Power: The Ethics Dog That Didn’t Bark

By Howard Brody, Ph.D., M.D.

Fans of Sherlock Holmes will recall the pivotal clue in the case of “Silver Blaze” which was provided by the dog that did not bark in the night-time. Most of the important and innovative work in medical ethics in the past couple of decades has focused on the issues and concepts which have been identified as ethically relevant. It is valuable at intervals to critique this enterprise by asking what issues and concepts are being omitted from consideration, and why.

It is in this vein that I have recently been working on a manuscript entitled, The Healer’s Power (Yale University Press, anticipated in 1991). My thesis is that “power” is a dog that hasn’t barked; and that it is worth asking both why it has not been heard from, and how medical ethics would be different if it were to be included more centrally.

This notion came to me as a result of a conference on medicine, ethics, and literature, organized for the Flint family practice residency by Linda Garcia-Shelton and Anne Hudson Jones. This conference juxtaposed readings which included Dostoevsky’s “The Grand Inquisitor,” Vonda McIntyre’s science fiction story “Of Mist, and Grass, and Sand,” William Carlos Williams’ “The Use of Force,” and Richard Selzer’s “Brute.” On reflection, it seemed that what all these stories had in common was a focus on the power of the physician, and the fine line between its proper use and misuse. But “the use and misuse of power” was not a title that

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When "No Problem" Is the Problem--Patterns of Trouble in a Clinical Experience

By Brian Brown, M.A. and William Rittenberg, Ph.D

One hopes that a physician and patient will leave a clinical encounter in agreement about decisions regarding diagnosis and treatment. While this may be part of a desired standard outcome, it is also an ideal. To look more closely at mutual satisfaction between patients and physicians, we did a qualitative clinical study to detect patterns underlying management of a common medical complaint--pediatric ear infections. In this study, we videotaped doctor/patient interaction, and interviewed parents (and patients) privately at length afterward. In most cases, we also discussed the clinical interaction with the physician separately. We hoped to observe factors associated with unsatisfying outcomes; our underlying assumption was that issues which arise in these relatively uncomplicated visits would also be significant in other clinical contexts. In reviewing our observations, we were intrigued by one particular matter--the “no problem” problem.

THE SETTING

Since illnesses and accidents that befall children do not respect the office hours of physicians, local pediatricians collectively arranged to provide a single central location for medical care of children outside of business hours. The “Clinic” is intended to treat patients with minor problems, not serious enough for a

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hospital's emergency department, but acute enough to merit prompt physician care. Each pediatrician who refers patients to the Clinic rotates through periodically as the "attending"; each typically pulls a shift one evening every 2-3 weeks. The clinic does not operate on an appointment basis; some evenings over forty children will visit, on others there may be only six or seven patients.

THE PROBLEM

Since a large number of patients present with complaint of possible ear infection, the means of its management does not vary significantly among the attendings. In a typical visit, the child's parent (usually mom) offers a suspicion of ear infection when first speaking with the receptionist, even before entering the clinic itself. A rather small but significant minority of mothers "know" their child's ears are infected; they come to the clinic not for a diagnosis, but simply a prescription for an antibiotic to attack the infection.

The framework of the clinical interaction itself is fairly well ordered: It begins with a nursing interview; then, when the physician enters, there is a review of relevant medical history, physical examination, announcement of diagnosis, and recommendation of therapy, in that order. Of course, there are several areas of variation among the visits, but they usually do not affect this basic framework.

Usually, but not always. The ultimate diagnosis of an ear infection is based almost solely on whether the patient's ear appears inflamed on examination; that is, if it appears to be "red" or "red and bulging." What happens when the physician looks in the ear and finds that it is neither "red" nor "bulging"?

