The Face of Hope in the Face of Advanced Disease
by John Mulder, M.D.

“There is a time for everything, and a season for every activity under heaven: a time to be born and a time to die....” (Ecclesiastes 3:1-2)

Death is the inevitable expectation of our human existence. Historically and culturally, the continuum of the natural life cycle has always been understood as finite. Even the most cavalier and arrogant among us admit that they cannot ultimately escape the throes of death. Yet the development of technological advances throughout the 20th century has produced the attitude that in fact, we can “beat” death – that we can actually “save lives.” Astounding scientific breakthroughs, “miracle” cures, and new surgical techniques have certainly served to modify disease processes, delay death, increase life expectancy, and restore health. But are they unwittingly furthering our subconscious notion of immortality? Without question, many of our medical advances have enhanced the quality and length of our earthly existence. In the process however, death has somehow become the enemy, as opposed to the ultimate conclusion: the expected, natural end to life, no matter how it may have been lived. Somewhere along the line, we have adopted the viewpoint that somehow death is an option for us. It is precisely that attitude that propels both the medical and lay populations into therapeutic decisions that are designed to battle death with virtually no accommodation for its acceptance. Extraordinary attempts are made to extend life by days or weeks, in many circumstances with little regard to the physical, emotional, or spiritual cost to the patient or family. At times these heroic efforts are imposed without consideration of the wishes or values of those being treated, instigated because this is what medical science has to offer. The arrogance of this system often prompts physicians and other health care providers to assume that because an invasive treatment is available, it should be applied. Bioethicist Dan Callahan observes, “we will live longer lives, be better sustained by medical care, in return for which our deaths in old age are more likely to be drawn out and wild.”

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Palliative Medicine: a definition

It is against this backdrop and to address this conundrum that palliative medicine developed. Over the past three decades palliative medicine has evolved as a distinct medical specialty with a unique set of knowledge, skills and practice. The primary objective of palliative care is the relief of suffering and improvement of the quality of life for patients and families living with life-defining illness. Initially seen as an inextricable element of the hospice movement, palliative medicine has been progressively integrated as a critical component of mainstream medicine, in community health systems as well as academic medical centers. continued on page 2
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Palliative medicine addresses the certainty that the majority of people will be faced with a diagnosis, condition or medical circumstance for which cure is not possible. Whether due to a chronic progressive disease (such as congestive heart failure, chronic lung disease, or dementia), many cancers, an acute event which cannot be remedied (such as a stroke or devastating accidental injuries), or certain congenital anomalies, most individuals and their families will have to address the reality that life is limited. In fact, it is estimated that at least 80% of people will die from chronic, incurable illness. The focus of palliative medicine is not on death and dying, but rather on the work of living well and living completely when afflicted with a serious medical challenge. The focus is on improving quality of life through aggressive management of symptoms that accompany most progressive and serious diseases, coordinating plans of care that are concordant with the nature of the disease and prognosis, assisting with decision making, accessing necessary community and health care resources to assist the patient and family in obtaining optimal care and working with the patient and family to negotiate the psychospiritual as well as physical impact of the disease. Palliative practitioners strive to understand the values, wishes and hopes of the patient, facilitate communication of these with family and other practitioners in the medical care system, and implement plans of care that are expressly consistent with these aspirations.

Perhaps as a vestige of the early link between hospice and palliative care, palliative resources were historically (and sometimes still are) withheld with the mistaken notion that adopting them eliminates options for disease modifying interventions, or somehow communicates a death knell. This is simply not true. To the extent that such interventions can in fact improve symptoms, functional capacity, and quality of life, then under a contemporary palliative plan of care these treatments would be implemented. Disease modifying and life sustaining treatments can still be pursued, so long as they are consistent with patient preferences.

