requirements would allow "specific people with specific stories" to be used as part of a PR campaign in the public media.

Here a careful distinction must be made. As part of its public accountability, an IEC must let the public know what it does and how it functions. This, however, is not the stuff out of which PR campaigns are made. At the same time that an IEC is publicly accountable for its procedures, it must stringently safeguard the privacy of the specific case discussions in which it engages.

My only hope is that hospital executives who actually serve as members of IECs realize the shallowness and short-sightedness of Summers' description of possible IEC roles. If hospital administration thinks only of PR, cost containment, and third party reimbursement, and does not recognize a duty to allow a forum of dialog in which hospital policies and hospital interest can be subjected to critical scrutiny, then the IEC movement may well be nipped in the bud. Howard Brody

Author's Response: Professional health care executives didn't need to be told some of the things which I was criticized for leaving unsaid. Health care executives already know that patients may request services which will add to the cost of treatment. Nor did I automatically assume the operation of an IEC should be or is for purposes of cost containment or that it should be for the purpose of protecting the hospital from the legitimate claims of patients. Health care executives already know an IEC is for the benefit of the patient. Scarcely any would think of it as a means of cost containment.

The entire point of the article is that doing good can be, should be, part and parcel of doing well financially, at least as the cases are averaged. To take the view that these two are separate is to assume ethics requires the endless passing of integrity tests. To pass the test, you must do things that are against your self interest, in the model of Job or of the virtuous man in Plato's Republic.

The article was a direct sales effort, one showing that there can be financial benefits to taking patient rights seriously, as opposed to the view that the bottom-line and ethics are somehow at odds.

As for the PR aspect, my view is that an IEC is proof that a hospital cares, saying a lot more than image advertising which is not backed by observable action. Respecting patient rights is an aspect of quality assurance in my view. And it is a type of quality which makes the institution more marketable. Isn't this the kind of excellence we are seeking?

As for having a "bottom-line" orientation, thanks. In situations where there is a threat of hospital closure due to financial pressures and there is no other facility nearby, the CEO is responsible first to ensure that the hospital remains open. Then
and only then is it possible to ensure that there are patients to have their rights respected. As some very devoted Catholic administrators say, "no margin, no mission." Again, my primary point, being made to health care executives, is that there are a number of situations in which taking patient rights seriously will have positive financial outcomes. As for the questionable citations, such as "less need for pain," these data came directly from the President’s Commission on Biomedical Ethics.

In these days of financial shortfalls, if I can show administrators that something they want to do anyway can also help them achieve other goals, then the motivations for doing what the critic and I both want will be that much greater. In management, we call that a "win-win". Everyone in management knows about the zero-sum game already. It is a compliment and a challenge to be both bottom line oriented and totally dedicated to patients as persons and the respect for their rights. Rather than nipping the IEC movement in the bud, the intent was to add additional motivations to it so that the impetus would be even more powerful, resulting in better treatment of patients and more financially sound institutions.

Were my article addressed to the audience reading this newsletter, it would have been far different. The assumptions would have been vastly readjusted. If the critic or others are interested, I have written more extensively about the subject in other publications. In any case, the criticisms were useful and appreciated.

Jim Summers, Ph.D., President, Plans and Actions Management Consultants, Austin, Texas

CASE STUDY: When the Team Members Disagree

K.T., a 91 y.o. widowed, black woman with a history of high blood pressure and heart disease, was admitted to the Critical Care Unit in severe congestive heart failure. Her doctors disagreed as to whether her condition was the result of a critical narrowing of one of her heart valves (surgically correctable) or damage to the heart muscle caused by chronic elevation of blood pressure (incurable). Cardiac catheterization could have resolved this disagreement, but one doctor opposed this on the grounds that even if the procedure revealed a damaged valve, the patient was not a suitable candidate for surgery. Catheterization alone poses some risk. Other physicians suggested that an appropriate alternative to surgery might be a less invasive, investigational procedure known as balloon angioplasty, and urged that cardiac catheterization be pursued.

In his initial evaluation, K.T.'s attending physician found her to be surprisingly alert and attuned to her surroundings given her extreme fatigue and difficulty breathing. He discussed with her his findings and diagnostic plans, including the catheterization, noting that "she desires full treatment and full code if needed." Others on the care team questioned her level of awareness and orientation.