At first, there is some sense that someone has made an error. Perhaps the parent has misinterpreted or misrepresented the child's subjective complaint. Is this a case of "bad" parenting? Is mom being duped by a youngster who just wants attention? Perhaps the child simply cannot be a credible informant, especially at a young age. After all, can a youngster be expected to accurately render an assessment of his own physical condition? Since there is normally little if any prior contact between parent and physician, parents may wonder whether their credibility is being questioned, if their child appears not to have an infection. In speaking immediately after the visit, a couple of moms whose kids did not have an infection articulated concern that they were seen as abusing the privilege of the clinic, but none of this was reflected in post-visit comments from physicians.

It could be that the physician has not looked closely enough at the affected ear, and may proceed to repeat the ear exam—sometimes spending a number of seconds peering into an inoffensive ear. Physician comments reflected concerns corresponding to the parents', but in which they felt their own credibility was being questioned; on more than one occasion a physician felt compelled to invite mom to look into the youngster's ears to convince her that there was nothing red to be seen.

Whatever the case, each participant has a goal. Generally speaking, the child wants to "feel better"; mom wants the "peace of mind" that comes with an understandable and workable diagnosis and treatment regimen; and the physician wants to provide an accurate diagnosis, an effective therapy, and send mom and child on their way. None of this can happen if the ear is not red. Expectations are not being met, and the framework of the visit deviates from its standard format to compensate.

In a limited number of cases, the physician simply states that there is no infection, and recommends symptomatic treatment. This rather uncommon strategy tends not to foster satisfaction. Nonetheless, two moms claimed to be satisfied simply with the knowledge that there was no infection—that there was nothing to be concerned about. More commonly, there begins a search for an alternate diagnosis, with appropriate therapy.

INTERESTING PATTERNS

We have been able to note a few general factors in "no-problem" visits that appear to significantly influence their outcome. The first involves how strongly the parent initially states expectations of an ear infection. If mom is "certain" there is an ear infection, and the diagnosis does not pan out, she is more likely to think that her credibility is being called into question—and yet the physician may be totally unaware of her concern. Unless mom can validate her initial understanding of her child's symptoms, she will likely leave the Clinic unsatisfied. If mom were more ambivalent in her initial feelings, or if she did not expect an ear infection from the beginning, she is less likely to leave unsatisfied, even if the physician can offer only a recommendation for symptomatic treatment.
A second (and related) concern is the extent to which the notion of an ear infection is blindly accepted by all. In all cases we observed, one of the principal actors (child, parent, nurse, or physician) originally offered the suspicion of an ear infection before the physical examination. If the others accepted the suspicion as a sure diagnosis before the physical exam began, problems arose. In one case a busy physician, assuming ear infection, began his visit with the physical exam, rather than reviewing medical history. When he saw no signs of infection, he backtracked into taking the medical history, and was required to perform the physical exam a second time.

This distortion of the normal framework, apparently intended as a time-saving measure, made for more work. Mom left with a vague sense that the visit did not go well, but could not say why. In a number of cases, physicians used their review of the medical history to dispel any preconceived notions before the physical exam began. One physician offered, even before she began the physical exam, the prospect that “maybe we don’t have an ear,” even though symptoms tended to point in that direction. When the physical exam verified that there was in fact no infection, the break from initial expectations had already been made, and mom was satisfied with symptomatic treatment.

A third factor is the ease of finding an alternate diagnosis. For example, an adolescent patient visited the clinic accompanied by his mother; both were certain that he an ear infection. Since they had had repeated experiences with ear problems, the physician initially seemed rather perplexed when the youngster came up with a healthy looking ear. Fortunately, in conversation the boy revealed that he had just visited the orthodontist two days before, and the attending was prompted to ask whether there was any new dental work in progress. The boy responded affirmatively, and the doctor had a possible cause for the ear pain. He still prescribed an antibiotic, in the event that the ear pain got worse, but when the parent and patient spoke afterward they each felt assured that new braces were the cause of the problem, and they would likely not fill the prescription.

One may argue that the points we have noted here would be obvious to any experienced clinician. However, each “no-problem” case we observed occurred in interactions with seasoned practitioners (although they tended to occur during busy times in the Clinic). It is noteworthy that difficulties reflect back on the integral framework of clinical interaction; a common denominator in these cases is the often slighted history-taking portion of a clinic visit. The importance of taking a good patient history is one of the truisms of medical training, but our findings merit a reminder that thoughtful and dynamic history-taking is more than just getting information. It is also a way of avoiding “no-problem” problems.