Differentiation between Hospice and Palliative Care

Given the historical linkage between hospice and palliative care, there remains confusion about their distinction. Hospice is the term that is generally applied to the spectrum of medical care offered specifically at the end of life. Agencies that use the name “hospice” and accept payment for hospice care are required to provide a basic menu of services to their clients. Hospice is unique within the medical community in that it provides its care through an integrated, interdisciplinary team. The basic team includes the home care nurse, social worker, chaplain, medical director, and volunteers.

These providers all offer distinct services to patients in their homes, and meet on a regular basis to discuss, refine, and implement a plan of care most appropriate for each patient and family. The hospice philosophy of care seeks to determine the unique interests and values of each patient and family, and bring the necessary resources into their environment. With the reality that death is imminent, the focus is on bringing a sense of meaning, beauty, and hope to the patient and family. Hospice workers are expert in the science of symptom management and specialists in the art of compassionate caring. The goal is relief of suffering, management of symptoms, reconciliation of relationships, and assistance in the transition between this life and the next.

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Palliative medicine is indeed an indelible part of hospice care – but they are not synonymous. Hospices must include skilled palliative practitioners as part of their service. But so must cancer clinics, heart failure services, ICUs, and neonatal units. The focus on quality of life, expert symptom management and strategic care planning is not an exclusive service of hospice organizations. Individuals with serious, chronic, or life-defining illness (an illness that has the potential of imposing a burden of suffering on the patient and family) deserve the opportunity of including palliative services as part of the plan of care. Hospice uniquely enters the life of a patient and family when a foreseeable prognosis of months or less is in view. The integration of palliative services can begin from the time of diagnosis, irrespective of prognosis.

Summary

Ultimately, we all want to accomplish true healing in our life. But “healing” cannot be seen as synonymous with “cure.” It is not simply the absence of disease, but rather the sense of peace that comes when complex symptoms have been controlled, relationships have been reconciled, emotional wounds soothed, and spiritual struggles resolved. If we continue to avoid or deny the reality of limited life expectancy, we prevent not only ourselves but also our loved ones from experiencing the richness and fulfillment that comes with honest, intimate sharing of life at its most vulnerable moments. It is for this express purpose that palliative care has evolved, why this service must thrive, and why it must garner the support of the communities it serves.

It’s not about dying – it’s about living, and living abundantly in the face of serious medical challenges. That is what palliative medicine delivers.


The Center Welcomes

The MHR would like to welcome Karen Kelly-Blake, Ph.D., who recently joined the Center for Ethics and Humanities as the Project Manager for the Coronary Artery Disease Shared Decision Making in Primary Care research project. Karen is a medical anthropologist and MSU alumna. Her research interests include health services research, shared medical decision-making, health disparities, cardiovascular disease, and men’s health. Karen is in the process of launching Phase II with Margaret Holmes-Rovner, Ph.D., the project’s principal investigator. The research project seeks to engage patients and providers in making evidence informed decisions that reflect patients’ priorities for achievable outcomes. Having just completed both a successful CME workshop with collaborators in Port Huron and cognitive interviews with patients for the newly developed decision aid, Phase II is on track to kick off in June 2011.
In my experience, this is hard work. It is so time consuming and difficult that it works best when an interdisciplinary team of people come together to evaluate and manage all the complex facets that incurable illness bring to patients and their families. There are certainly many societal factors that push patients and families to continue to seek curative care when the chances of success become as rare as “winning lottery tickets.” However, I sense that the medical community is also uncertain about where palliative medicine fits in the continuum of care despite the fact that incurable illness is a common and inevitable reality. This lack of understanding and trust has created a gap in the medical fabric of care in most communities and this void deserves careful attention.

Nicholas Christakis’ work on physician attitudes about prognosis, death and optimism show a strong bias towards overestimation of length of life and a fear that by having honest discussion about the likely outcome of an illness we will destroy hope. Physicians fear that their attempts at prognosis will negatively impact the patient and that patients die earlier as a result of being given “bad news.” I have felt these fears in the pit of my stomach as I prepare to talk to a patient with a poor prognosis and can testify to their power. Palliative medicine with its unique structure and skill set can intervene before a person is “hospice appropriate.” In my experience, when the care team fully understands the goals of care, our treatment planning becomes very creative. As we empower patients and families to stop tiptoeing around the disease and to meet the challenges it is bringing into their lives head on, a new sense of hope and resiliency becomes manifest.