Over the next few days doctors attempted with limited success to manage the patient with medications. As her physical condition deteriorated, so did her mental status. She became confused and agitated, pulling out intravenous lines and a urinary catheter. The issue of cardiac catheterization was re-introduced to the patient and during a period of relative lucidity a nurse attempted to obtain her consent. At this time K.T. expressed a desire to "take more time to think about it." This was thought by her doctors to reflect her confusion rather than her true wishes and the question of her competency arose. A psychiatric consultation was obtained and she was diagnosed as having an organic brain syndrome directly related to the treatment of her heart failure. Furthermore, as a consequence of this syndrome the psychiatrist felt that medical decisions should be weighted toward her initial desire for treatment. Nursing staff felt that her desire to wait was in keeping with what they had learned of her during their care. A member of the medical staff, acting on behalf of the hospital administration, suggested that advanced resources be withheld from the patient because of age and lack of consensus on prognosis. A cardiologist was consulted and specifically discouraged further studies, based on the patient's age and debilitation. An interval passed during which time the patient's condition continued to deteriorate, and the caretaker established guardianship and signed a consent form for further studies.

K.T. suffers no other known major organ disease and has never undergone surgery or hospitalization. She is extremely hard of hearing and essentially blind from cataracts. She has no surviving family members or close friends and lives with the caretaker who has known her for thirty years. Her caretaker believes that treatment is consistent with K.T.'s previously expressed desires.
Commentary

There are several faces to the quandary over what action is appropriate in this case. First there is the question of whether or not cardiac catheterization, with its inherent risk, would provide any benefit to the patient. Ultimately, this benefit relates to the possibility for correction of the underlying disorder, and should be left to her physicians to decide. The second problem is whether or not the patient is presently competent to make her own decisions. This has become, via the actions of her caretaker, a basically legal matter.

It is my guess that K.T.'s autonomy is what the nursing staff may have been most concerned about, since they acknowledged the deficits in her mental function. My own concern is that in the midst of complicated care and controversy over diagnoses, procedures and the patient's competency, the flow of essential decision-making information to the patient (or her representative) be maintained. Very often we health care providers delude ourselves with the notion that we cannot present choices to our patients until we resolve our own indecision. We worry about confusing and stressing our patients unnecessarily. In fact, in the event that treatment involves investigational procedures or outcomes of questionable value, it is imperative that the patient or guardian be well aware of the conflicts in clinical judgement. Without such disclosure it becomes impossible to determine whether the patient's decision reflects a clear understanding of the uncertainty of outcome and values the treatment for other merits, or erroneously anticipates a definite benefit.

In this particular case we are presented with a 91 year old woman who has never been hospitalized or undergone surgery. Her request for "full treatment" (at whatever time she expressed it) is thereby laden with limitations. She had not, prior to admission, experienced the unexpected side effects of medications, the discomfort of an incision, or the cumbersome walk with an IV pole and foley catheter which are common aspects of even an uncomplicated hospital course. Most individuals would gladly endure these hardships if assured a greatly improved quality of life as a result. It does not seem that K.T. can be offered such assurance. Therefore it is mandatory that we know something of what she expects of her remaining life, how she has reconciled past setbacks, and what she feels about uncertainty, particularly related to death. I think it is significant that this patient expressed a desire to forego treatment after she had a taste of highly technological medical care.

Debra Mulrooney, BSN
Year III Medical Student (CHM)

Commentary

The patient was felt to be mentally competent on initial evaluation, and when told of the probable diagnosis and the potential usefulness of cardiac catheterization, surgical intervention, and the promising but investigational procedure of balloon angioplasty she expressed a desire for aggressive therapy. Soon thereafter, her heart failure worsened and complications resulted in delirium, during which time she became indecisive. The nursing staff became concerned that an investigational procedure might be planned for a patient who was unable to give consent, and they were not reassured by the attending physician's contention that the procedure reflected the patient's wishes expressed while in a mentally competent state. They also suggested that age and debilitation mitigated against further invasive procedures.

As a community physician, I found this case disturbing in several ways. First, it appeared (and was occasionally specifically stated) that diagnostic and treatment options for this patient should be limited because of her advanced age, independent of her previously expressed wishes while mentally competent, and despite the potential reversibility of her condition. This discrimination based on age was only made more unpalatable when deftly camouflaged by comments regarding "limited national health resources (i.e. DRGs)" and concerns about her "true wishes". It also appeared that, as her condition deteriorated, her health care providers increasingly imposed their philosophical interpretations of her wishes and best interests in trying to influence her care. The result of this was suboptimal supportive care, delayed diagnostic testing, and greatly postponed definitive therapy.

In this era of DRGs and other capitated health care plans, the pressures to limit treatment of patients will likely increase. The elderly and infirm may often be incapable of vigorously resisting attempts to limit their access to care, and need strong patient advocates to represent their interests. Physicians must determine the validity and appropriate response to pressures to limit treatment, while providing optimal care based on the expressed wishes of mentally competent patients. The inertia encountered in the care of this patient implies that expressed
patient wishes may not ensure reasonable access to optimal and established medical care, particularly if the illness impairs mental function and the patient is elderly. That this may also represent a physician conflict-of-interest is disturbing and deserves thoughtful discussion by physicians and other health professionals.