JUSTICE, PARTIALITY, AND THE DOCTOR-PATIENT RELATIONSHIP

By Leonard Flick, Ph.D.

In the past several years there has been a spate of books and articles by moral philosophers defending the moral legitimacy of partiality as opposed to impartiality. [See, for example, Thomas Nagel’s The View from Nowhere.] Thus, parents may justifiably give preferential treatment to their children as opposed to the children of strangers. There is, of course, an obvious danger to this perspective, especially when we consider the multiplicity of special relationships that bind us into various social groups, i.e., friends, co-workers, members of a profession or a church or a union. That danger is the fragmentation of the moral community and the claims of impartiality. Concerns regarding justice seem especially jeopardized by this fragmentation.

In this essay I wish to focus on one special relationship, the doctor-patient relationship and the problem of just rationing. How partial may a physician be to his/her patients? One next way of resolving this problem is to say that physicians must be scrupulously impartial when they are allocating public resources, like ICU beds, but they may allow partialities to shape their allocation decisions when private resources are at stake, such as their medical time and attention. Unfortunately, the real world is lacking very often such bright lines of division. This may be especially true for the rural practice of medicine where the personal and professional lives of both physicians and their patients are intertwined in complex ways.

Ruth Putillo and James Sorrell [Hastings Center Report (August, 1986)] have addressed this problem in rural medicine. Putillo relates the story of Dr. Palmer who has cared for the Roubal family for twenty years. Last year their 12-year old son required four weeks of hospital care, for which neither the hospital nor Dr. Palmer was paid because the Roubal’s health insurance had lapsed. Now Mrs. Palmer is in acute gastric distress. Outpatient testing [uncompensated] (Partiality continued on next page)
Partiality continued from page three

has failed to turn up anything. More complicated in-patient testing is now recommended, except that the hospital administrator has recently warned the medical staff that the hospital is in financial crisis because of a large volume of uncompensated care and inadequate DRG payments. The hospital will be forced to close in a year if nothing is done to manage the problem.

The hospital, of course, is a major community resource in virtually all rural communities. It is a major employer and it anchors a lot of extended health services. On the other hand, there is a strong rural ethic of mutual aid, sustained in part by the strong personal ties that bind everyone into something analogous to a very large extended family [unlike the more distant, impersonal, contractual-like relations that define urban life and the doctor-patient relationship in those settings]. As Purtilo/Sorrell point out, a rural physician is expected to be an involved [and generous] member of this community who could hardly say "no" to a patient needing medical care because of "the high probability that the physician will see a rejected patient at the drug store, Lions Club dinner or next PTA meeting." Still, rural hospitals do close and are closing at an alarming rate.

Dr. Palmer admitted Mrs. Roubal for moral and professional reasons, though he added that he knew virtually everyone in admissions and on utilization review. Also, he plans to head up a fundraising drive to cover the costs of Mrs. Roubal's care. This is a clever way of dealing with this particular dilemma, though we must wonder about the stability and generalizability of this strategy. After all, for such a public appeal to work some details about Mrs. Roubal's medical circumstances must be revealed. What happens if she (or a similarly situated patient) insists that confidentiality be protected? And how many such individualized fund drives could be successfully and simultaneously mounted? And how should a physician be judged from a moral point of view [either partial or impartial] who simply admitted the patient and let some hospital administrator worry about how that care would be financed? Mrs. Roubal was admitted to a rural hospital, which itself reflects a perspective of partiality since funds for her care continue to circulate in the community. But what if she needed surgery that cost $60,000 and that needed to be performed at a distant medical center? Could Dr. Palmer then spearhead a fund drive with an equally untroubled conscience? Or would it be morally permissible for him to just leave her to her own devices and the charitable impulses at that distant medical center?