So why are there gaps and barriers to something that sounds so promising on paper? In fact, there is still a great deal of mistrust and misunderstanding about what palliative care does within the medical community. We don’t emphasize “acceptance” and “surrender” as many fear. If you have been a fighter all your life, then let’s use that as a way of helping you through this disease but first we must clarify what we are fighting for if your disease
The Hard Work of Culture Change
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is progressing towards its end stage. Our job as medical professionals includes prognosticating to the best of our ability. Patient autonomy without prognostic information can become false hope and this creates a new set of ethical problems. As Dr. Diane Meier points out, palliative medicine at its core matches patient goals and needs with a treatment plan that is most likely to succeed.³ This takes hours of careful discussion.

In the past, the hospice medical benefit was set up as an “either/or” program. You made the decision to opt into hospice for its symptom management with the agreement that you would not seek other curative therapy. The palliative care paradigm is a “both/and” sort of service. The question is “Will the medical community embrace this new structure and develop ways to work collaboratively in the places that palliative medicine is desperately needed?” Palliative medicine as a specialty provides solid ground in the continuum of care between what can be cured and what can not be cured. It provides a new doorway for an orderly transition into hospice care when it becomes appropriate. Most of us in the future will need these services in some way. Let’s hope they are available in the community where we live.


Aligning Practice and Passion

by James E. Mayle, M.D.

As Dr. Mulder’s article accurately describes, a palliative care approach is time intensive and demands excellent listening and communication skills. Patients and their caregivers need objective, accurate information to make diagnostic and therapeutic decisions. What are the pros and cons of wanting “everything done” in a given clinical situation? How might a repeat CT scan potentially benefit or make decisions more difficult? What is the probability of a positive outcome from CPR in an 85 year old man with vascular dementia, coronary artery disease with congestive heart failure, peripheral vascular disease and renal insufficiency? These examples draw from the spectrum of issues that palliative care specialists strive to illuminate for patients, families and health care providers.

I contend that the vast majority of health care providers decide to study medicine out of a sincere desire to relieve suffering and to help fellow human beings through challenging times. In essence, most health care providers made their career choice with goals similar to palliative care medicine. The rapid growth of palliative care programs has re-exposed many health care professionals to what is really important. The challenge will be sustaining and expanding those valuable palliative care services.

Today, 53% of hospitals with greater than 50 beds have a palliative care program.¹ As of January 2010 there were 74 active physician palliative care training programs. Through an American Board of Medical Specialties approved procedure, board certification examinations are available through at least 10 specialty boards. However, unlike hospice care which is included as a Medicare benefit, the funding of palliative care services is less reliable, and comes from fee-for-service, philanthropy, and hospital support. I sincerely hope health care reform will provide significant support for these valuable services. Well-funded palliative care services are needed and would allow physicians to practice their craft in a manner congruent with the ambitions that originally motivated them to pursue medicine.

1. Center to Advance Palliative Care. www.capc.org
The Quiet Moments: Palliative Medicine and the Bedside

by Malinda H. Bell, M.D.

“There’s nothing more we can do,” said the doctor as he left the room. For all intents and purposes, the doctor abandoned the patient, the family, the nurse and me—I was a medical student. The doctor was my instructor, my mentor, and his response caught me off guard and I felt the oxygen leave the room. “Really?” I recall thinking to myself, really . . . as physicians, we can jump ship when things get tough and leave everyone behind to fend for themselves in the swirling, sinking, waters of devastation, hopelessness, and fear? There’s no lifeline we can throw out there, no safety net, no safe harbor for us to provide shelter until the storm passes? Does his dismissal of the patient suggest to me that when I cannot cure a patient, then I need no longer care either? Thirty years ago I knew in my gut the doctor was wrong; thirty years later, my head and my heart have learned that there is much to be done and it is precisely the time when the physician is most needed.

