In September, 2002, a *Washington Post* article accused the Bush administration of stacking several scientific advisory bodies to the Federal government, dismissing panels and panelists that said things that President Bush didn’t want to hear and replacing them with hand-picked scientists who would be sure to tell him what he liked (Rick Weiss, “HHS Seeks Science Advice to Match Bush Views,” *Washington Post*, Sept. 17, 2002). This brought forth an op-ed piece from Arthur Caplan, the nationally known bioethicist from the University of Pennsylvania who is always entertaining and stimulating and is often correct. Just before favoring Michigan State University with a guest appearance, Caplan castigated the Bush administration in the pages of the *Philadelphia Inquirer*, and called for the appointment of “the best experts” to government commissions (Arthur L. Caplan, “If Science Becomes Politicized, Where Do We Go for Truth?” *Philadelphia Inquirer*, Sept. 22, 2002).

As a rule I yield to no one in the Bush-bashing arena, but I think in this instance that Caplan’s too-facile call for “good science” papers over some important problems. I will describe what those problems are, and then ask whether the fields of bioethics and health care humanities can offer any help in solving them.

America seems to become more ideologically divided year by year. Debates over a wide variety of issues always seem to be more partisan and more bitter. Optimists might hope that an infusion of good science would resolve this problem. Let’s stop debating ideology and look at the facts, and then we could decide how best to fight drug abuse, whether or not global warming is getting worse, and so on. But science has not been of much use so far, it seems. A good part of the reason is that both sides of the ideological divide fully appreciate the importance of science as public relations and marketing. So, each side has cloaked itself in a set of scientific studies, and has a stable of scientists at its disposal, ready to “prove” that its point of view is right and that of the opponents is wrong.

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Real vs. Junk Science?

Reading Caplan, one would think that the appearance of a gaggle of scientists on both side of the debate would only be a temporary setback for “real” science. If the two groups of scientists disagree, then one set of studies must be “real” science and the other set must be “junk” science. “Real” scientists can tell the difference, so if, as Caplan says, we could just get the real scientists appointed to the advisory panels, we would soon see through all the smoke and perceive the truth.

My fear is that it is hardly that simple. As medicine struggles to become more evidence-based, and to better assess the quality of the scientific studies from which we decide how to treat patients, we are becoming more and more aware of the inherent limits of scientific research. It is commonplace today to read a systematic review on a medical topic, based on dozens of studies funded by reputable agencies and printed in the best medical journals. Virtually never does one come across a study that is without some methodological flaws, and fairly often, the reviewers are forced to conclude that the quality of the accumulated evidence is so poor that one really cannot recommend a firm course of action. This is not a problem of “junk science” or bad scientists. It is an inherent problem of doing science in the real world on complex issues.

Doing a scientific study requires a string of value judgments. One must decide what is worth studying. One must decide what questions to ask about it. One must formulate reasonable hypotheses. One must decide on the best methods to confirm or disconfirm those hypotheses. When, as inevitably happens, something goes wrong in gathering the data (patients are lost to follow-up, for instance), one has to decide what statistical corrections might fix the problem. Once the raw data are accumulated, one has to interpret them and decide what they mean. Finally, one has to reason from the conclusions of this particular study to the treatment implications for patients in the general population.

Well-intentioned, expert scientists who make these disparate value judgments in different ways will draw radically different conclusions about what counts as “truth.” I will cite one example from some work our colleague Leonard Fleck is involved in now.
A number of studies have been done on whether stroke caused by blood clots can be effectively treated by “clot-buster” drugs such as tissue plasminogen activator (tPA). One thoughtful and reasonable group of medical scientists believe that these studies clearly support the use of tPA so long as it can be used on selected stroke patients within the first few hours of the stroke—hence billboards calling strokes “brain attacks” and urging us to run to the nearest emergency room at the first sign of any symptoms of stroke. Another group of thoughtful and reasonable physicians interpret the data to show that tPA will kill or maim more people than it helps, and that it should be studied experimentally for much longer before being used in the community setting.

Another example comes from one of my own fields of interest, physician-assisted suicide and euthanasia. One would think that we would know everything there is to know about the actual social consequences of allowing these practices to be legalized. Euthanasia has been legal for many years in the Netherlands and assisted suicide was more recently legalized in the state of Oregon. These two jurisdictions thereupon became living laboratories in which physicians, social scientists, and policymakers could study the actual consequences of those practices. Many data have been published from both venues. The result, so far as I can tell, is of no help whatever in resolving the largely ideological dispute over whether legally to permit these practices. One side looks at the accumulated data and decides that the policies are working fairly well and that very few abuses are occurring. The other side looks at the same data and concludes that abuses are widespread and that the policies are a social disaster.