Mrs. Roubal and her family had been cared for by Dr. Palmer for twenty years, and we can imagine that there was some degree of friendship there. What does Dr. Palmer owe Mr. Labour who has been a somewhat crotchety patient for only three years, who also lacks health insurance, and who has the same medical problem as Mrs. Roubal? Is it morally justifiable that Dr. Palmer should be more partial to the interests of Mrs. Roubal than Mr. Labour? I do not mean to suggest that there is a perfectly obvious answer to this question. Surely I want to defend the moral legitimacy of loyalty and fidelity to the interests of each patient by their physician. This is a kind of partiality, but it is a bounded partiality whose bounds will need to be established from an impartial perspective.

Due to the enthusiastic response of the participants in last August's intensive summer ethics Institute, the Center for Ethics and Humanities in the Life Sciences will be offering a similar program this coming summer, August 10 through the 16. The Institute is designed to meet the educational needs of members of institutional ethics committees, faculty in colleges of medicine and nursing, and hospital administrators. Topics will include informed consent, treatment refusal, withdrawing life-sustaining treatment, confidentiality, ethical issues in neonatal care, reproductive rights issues, AIDS-related issues, "gatekeeper" issues and health policy. But the primary emphasis of this Institute will be skill-building, especially skills needed to engage in productive moral conversation. Hence a substantial amount of time will be spent in small groups. Due to a desire to improve accessibility to the institute by out of state residents (and enlarge the number of inexpensive, high quality restaurants available for participants) the location will be moved from Shanty Creek Resort to the Kellog Center in East Lansing.
A VERY SHORT STORY OF SICKNESS

In the course of casual conversation with an acquaintance I mentioned my research interests in health rationing and justice. He responded by complaining about excess and inefficient billing methods in hospitals, pointing out that the money saved could be better used to provide more patient care. He then went on to tell me a truly outrageous story about his aunt who had serious heart problems along with an advanced form of diabetes. She lost her job because of her health, and, of course, lost her health insurance as well. She was then unable to afford the insulin she needed as well as her other medications. These were then provided by a county welfare program—except that program would routinely run out of money before the end of each month. In order to get these medications then she had an arrangement with the local sheriff who would pick her up for vagrancy, which then gave her access to the health care she needed since the state has a responsibility to meet the health needs of prisoners. But this was a county budget too, and the health line ran out after a while. She died shortly thereafter. I thought to myself that it was terrible that this should happen in Alabama or Mississippi. By chance I asked where it was she lived. It was Michigan.

How many other stories are there like this in Michigan? It might be a project worth undertaking to collect such stories. As Robert Solomon has noted in a recent book with this title, such stories are necessary to elicit "a passion for justice." If we are simply told that there are a million people without health insurance in Michigan, then our capacity for compassion is dulled. Indifference and intellectualization are the only ways in which we can deal with numbers that large. We invite your stories.

Leonard Fleck, Ph.D.

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recalled having seen at the head of any scholarly paper on medical ethics.

Eventually I located a very useful 1980 paper by John Ladd—significantly, published in The Lancet, and thus having little impact on U.S. thinking in medical ethics. Ladd proposed briefly in that paper that the "responsible use of power" is the central problem in medical ethics, and offered some proposed criteria for the responsible use of power. Much of my own work is an attempt to elaborate upon that beginning.

My proposed list of guidelines (adapted from Ladd) holds that power is most likely to be used responsibly when it is aimed, owned, and shared. That is, the responsible use of power entails clearly identifying the objective toward which the power is to be applied; using power openly and with full willingness to accept accountability; and willingly sharing power with others whenever feasible instead of demanding a power monopoly. This latter feature is especially important for medical ethics, since it leads to further discussion of "patient empowerment" as a goal of the physician-patient relationship, and challenges any view that the physician-patient power balance must be zero-sum.