You sustain a facial laceration, you break a leg, or you need your appendix out, everyone wants the technically most proficient physician to perform the procedure. You are critically injured in a motor vehicle accident, or you suffer a stroke, you want the state-of-the-art trauma center with all of the bells and whistles, including the latest imaging technology, interventional devices and board-certified specialists immediately available. In fact, hi-tech is preferred by the hospital and many practitioners—the more procedures, the more revenue. But the decision to do more and more comes with a less obvious price-tag and consequence—hi-tech generally translates into lo-touch. Medicare and other third party payers aren’t as interested in reimbursing time spent with the patient but readily reward practitioners for doing specific procedures. Bedside presence and hand-holding are undervalued by everyone—everyone, that is except the patient and family.

So what happens if you don’t have a medical emergency but you do have a chronic or serious life-limiting condition? What if you are seeing numerous specialists, taking multiple medications for reasons you can’t recall, making frequent trips to the Emergency Department (ED) and yet, your symptoms continue unabated. What happens if you are dying but you don’t need or request expensive procedures or heroic interventions? Does it really help to consider adding another specialist to an already complex, overburdened health care system? Can one more physician make an impact? The answer is a qualified “yes.” Yes, when that physician

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embraces palliative medicine practices, including an interdisciplinary team whether or not those members are on-site, “virtual” or otherwise readily available.

Palliative medicine is practiced by any physician devoted to caring for the whole patient and family with the goal of reducing suffering and maximizing quality of life. The optimal symptom management and patient-focused communication of palliative care reduces the stress of a chronic or serious illness by assisting individuals, families, and care providers to work together to better coordinate goals. If your physician is addressing your physical, emotional, and spiritual needs and your symptoms (such as pain, fatigue, shortness of breath) are well-controlled, then you are already receiving palliative care. Hospice is just one example of a type of palliative care; but all palliative care is not hospice. Both have expertise in end-of-life care. The difference between these two areas is that palliative medicine patients may choose to undergo curative treatments while also receiving palliative care; such patients may live for years. Hospice patients are no longer seeking cure and have a life expectancy of six months or less.

Sixty years ago, what could a physician offer a seriously ill patient? Doctors had few drugs to prescribe and only the simplest of instruments and interventions and yet, patients often felt better after a doctor’s visit. Quite simply and rather elegantly, the doctor sat at the bedside and listened intently to the patient and his/her family. And when “nothing else could be done” the doctor dispensed hope and offered tincture of his/her time. It is in those quiet moments when the privilege of being a physician is most apparent, most needed, and most appreciated. Unfortunately it does not translate into “most” financially rewarding.

To understand the whole person requires examining all of the pieces and determining how they fit into the puzzle. It is time-intensive, brain and emotion intensive, but it is not procedure/intervention driven and the result is dismal reimbursement for the care provided. There are insufficient numbers of physicians specializing in palliative medicine or self-educating in this area today and the workforce shortage can be anticipated to be even greater as more people live longer than ever before with their chronic illnesses. The challenge we have as a society is to recognize and reward physicians whose skills and time enhance the quality of one’s life in a manner that we currently give only to the procedure-based physicians. A post-graduate fellowship is one route to learning how to practice palliative medicine, but this can never meet the demand. The viable and most reasonable alternative is to provide continuing educational and experiential opportunities to expand the knowledge and skill set of all practitioners, both primary care providers and specialists. In fact, if we want to introduce and encourage a palliative approach to all patient care, we must begin in medical school. We must not allow the maxim to become, “First, do a procedure, AND THEN do no harm.” And likewise, students must be taught by example and by instruction that some things have no place in the healing profession, especially the words: “There is nothing more we can do.”