When it comes to the major public issues that divide us as a society, I think there truly is a problem of “junk science” and that we should do our best to expose it and clear it away. (I imagine, for instance, that much of the science used to argue that global warming does not exist or has been overblown as an issue falls into this category, though I can hardly claim expertise in that field.) We know that at least some scientists are for sale to the highest bidder, and the bidding wars these days seem to be becoming more fierce as an increasing number of scientists in academia feel obliged to turn to private industry for financial support.

But after the junk science is cleared away, I suspect that we will find a lot of remaining “good” science where we simply cannot choose between the disputants at first glance. Honest differences in methods and interpretation will lead the scientists to provide some answers, the policymakers basically are begging for junk science.

Sometimes policymakers need answers, and all that the best science can provide is a better understanding of the layers of uncertainty. By asking the scientists to provide some answers, the policymakers basically are begging for junk science.
Can Bioethics and Humanities Help?

The picture I have painted so far is a grim one. Our society will become increasingly mired in endless ideological wars over virtually every issue of major public concern. Instead of science elevating the debate out of the muck, the ideological debate will drag science down into the muck. What to do?

First, it is at least helpful to be sure that we have identified which assertions are ideological, which are scientific, and which are a blend of both. People with training in bioethics, especially those with some background in philosophy of science, may be better positioned than the average person to make those distinctions.

Second, it may be that we can take a page from those in evidence-based medicine now working on refining the writing of clinical practice guidelines. Fairly stringent and reasonably objective criteria now exist for grading medical-scientific studies on the quality of their methods and their execution. For instance, guidelines can now be written saying that prescribing aspirin to all patients who have had a prior heart attack is supported by level A evidence, while the recommendation to lower these patients’ cholesterol below 180 is supported merely by level C evidence.

One could sit the opposing camps of scientists down together and ask them to decide, not who’s right and who’s wrong, but rather whether they can agree on criteria for judging the adequacy of any individual study. Once criteria are selected, the group can then look at the selected body of literature, proposed by both sides of the debate, and grade each study. Assuming some level of rationality and good faith, this may result in a move from culture wars to a frank admission of where the gaps lie in each side’s body of evidence, and more to the point, what sorts of studies could be designed in the future that would more definitively answer the outstanding questions.

Some humanists have practical experience with methods to get groups of citizens to stop shouting at each other around controversial issues and, instead, to begin the process of rational deliberation suitable for deciding upon policy in a democratic society. Returning to Leonard Fleck’s work, he has pioneered the application of group dialogue in the form of “rational democratic deliberation” to both the allocation of limited health resources and, more recently, policy issues related to genetics. Many of the strategies shown so far to work as part of rational democratic deliberation may be adapted for the use of warring camps of scientists, or warring camps who rely upon conflicting scientific information. This solution is not a quick one; the process, in order to work, usually requires a commitment to keep coming back to the table even after finding areas of apparently irreconcilable disagreement.

Bioethics and humanities thrive in a setting where there is sufficient trust in both reason and in other people to encourage honest, searching dialogue. Perhaps I am overly optimistic in thinking that our society as a whole can move in that direction. (To return to Bush-bashing mode, I am especially discouraged that the President who ran for office on the campaign promise of putting an end to partisan gridlock in Washington, pointing to Texas as a supposed proof that he knew how to achieve bipartisan cooperation, is now presiding over an administration that seems determined to exacerbate every political and ideological divide in our society.) Nonetheless, bioethics and humanities has had some limited success in bringing a greater degree of reason and civility to some decision processes within health care. It is time we tried to export these methods to the wider social arena.

Howard Brody
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Participating in Public Policy: Rarely Easy, Always Important

In his lead article for this issue, Howard Brody discusses some controversies associated with presidential commissions on bioethics. *InkLinks* presents a view from inside: what it is like, and why it is important, to take part in the glorious, tedious mess of democratic policy-making. 

*InkLinks* is a regular column giving voice to readers, their research, their scholarship, their thoughts, and their activities. We welcome your contribution.

—JA

A Physician Working for Those in Pain: “I’ll never give up.”