I found that the concept of "power" provided a novel perspective in some areas and added fairly little in others. For example, I could not say much about medical confidentiality using "power" terminology that had not already been said in the more usual autonomy-beneficence terminology. On the other hand, two chapter titles from my manuscript are "Care Versus Work" and "The Physician's Income." I do not recall seeing these two topics appear in anthologies of medical ethics previously; but from a "power" perspective, it seemed critical to include them.

One major benefit of bringing talk of "power" back onto center stage in medical ethics is that it may facilitate collaboration between ethics and philosophy and the social and behavioral sciences. These two groups have generally had little useful interaction in the past, and I think this has been to the detriment of medical ethics. A more actively interdisciplinary approach may be very beneficial in the future. Since "power" is a concept much more familiar to the social scientist, more self-conscious use of it in ethics can foster further dialogue among the disciplines.
CASE STUDY: The Physician, the Family and the Consultants

Ethics consultation was requested by the attending physician regarding a seventy-two year old hispanic woman who was presently in the coronary care unit suffering from multiple organ system failures. She has had several hospitalizations over the past few years and was admitted to the hospital on this occasion three and one-half months previously. Her problems included endstage renal disease requiring peritoneal dialysis, severe congestive heart failure, chronic pulmonary disease requiring ventilator support, multiple episodes of sepsis, and new onset of hepatic failure. The family consists of ten adult children. The patient’s husband died in this hospital several years ago, and there were charges that his care had been inadequate, resulting in a lawsuit filed against the hospital. The children have mentioned on a number of occasions that they are considering filing a lawsuit in the present case as well. Two daughters, one who visits regularly and one who declares herself unable to visit, have indicated that they think continued life sustaining treatment is contrary to their mother’s interest. However, the view voiced by all other children is to continue maximally aggressive support. On some occasions, this has been related to the religious convictions of the children, and on other occasions has been linked to their bad experiences in the care of their father.

The patient herself, when first admitted to the hospital, was able to express her wishes and indicated a general desire to receive aggressive treatment. As her condition deteriorated, she was then heard to make a number of statements which the nursing staff interpreted as expressions of suffering and dissatisfaction with the continuation of aggressive management. She is currently comatose and unable to participate in decision making or in discussion.

Multiple attempts have been made over the past three months by the physician, the nursing staff, and the social work staff to convene family conferences and to discuss with the family the possibility that continued care will be futile, or that it may cause increased suffering without corresponding benefit. The statement from the nursing staff and the social worker is that they have been unsuccessful in linking with the family. The family expresses anger and hostility at any new requests for a conference, stating that they have made up their mind and don’t see any further point in talking about it.

The attending physician increasingly feels that treatment is useless and will not alter the patient’s status. The physician is however unwilling to resign from the case, because there is no other physician in town of the appropriate specialty training to undertake the patient’s management. The physician requests an ethics consultation to clarify the options.

The ethics consultants review the chart, and discuss the case with the attending physician, a nurse, and the social worker who has been most directly involved. Because of the delicate family situation, they elect not to interview family members or discuss the case with the family directly. They review options ranging from continued aggressive care to refusal to provide any further aggressive treatment, and indicate on their consultation note the rationale that can be provided for each course of action.

Commentary: Howard Brody, Ph.D., M.D.

I will argue that the ethics consultants should have insisted on interviewing at least some of the family members, and if this was not feasible, should have refused to carry out the consultation.

One of the most difficult aspects of ethics consultation is determining the extent to which the consultant ought to be responsible for double-checking the data that are reported. This has led some to recommend that only a physician ought to do ethics consultation, and that the ethics consultant ought to complete a physical examination of the patient as part of the consultation process. Few would go along with this extreme interpretation; but all agree that the consultants should not simply accept the data that are offered totally at face value. The possibility that the data are skewed or incomplete should always be kept in mind, and indeed

Commentary: Tom Tomlinson, Ph.D.

The consultants in this case were correct in not trying to talk with the family, because the purposes which normally recommend such conferences would not have been well served by the consultants’ involvement.