“The patient should feel better after the doctor’s visit, else why the visit?”
Francis W. Peabody, M.D. (1927)
Ya Sartan Ya Mout: An Alternative Approach to the Mammography Screening Controversy in Israel

by Emily Antoon

Despite vast research, breast cancer screening policy remains a controversial issue. In line with such controversy, debates regarding the optimal age for first mammography screening and the value of self-exams are points of contention in Israel, where discourse around breast cancer screening policy takes on ethnic dimensions.

Health advocates for the Palestinian citizens of Israel have expressed concern that the current state policy of beginning routine mammography screening at the age of 50 reflects state level neglect of the well-being of those citizens. Palestinian women are less likely to survive breast cancer than other Israeli groups, and they are more likely than other groups to be diagnosed at younger ages. Policy makers, however, argue that lowering the age of mammography screening would not address this problem, citing Palestinian women’s low adherence to regular mammography screening.

This study employed a medical anthropological lens to contribute to the discourse around breast cancer screening policy in Israel. A series of 15 semi-structured focus groups and interviews were conducted with 57 Palestinian Israeli women. Health workers and policy makers were also interviewed, contributing to 17 hours of recorded conversation. A textual analysis was conducted to illuminate points of disjuncture, with the goal of identifying ways in which women’s embodied knowledge (knowledge that is created and embedded in their lived experiences) can inform health work activism.

Findings identified fear of cancer, cancer and destiny, and stigma as themes in the interviews. Salient issues implicated by this study include disparities of access to health care and conflicted relationships to the state through the political economy of the health system. Alternative paths to women’s engagement are suggested for future health advocacy work. This study illustrates the importance of soliciting public participation in setting health policy, and lays out clear recommendations for further advocacy work with Palestinian women in the area of breast cancer disparities.

From left to right: Emily Antoon, David Kozishek, Elizabeth Bogdan-Lovis

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A semantic network modeled after that developed by medical anthropologist Byron Good was constructed from the textual analysis of the focus group discussions. Fear of cancer, cancer and death, and fate were prominent themes in discussion. Other salient issues were destiny and issues of God or faith, the pain of treatment, mammography as a requirement, issues of transportation, issues of literacy and health services accessibility, and the complex relationship of the Palestinian citizens of Israel to the Kupot Holim (national sick funds). The Palestinian women’s perspectives surrounding cancer and mammography do not always view mammography as a useful tool to save lives; mammography, rather, may simply foreshadow death after painful and toxic treatments.

I argue that Palestinian women’s lived experience contributes to an embodied knowledge of breast cancer that is expressed in health choices, behaviors and ultimately health outcomes. This study illustrates how several aspects of everyday life – seeing family members die of breast cancer, hearing the talk of neighbors, experiencing a healthcare system in a foreign language, utilizing healthcare that may not be responsive to one’s needs, feeling helpless in a setting of environmental pollution, and alternately, the belief that cancer cannot be cured – are incorporated onto women’s bodies as a dictatorial fear of cancer.

Until policymakers and health activists interested in improving health outcomes for Palestinian women in Israel pause to inquire how women know what they know, and respect that knowledge, efforts will be futile. I argue that as an alternative strategy to lowering Palestinian women’s breast cancer mortality, special attention should be given to health access barriers, and an attempt should be made to understand, embrace, and respect Palestinian women’s embodied knowledge around breast cancer; such an attempt may take the form of home-based social functions where the conversation is multidirectional. The policymakers and epidemiologists should take into account the needs of all members of society, and make a sincere effort to understand and incorporate women’s experiential and embodied knowledge into outreach efforts.

Ethics Services Contract with Sparrow Hospital

In January 2010, the Center for Ethics entered into a contract with Sparrow Hospital, Lansing, Michigan to provide a variety of ethics-related services. The contract was renewed for 2011. In this partnership, the Center for Ethics is helping strengthen the hospital’s ethics program by supporting three kinds of activities:

• Ethics Briefings are unit-level meetings to discuss recent cases or ongoing ethical challenges that are troubling to care providers working in the unit. The goals of these meetings are to more fully understand the nature of the problems, develop a variety of strategies for addressing them, and identify ways in which the hospital Ethics Committee could assist.