Michael Zaroukian, M.D.
MSU Department of Medicine.

Commentary

This case illustrates both the complexity of ethical problems that commonly arise in the hospital setting, and also the way in which many ethical problems turn out on investigation to revolve primarily around staff communication. For example, it took only a very slight shift of perspective and orientation for this case to appear either as age discrimination being used to deprive a patient of a potentially beneficial treatment, as opposed to an elderly, dying woman being turned into an investigational guinea pig.

One of the most difficult features of many cases encountered in hospitals among the elderly is the problem of fluctuating level of capacity to decide. While this was a feature of this case, it did not pose a great barrier to practical decision making. If the patient was viewed as competent when she first arrived in the emergency room, and before she developed the full blown organic brain syndrome under therapy, the content of her expressed decision appears to be in favor of treatment. If, on the other hand, the patient was felt to be totally incapable of choosing, the surrogate who could best represent her wishes also favored treatment. Thus there is no disagreement about her course of therapy.

If capacity to choose is not the central issue, attention turns to how the options were presented - either to the patient or to her surrogate - by the responsible physicians. In order for those staff who felt that aggressive therapy was an unwarranted intrusion upon the dying process in a vulnerable elderly patient to defend their perspective, it must be the case that the decision of the patient (or surrogate) was based on flawed information - that the likelihood of success with balloon angioplasty was not as great as they were given to believe. This is a technical question of cardiology that is beyond the scope of this commentary. However, a problem frequently encountered in cases like this, particularly among residents and other relatively inexperienced practitioners, is the confusion between a treatable disease and a treatable patient. Aggressive therapy is sometimes recommended for a patient because the particular diagnosis assigned to that patient, when looked up in the textbook, is described as a potentially reversible or curable condition. What is sometimes forgotten is that an individual patient may be so far advanced in the course of that particular disease that the intervention strategy is much less likely to provide that particular patient with any real benefit. Nonetheless, medical staff may persist in encouraging aggressive treatment because "you simply can't let a patient die when they've got a reversible condition". Therefore, appropriate presentation of options to this patient would include not merely statistics on the success of balloon angioplasty, but also specific estimates of the reversibility of critical aortic stenosis in the face of the patient's other medical problems and at her particular stage of the progression of illness.

Howard Brody, MHP

London Revisited!

Medical Humanities in London (England), with a home base at St. Bartholomew's Hospital and Medical College, was offered for the second time July 7 - August 7. Fifteen students, including undergraduates with a variety of majors and several graduate students, enrolled in the program. Most of the enrollees were from Michigan State University, although a third were associated with other institutions--University of Michigan, University of Wisconsin-Madison, Loyola University, and Harvard University.

The program was organized, as last year, into two courses that analyzed, from interdisciplinary and comparative perspectives, the history of medicine and medical ethics in Great Britain and the United States. The emphasis was on Great Britain, particularly the historical development and present operation of the National Health Service (NHS) within the larger context of the modern British welfare state, as well as the healer-patient relationship, informed consent, and allocation of medical resources under the NHS. Central to the course were the field experiences, including morning sessions with British general practitioners and health visitors, workshops in several London museums, and directed tours of various hospitals. These experiences provided concrete evidence of the themes and issues raised in the readings and discussed in seminar meetings; at
times, the field experiences forced the students and the instructors to question what we had read, whether written by U.S. or British commentators; and always, the field experiences enhanced the seminar discussions with guest lecturers on a variety of topics. Short, analytical writing exercises served as synthetic devices. For example, students were asked to describe the communication and information-giving styles of the general practitioners with whom they had seen patients, utilizing the vocabulary and conceptual models of the doctor-patient relationship and informed consent developed in the readings and seminar discussions.

The instructors (Peter Vinten-Johansen, from the Department of History, and Tom Tomlinson, from the Medical Humanities Program, at MSU) made substantial strides toward the goal of offering a program of two integrated courses, in which each discipline informs the other. Success was most apparent in the last two weeks of the five-week program, when ethical dimensions of resource allocation in the original conception of the NHS were related to the historical and sociocultural parameters of the British welfare state. On a comparative note, the students wondered whether the greater appeal of collectivist ideals in Britain than in the U.S. in the post-World War II era was an outgrowth of differential experiences in the war itself, particularly the blitz; if so, current proposals to privatize parts of the NHS may reflect a waning, collective memory.