Family conferences are usually imperative for resolving problems concerning foregoing treatment for an incompetent patient, because most such problems concern the patient’s rights to have treatment preferences respected, and the family is the primary source of information about the patient’s wishes. Secondly, the family’s needs may also have to be identified and addressed when this is helpful in removing obstacles to reaching agreement between the family and the staff on what course of action will best serve the patient’s interests.

None of these objectives would have been met by a family meeting with the ethics consultants.
Brody (continued)

the resolution of a number of perplexing “ethical” problems hinges on challenging mistaken assumptions or gathering data that have been omitted from the workup.

In the present case, the ethics consultants are totally dependent upon the impression of the family as reported by the physician, the nurses, and the social workers. There are a number of reasons to doubt the validity of these perceptions. They are of a different cultural background; they are potential litigants; they express hostility openly; and they have been resistant to persuasion by the “reasonable” arguments of the medical team. Anyone of these factors would be sufficient to create a barrier in communication; all the factors taken together make it very difficult for any member of the health care team to hear clearly and without bias the thoughts, views, and concerns of the family members.

Perhaps everything humanly possible has been done to try to form a productive working alliance with this family. Alternatively, it may be that an adversarial relationship was established early, and all further attempts at communication have simply hardened the original adversarial postures. Someone coming to the case with a totally fresh perspective, especially someone who is prepared to listen with sympathy and concern to the expressed wishes and thoughts of the family members, might be able to suggest an opening for dialogue and for renegotiation. On the other hand, anyone who comes to the case and simply takes the perspective of the health care team at face value will inevitably conclude that there is no chance to work further with this family in any reasonable fashion.

There are a number of good reasons in this case why the attending physician would not have wanted the ethics consultants to directly speak with members of the family. It is quite possible that their hostility and their litigiousness could merely be increased by the appearance, late in the game, of these additional strangers. But if that is so, the “strangers” also have an obligation to lay down conditions that are necessary for the performance of their professional duties. If this means that they cannot provide sound ethical advice for the attending physician, they ought to say so and refuse to participate in the consultation under those conditions. They can certainly offer sympathy for the difficult experiences that the attending physician has had over the past several months; but they should not presume to offer an ethical analysis of all relevant aspects of the case.

Tomlinson (continued)

First, at this juncture this family is not going to support any assertions about the patient’s wishes which run contrary to the majority’s own strongly-expressed views about aggressive treatment. Approaching the family to ask them what their mother would have wanted would produce a predictable answer from most of the children; and to the extent that it revealed dissenting views from one or two of them, it would only fuel suspicion that the ethicists were trying to divide and conquer just like the rest of the staff. No fruitful dialogue about the patient’s wishes would result.

Second, such a meeting is unlikely to identify any needs of the family’s which would be best unearthed or met by the ethicists. The dynamics of the family’s demands are quite clear in the history provided by the attending physician, as well as by social work and nursing staff, all of whom had attempted to open conversation with the family about the patient’s care. The family’s fervent religious belief in miracles was used by them as a conversation-stopper, not as a prelude to theological explorations. Perhaps a minister of their faith would have the religious authority to command their attention; the ethicists certainly don’t. Their suspicion of incompetent or negligent care in their father’s case can only be addressed by convincing them that the attending physician’s medical judgment is well-founded. That’s a job for an independent medical consultant, not the ethicists.

Finally, insisting that the ethicists should have met with the family misunderstands what the ethical problem was. The ethical problem facing the attending who called the consultation was how to ethically respond to the family’s demands that the attending continue to provide care that the physician thinks is useless and harmful. Should she threaten to sign off the case if the family continues in their demands, or would that be morally objectionable “coercion”? And could she ethically make good on such a threat? How could she do so without compromising the care being received by the patient? The job of the ethics consultants was to help the attending wrestle with her professional conscience over these questions, which presume that the family is recalcitrant in their demands for aggressive futile treatment. Of course, if the family couldn’t have been persuaded to change their mind, the physician’s problem would have gone away. There’s nothing but heroic rescue fantasies to suggest that the ethicists would have succeeded where everyone else had failed.
WANTED: STUDENT MEMBERS FOR
SOCIETY FOR HEALTH AND HUMAN VALUES

The Society for Health and Human Values is an interdisciplinary organization devoted especially to scholarship and academic work in the interface between human values and the health care professions. The Student Interest Group within the Society has been growing and has been expanding its activities. Medical students, nursing students, and graduate students in disciplines relevant to health and human values are all invited to join. There is a special student annual dues of $29.00.