• Ethics Grand Rounds are scheduled quarterly, as part of the Critical Care Grand Rounds series. The topics for these hospital-wide discussions are drawn from the Ethics Debriefings, or from suggestions from the Ethics Committee or others.

• Finally, the Center faculty provide assistance as requested in ethics case consultations conducted by the Ethics Committee.
2011 Foglio Conference Report

by David Kozishek

On March 3, 2011 Michigan State University College of Human Medicine (CHM) hosted the 14th annual Foglio Conference on Spirituality in Medicine. A primary goal of this year’s conference titled *Just What Are We Professing? Grounding our Medical Education and Practice in Communally-held Values and Virtues* was to build on the successful tradition of teaching professionalism in medicine at CHM through the concept of ‘The Virtuous Student Physician.’ As originally conceived, this model intended to teach professional values to students. It since has been broadened by the CHM Faculty Professionalism Task Force (2008-10) to the more inclusive notion of ‘The Virtuous Professional.’ In this way not only students but also all staff and faculty associated with CHM might be called to integrate and exemplify the CHM virtues and professional responsibilities in their daily work. The Task Force identified three primary virtues (Courage, Humility, and Mercy) to emphasize in conjunction with the six professional responsibilities traditionally taught by the College: competency, social responsibility, professional responsibility, honesty, compassion, and respect for others.

This movement toward a more inclusive treatment of professionalism was initiated in response to student feedback. Students have reported a discrepancy between the professional behavior being required of themselves as students and behaviors observed in faculty & staff—behaviors that seem to directly contradict the goals of ‘The Virtuous Student Physician’ curriculum. Known as ‘the hidden curriculum’ this perceived discrepancy is not unique to CHM. By integrating those explicitly stated professional values and virtues upheld by CHM into all administrative levels of the wider CHM community, CHM aims to become a model for medical schools that want to achieve greater alignment between their publically professed ideals and observable practice. The 14th Annual Foglio Conference marked the public unveiling of this CHM initiative. Jeannette M. Shorey II, MD, Associate Dean for CME and Faculty Affairs, College of Medicine, University of Arkansas for Medical Sciences, appropriately set the stage with her keynote address *Stories that Called for Action—the Arkansas Experience in Professionalism.* The conference provided an afternoon of reflection and dialogue on the teaching, learning, and practice of professionalism in medicine.

1. Established in honor of Father John “Jake” Foglio, DMin, the 2010-2011 conference was co-sponsored by the College of Human Medicine’s (CHM) Department of Family Medicine, the Office of Faculty Affairs and Development, and the Center for Ethics and Humanities in the Life Sciences.

2. Dr. Shorey is also the Steering Committee Chair for the Group on Faculty Affairs at the Association of American Medical Colleges.
Brocher Foundation Sabbatical Update

by Len Fleck

One thing I have discovered on sabbatical is that there are no clean breaks from the rest of one’s commitments and responsibilities back home. Still, I have managed to achieve some research goals. I have completed an essay for the Cambridge Quarterly of Healthcare Ethics on justice issues related to personal responsibility for health. This was an issue of considerable debate in the 80s and early 90s. And now the intense interest in controlling health care costs has resurrected the debate. One can readily understand the views of political conservatives on this issue: care can be denied to individuals justifiably because they do not “deserve” care because they have failed to take good care of their health. Such denials are not regarded as a form of rationing by conservatives. But liberal egalitarians have also become advocates for more “responsibility” integrated into our understanding of health care justice. Most of my essay is critical of that latter effort, which I see as being neither liberal nor egalitarian.