In 1989 Michigan passed legislation that makes it difficult for physicians to prescribe the more potent opioids. I have been working to change those laws since 1990. The Michigan Official Prescription Program (MOPP), as this legislation is known, requires that prescriptions for these opioids be written on special prescription pads that must be ordered from the state. (The medications in question are known as Schedule 2 narcotics and include morphine, oxycodone, and meperidine.) Until the mid 1990s, all prescriptions for them had to be written in triplicate on serially numbered forms, and prescribers were required to keep their copy of the triplicate for years writing it. The state had a warehouse full of boxes of these forms, material never used for any purpose. A modification of the law lifted the requirement for a triplicate form (transferring because the burden of record-keeping to pharmacists instead), but still required the prescriptions be written on special, serially numbered forms that had to be ordered from the state.

A large percentage of Michigan physicians never obtained the special forms, and many of those who did never used them. Following the initial law, there was a marked increase in the prescribing of acetaminophen/hydrocodone analgesic combinations - ordinarily much less effective in helping with severe pain - almost certainly because those medications did not require the special forms. Today, Michigan lags behind many other states in its use of the highly effective opioid analgesics.

The purpose of restrictive prescribing laws like this is to reduce the illegal diversion of opioids: to keep the drugs off the street and out of the illegal drug trade. This is a goal most responsible citizens would support. The problem is that the laws also intimidate physician prescribers, who fear that they will get in trouble if they prescribe the drugs that will most help their patients. Although this is unlikely, efforts to change that perception have failed. And ironically, there is no evidence that such laws actually reduce illegal diversion.

Working to change this law has been a long, demanding, and frustrating process. I have spent many hours testifying at legislative committee hearings, getting patients and families to testify, meeting with legislators and their aids, writing newspaper pieces, trying to start a dialogue with the law enforcement representatives who supported the existing legislation, and so forth. Too often promising efforts fell apart at the last minute or languished in committee until the end of a legislative session.

On January 3, 2002, a bill repealing the MOPP was signed into law - a triumphant moment. Unfortunately, last minute disputes

(Continued on next page)
about the bill led to its sponsors accepting an amendment that allows the state to decide whether or not to require special “tamper-resistant” paper for opioid prescription. If this requirement is implemented (still under consideration as of this writing), we will be back where we started - physicians will need special pads to write opioid prescriptions.

Working for change in public policy can be time-consuming and discouraging. But it’s vital that we keep trying - decade after decade, if need be. Citizenship in a democracy is a responsibility as well as a privilege, and no one has ever said it was easy.

Karen Ogle
Department of Family Practice

A Philosopher Bioethicist: “I never dreamed . . .”

As a graduate student in philosophy in the 1960s, I never dreamed I’d be writing articles for journals like Liver Transplantation and Surgery or JAMA. Nor did I think I’d be chairing a statewide committee on ethics and organ transplantation, testifying before a subcommittee of the Michigan House of Representatives about advance directives, or co-teaching courses with nurses or physicians. Yet these and related experiences have opened my eyes and the eyes of other philosophers to a number of new and interesting public questions that are now part of the philosophical mainstream.

Not surprisingly, William James - one of the classical American philosophers, in the tradition called pragmatism - understood this long ago. According to historian George Cotkin, the key to understanding the life and thought of James is the “centrality of his role as public philosopher.” A public philosopher accepts “responsibility for addressing public problems and for applying insights gained from ones technical work to public issues” (William James: Public Philosopher, p. 4). In James’s case, the influence also went the other way: popular concerns and public issues found their way into his technical work. Cotkin adds that philosophers like James are “regrettably absent from the scene of present-day academic and public life.” I disagree.

Philosopher/bioethicists who participate in hospital or public policy ethics committees, testify before legislative committees, make presentations in church basements, turn out op-ed pieces for newspapers, articles for medical journals, and accessible books on bioethical issues and reasoning seem to me to satisfy Cotkin’s conditions for public philosophy. Twenty or thirty years ago this took some courage. In the early 1970s when K. Danner Clouser was considering leaving the Philosophy Department at Carleton College for the Milton S. Hershey Medical School his Carleton colleagues warned he would be committing professional suicide if he did. These days, however, the situation is reversed. It’s philosophy departments that fail to address questions in bioethics and related areas that seem to be exhibiting a professional death wish.