It appears that the Society is expanding opportunities for students to talk with others about career goals and future plans in the medical humanities and related disciplines. Any students at Michigan State University who would like more information about the Society, or who would like to consider joining, should please contact the office of the Center for Ethics and Humanities.
An Update on Recent Activities at the Center

The Center Bids Farewell To Dr. James Nelson and Welcomes Dr. Andrew Hogan

In June of 1990 James L. Nelson resigned his position here at the Center for Ethics and Humanities in the Life Sciences to accept a post at the Hastings Center in Briarwood, New York. Although Dr. Nelson was only with us for a short time his contributions, both intellectual and personal, will be missed. We wish him success in his new endeavors and look forward to working with him on future projects. At present the Center is engaged in a national search to find a replacement.

While the search is being conducted some of Dr. Nelson’s responsibilities have been assumed by Center members James Waun and Wayne Cooper. Dr. Waun, an anesthesiologist at Sparrow Hospital and doctoral candidate in philosophy at MSU, is teaching sections of the Focal problems course in the College of Human Medicine. Dr. Waun is also working with Dr. Mary Ciotti on organizing the monthly ethics case conferences for the OB/GYN medical staff and residents at Sparrow Hospital. Dr. Cooper, a cardiologist and doctoral candidate in philosophy at MSU, is also teaching sections of Focal problems in the College of Human Medicine. In addition, he is instructing several medical clerkships in Grand Rapids.

The Center would like to welcome our new part time member, health policy economist Dr. Andrew Hogan. Andrew Hogan, who is an associate professor at the Office of Medical Education Research and Development, will be working on two projects in his year here. First, he and Leonard Fleck will be setting up the “Just Caring” project: securing funding, procuring personal, conducting research and other related tasks. Second, in anticipation of the curriculum change, he will be assisting in the reorganization of the Focal problems classes, concentrating on how best to incorporate health policy issues into the courses.

A Partial Listing of Recent Presentations, Publications, and Activities by Center Members

Tom Tomlinson has accepted the chairmanship of the Human Subjects Committee for the Michigan Department of Public Health and is a member of the newly formed ethics committee at Ingham Medical Center. He has also delivered papers recently on “Futility and the Ethics of Resuscitation” to the Society for Bioethics Consultation, “Determination of Competency” to Ingham Medical Center, and “Active Euthanasia” to the Saginaw Cooperative Hospitals. He also conducted a poster session session with Dale Singer at the Academy of Pediatric Hematology and Oncology entitled, “Obtaining Voluntary Agreement from Older Children and Adolescents for Bone Marrow Transplantation.”

Leonard Fleck will have an article in the forthcoming Biomedical Ethics Review entitled, “National Health Insurance: How Just Must We Be?” Recently he has presented papers at the Third International Conference on Justice in Health Care in Chicago, “The Oregon Medicaid Experiment: Is it Just Enough?” and at the annual meeting of the North American Society for Social Philosophy, “Is National Health Insurance Congruent with Liberalism?” He delivered the keynote address, “Just Caring: Justice, Health Care and the Good Society,” at the Conference on Justice and Health Care Policy sponsored by the University of Arkansas Health Science Center Medical Humanities Program.

Howard Brody has authored a chapter for the book Ethics at the Bedside (edited by Charles Culver). Recently he has spoken on, “The Healer’s Power” at the Chicago meeting of the Society for Health and Human Values, as well as at Henry Ford Hospital and the Society of Bioethics Consultation. He has just completed a year as president of Society of Health and Human Values and been named to the editorial board of the Journal of American Board and Family Practice.

The Center Welcomes these New Associate Members