Plans are well underway for the summer of 1988, when Peter Vinten-Johansen and Martin Benjamin (Department of Philosophy at MSU) will team-teach the courses in the program. If you would like additional information, please contact Peter Vinten-Johansen at (517)353-9417 or in care of Interdisciplinary Programs in Health and Human Values, Michigan State University, 328 Morrill Hall, East Lansing, MI 48823-1036.

Peter Vinten-Johansen

MHP Faculty Involved in SHHV and MSMS Meetings

Howard Brody, Tom Tomlinson and Leonard Fleck made several presentations at the national meeting of the Society for Health and Human Values (SHHV) November 6-8 in Arlington, Virginia. Dr. Tomlinson participated in a panel discussion on "Empirical Research in Medical Ethics" and is co-author of a paper presented by former MHP faculty member Ken Howe titled "Proxy Consent for the Elderly: Final Report". Dr. Fleck presented a poster session on "Justice and Catastrophic Illness: Health Care Cost Containment and the Just Treatment of Bottomless Pits". Dr. Brody, president elect of the Society, participated in a panel discussion at the plenary session for the Faculty Association of the Society on "DRGs: Behind the Economic Issues". Dr. Brody also addressed the Society of Teachers of Family Medicine at the annual meeting of the American Association of Medical Colleges. Dr. Brody's talk was titled "Ethical Issues in Measuring Quality of Care".

On November 12 the MHP faculty addressed the members of the Michigan State Medical Society (MSMS) at their Annual Scientific Meeting at The Hyatt Hotel in Dearborn, Michigan. Dr. Brody and Dr. Leonard Weber (Mercy College, Detroit) presented a panel discussion "Quality of Care, Quality of Ethics - Who Decides?". This year for the first time these presentations were jointly sponsored by The Medical Humanities Program at MSU and the newly formed Medical Ethics Resource Network (MERN) of Michigan.

Paul J. Reitemeier

NOTABLE NOTES


Howard Brody has a new book due out in January from Yale University Press titled *Stories of Sickness*. In his book Dr. Brody emphasizes the critical importance of physicians attending to how patients describe their experience of sickness as an essential part of the healing process. When viewed as a narrative, Brody argues that important ethical questions develop new emphasis in the doctor-patient relationship.

Leonard Fleck published a feature article in *OR Nurse*, "The War Between Technology and Health Care Costs" in September, 1987. Dr. Fleck also wrote the feature article "Justice and Health Care" to be published in the February, 1988 issue of *Theoretical Medicine*. This past June Dr. Fleck accompanied Dr. Ruth Hoppe on hospital rounds at Ingham Medical Center in Lansing where he got a "bedside" look at the day-to-day medical care of patients. Dr. Fleck described
his experience as "extremely valuable in seeing the real nature of communication and decision making between physician and patient." Dr. Fleck's article "The Physician and the Rationing of Health Care Resources" was published in the Philosophy and Medicine Newsletter of the American Philosophical Association.

Howard Brody, Leonard Fleck and Tom Tomlinson have each given several talks on ethical issues in the treatment of AIDS patients throughout Michigan as part of the Michigan State Medical Society's Seminar Series on AIDS. By December first over 120 seminars will have been given by MHP and other speakers through a grant funded by the Michigan Department of Public Health which runs through 1988. All three faculty members and former faculty member Ken Howe (now at the University of Colorado) participated in a symposium in August on "Hospice Care in Terminal Illness," sponsored by the International Hospice Institute, at Snow Mountain Ranch in Granby, Colorado.

### MEDICAL HUMANITIES PROGRAM CALENDAR

<table>
<thead>
<tr>
<th>Date</th>
<th>Location and Event</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 2</td>
<td>Medical College, University of Rochester, New York</td>
<td>&quot;Medical Ethics and Economic Issues: Physician Incomes&quot; Howard Brody</td>
</tr>
<tr>
<td>Mar. 1</td>
<td>All College Retreat, Hope College, Holland, Michigan</td>
<td>&quot;Justice, DRGs and Invisible Rationing&quot; Leonard Fleck</td>
</tr>
<tr>
<td>Mar. 28</td>
<td>Internal Medicine Dept., Hurley Medical Ctr., Flint, Michigan</td>
<td>&quot;DNR Decisions: The Ethical Issues&quot; Tom Tomlinson</td>
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<tr>
<td>Jan - Feb.</td>
<td>Michigan Dept. of Public Health and Medicaid Staff, Lansing, 6 weekly presentations</td>
<td>&quot;Issues in Justice and Health Care Policy&quot; Leonard Fleck</td>
</tr>
</tbody>
</table>

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