Some of my other work has focused on an edited collection of essays around ethical issues related to bedside rationing. This is an issue that will become increasingly salient and painful for clinicians for the remainder of this decade. Over the next several weeks I will turn to writing chapters for a new book, which has the working title “Justice, Liberty and Responsibility: Medicine, Genetics, and Public Policy.” Health care justice issues will become even more complicated than they are already as we see emerging genetic knowledge alter the practice of medicine. We will also see many issues raised with regard to reproductive decisions and the genetic endowment of future possible children. One critical dimension of those issues can be captured with the question: How can a society be both “liberal” and “genetically responsible” with regard to the best interests of future possible children?

Bioethics for Breakfast

This year the Center partnered with the Michigan offices of Hall, Render, Killian, Heath & Lyman, PLLC law firm to launch “Bioethics for Breakfast” – a thrice yearly, law, medicine and society seminar series. These morning seminars bring together bioethicists, clinician and policy experts to present on public policy dilemmas. Invited audience members engage both with speakers as well as with each other to consider ethical approaches to pressing policy issues.

Emissaries from the University of Costa Rica School of Medicine Visit MSU

In April, the Michigan State University College of Human Medicine (CHM) hosted two emissaries from University of Costa Rica (UCR) School of Medicine. Drs. Sergio Solano Rojas, Director of Research and Development in Health Education and Jorge Granados Zuniga, Director of the Biological Testing Laboratory, met with CHM faculty to explore development of a collaborative CHM/UCR Health Sciences Education master’s program. This visit represents a further extension of CHM’s engagement in Costa Rica. Of relevance to the Center is Dr. Granados’ interest in both bioethics and incorporating bioethics and professionalism in medical education curricula. Center Assistant Director, Libby Bogdan-Lovis, will continue discussions in June while attending the First Latin American Regional Symposium on Women’s Reproductive Health, San Jose, Costa Rica. The June 2011 symposium builds on the MSU/Costa Rica OB/GYN resident exchange and lays groundwork for cross-cultural dialogue on maternal/fetal bioethical concerns.
Sabbatical Update from Monir Moniruzzaman

Center for Ethics faculty member Monir Moniruzzaman is spending his sabbatical working on journal articles and a book chapter on the human “organ bazaar” of Bangladesh. He is enjoying the company of his son, Raga Zaman, who was born in Toronto on December 1, 2010.

Moniruzzaman gave an invited presentation at the December 2010 Brocher workshop *Bodies Across Borders: The Global Circulation of Body Parts, Medical Tourists and Medical Professionals*. Organized by Queen Mary University of London, the workshop explored how the field of medicine is transformed by new technologies, facilitating market increases in the global circulation of body parts, patients, and medical professionals. Moniruzzaman’s presentation *Moving Organs—Who Benefits? Who Supplies?* addressed global, regional, and domestic organ trafficking. He examined how impoverished kidney sellers suffer unjustly to prolong the lives of transplant recipients while organ brokers flourish and medical specialists profit – all at the crossroads of technological advancement, healthcare commercialization, and grinding poverty.

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3 ways to join us

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OR

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Summer 2012 Study Abroad

Medical Ethics and Health Policy (UK)
BIOETHICS OUTREACH

Publications


Grant Submissions
Holmes-Rovner, Margaret and Alla Sikorskii “Consequences of Inserting Cardiology CER Tools into an Incentive Program,” National Institutes of Health, Common Fund initiative on Health Economics for Health Care Reform, R21.


Grants Awarded


Presentations

Kozishek, David. Negotiating Conflicting Values When Working Outside Your Comfort Zone. For Leadership in Medicine for the Underserved/Vulnerable Program (LMUV) at the MSU CHM-Synergy Saginaw Campus. Saginaw, MI. January 2011.

Tomlinson, Tom. Ethical Problem-Solving in Otolaryngology. For Otolaryngology Residency Program, St. Johns Hospital. Oakland, MI. February 2011.


Tomlinson, Tom. Ethical Questions about Stem Cells. For Dong-a University, Busan, South Korea. June 2011.