At one point in a lecture delivered to a general audience James said that philosophy should do more than exercise our “powers of intellectual abstraction.” It should also “make some positive connection with this actual world of finite human lives.” This has always seemed right to me. And it’s hard to think of an area of philosophy that makes more direct and positive contact with “this actual world of finite human lives” than philosophical bioethics.

Martin Benjamin
Department of Philosophy
Center News & Announcements

Judith Andre’s *Bioethics as Practice* was published this fall by University of North Carolina Press. In this book, Andre explores what it means to work in bioethics and the medical humanities for persons in wide range of backgrounds. For more details on this book, please see http://uncpress.unc.edu/books/T-5200.html.


Libby Bogdan-Lovis spoke at the University of Sheffield, UK, on “The Slow Death of Birth.” This paper was presented as part of a social history conference “Birthing and Bureaucracy: The History of Childbirth and Midwifery” (Oct. 12, 2002).

Judy Andre presented, “Nurses in Two Countries: Organizational and Cultural Contributors to Moral Distress,” co-authored with Allison Wolf. This paper was presented as part of the International Network of Feminist Approaches to Bioethics, Brasilia, Brazil (Oct., 2002).

Howard Brody, as a visiting professor to the Department of Clinical Bioethics, National Institute of Health, presented “Clinical Care vs. Clinical Research and the Therapeutic Misconception” (Nov. 13, 2002).

As part of the 6th World Congress of Bioethics, Judy Andre presented “Bioethicists, Boundaries, and Borders: The Moral Work in Public Speaking” (Oct., 2002).

Leonard M. Fleck and Oliver Hayes’s article, “Ethics and Consent to Treat Issues in Acute Stroke Therapy,” appeared in *Emergency Medicine Clinics of North America* 20 (2002), 703-15. This paper was also the basis for a presentation at the 14th Annual Bioethics Summer Retreat in Lake Placid, NY (June, 2002).

A number of MSU’s graduate students presented as part of the 5th annual meeting of the American Society for Bioethics and Humanities, Baltimore, MD. Chirsty Rentmeester (Philosophy) shared and presented a panel session titled “Jaded: Characted and Professionalization in Medical Education.” Howard Brody also served as a speaker for this session. Allison Wolf (Philosophy) presented “Justice Across the Americas: Who is Obligated to Provide Resources for Nicaraguan Health Care in Costa Rica?” Finally, congratulations to Beth Linker, an alumni of MSU’s Interdisicplinary Program in Health and Humanities. Linker was awarded the Student Paper Award for her work titled “The Buiness of Ethics: Women in Medicine and the American Physiotherapy Association’s 1935 Code for Ethics” (Oct. 2002).

The Center for Ethics and Humanities Spring 2003 Brown Bag Series

The Center for Ethics and Humanities in the Life Sciences at Michigan State University invites you to join us for our Spring 2003 Brown Bag presentations. An informal atmosphere invites students and faculty to participate in friendly discussion as well as interdisciplinary feedback following each presentation. We hope you’ll join us. For a schedule of speakers and topics, please visit the Center’s website at http://www.bioethics.msu.edu/.
Study Abroad Opportunities in Medical Ethics and History of Health Care

Michigan State University will offer a six week study abroad course, “Medical Ethics and the History of Health Care in London” next summer, June 16 - July 25, 2003. The 8-credit course will be co-taught by Howard Brody, M.D., Ph.D. (Michigan State University) and Declan O’Reilly, Ph.D. (Wellcome Centre for the History of Medicine, London). It includes two half day experiences for each student shadowing a health care practitioner. For further information, see http://studyabroad.msu.edu/programs/ukmed.html.

Michigan State University will offer an eight week study abroad program, “Ethics and History of Development and Health Care in Costa Rica” next summer, June 2 - July 25, 2003. The 11-credit program includes one integrated course co-taught (in English) by Professor Fred Gifford, Dept. of Philosophy at MSU, and Professor Francisco Escobar, Dept. of Sociology at the Universidad Autonoma de Centro America (Costa Rica), and also 4 credits of Spanish language instruction. Students are housed with Spanish-speaking Costa Rican families within walking distance of our classrooms. Field trips include visits to a variety of health care settings, including clinics in rural and poor areas and various regional and national hospitals; students also travel to national parks and eco-tourism sites to explore environmental issues. For further information, contact Fred Gifford at gifford@msu.edu or see http://studyabroad.msu.edu/programs/costaethics.html.

For CME information, as well as other other Center activities, please visit our website at http://www.bioethics.msu.edu/.