WMU Medical Humanities Conference 2016
Conference Abstracts

Hosted by the WMU Medical Humanities Workgroup

Our Sponsors: Western Michigan University Homer Stryker M.D. School of Medicine, Borgess Health, WMU Bronson School of Nursing, WMU College of Fine Arts, Center for the Study of Ethics in Society, Department of Philosophy
Patient Autonomy, Epistemic Deferece, and the Varieties of Medical-Ethics Expertise

Ben Almassi, PhD
Division of Humanities and Social Sciences
Governors State University

Abstract: Divergent opinion on whether and how patients should defer to the expert judgments of healthcare professionals turn also on divergent value judgments on what is owed, what is deserved, what autonomy requires, what is unfair or unjust, what is negligent or reckless or acceptable risk. What constitutes putative and genuine expertise on these issues can be far cloudier and more contentious than medical-scientific expertise. Indeed, widespread suspicion extends throughout our communities and within philosophy, bioethics, and medical humanities as to whether ethics experts generally and medical-ethics experts specifically exist, and further, whether it is immoral, inauthentic, or somehow otherwise wrong to defer to others on ethical issues rather than making such value judgments and decisions for oneself.

Skepticism on putative medical-ethics expertise is not merely academic, nor is it entirely groundless. Yet such skepticism, I argue, encourages a moral stasis that is contrary to the values of informed consent and patient autonomy and at odds with contemporary scholarship in science and technology studies on the nature and varieties of expertise. A firm commitment to a narrow account of individual moral autonomy as incompatible with trust in medical-ethics experts is no more required for respect for patient autonomy than the similarly strict epistemic autonomy which informed-consent practices rightly rebuff.

The problem of medical-ethics expertise is distinctive, but it is not entirely unprecedented. In revaluating this particular yet critical area of expertise, I look to recent work on scientific expertise and ethics expertise. Many of the challenges facing a workable model of medical-ethics expertise have been engaged fruitfully in one, the other, or both of these related critical analyses. I suggest that we may draw two useful lessons. The first concerns the compatibility of bioethical trust and critical engagement made possible by relational autonomy, not unlike the epistemic interdependence made possible by critically reflective social-epistemological practices. The second lesson to be drawn and defended here, concerns the disambiguation of multiple varieties of medical-ethics expertise, variously held by a diverse range of individuals and groups in bioethics and other areas in the medical humanities. In this way, I recommend that medical ethicists embrace their work of pointing out those with medical-ethics expertise, rather than presumptively assuming an exclusive claim to such expertise ourselves.
Narrative Medicine: Changing the Story of Medical Ethics
Janyne Althaus, MD, MA
Department of Gynecology and Obstetrics
Johns Hopkins University

Abstract: Every day, clinicians and patients encounter ethical dilemmas within the hospital setting that have significant ramifications. Traditionally, medical ethical problems have been addressed using a principle-based approach. Documents such as the Belmont report of 1979 and the influential book *Principles of Biomedical Ethics* by Beauchamp and Childress have become mainstay references in wading through the turbulent waters of bioethics. Viewed through the principle-based lens, relative values of autonomy, beneficence, non-maleficence, and justice are assessed within the context of an individual patient’s situation to arrive at a solution; however, this principle-based approach has limitations and sometimes fails to resolve the problem in a satisfying way for all parties involved. In these situations, a decision is made that can leave one or more parties still ethically conflicted which can lead to a variety of unwanted side effects including erosion of the doctor-patient relationship, mistrust of the medical system, job burnout, or moral distress.

An alternative to traditional problem-based application of principles to medical ethical challenges is through narrative ethics. Narrative medicine is a conceptual shift to the practice of medicine from the statistical, fact-oriented pursuit of diagnosis and pathology to an analysis of the context that gave rise to the disease. Recognizing the intrinsic role that stories play in how individuals view their lives, illnesses, and the world around them, narrative medicine uses the skills needed to read, write, interpret, and tell stories to enhance patient care, improve clinical diagnostic accuracy, and strengthen the doctor-patient relationship. Narrative ethics similarly applies these same skills to attend to medical ethical challenges. By seeing ethical dilemmas as a collection of dissonant narratives rather than just a quantitative application of principles, clinicians can apply literary analysis to parse out the nature of the conflict and help guide ethicists, caretakers, and patients to decisions that remain congruent with one’s sense of self.

Scholars of the humanities recognize that the ability to interpret a story and discover the meaning imbued within it requires careful reading and analysis of literature, didactic training that rarely occurs within the science-dominated medical school curriculum. Thus, the practice of narrative ethics requires a close collaboration between academic and medical communities. This collaboration, though, must be incorporated seamlessly into the rigorous curriculum required of medical schools as they train future practitioners in the complex, technological world of medicine with its exponentially increasing body of knowledge.

This presentation will discuss what narrative ethics is, how it differs from standard principle-based approaches to ethical problems, and discuss the innovative ways practitioners of the humanities and medicine can work together to bridge the gap between the data-driven – and sometimes impersonal – face of medicine and the rich body of knowledge the humanities can infuse into 21st century healthcare.
Abstract: Good mentors and role models can be invaluable to medical, as well as to all professional, students to engender a realistic view of professional life and also in order to balance undue optimism or undue skepticism which they may encounter in their training. In teaching medical students, it is important to introduce them to physician clinicians and researchers who have overcome significant challenges to achieve professional and personal goals.

Some physicians and scientists have had the good fortune to have excellent mentors, e.g. the Nobel Laureate, Mario Capecchi, who was mentored by James Watson, among others. It seems hard to believe, but the same Mario Capecchi underwent heart-wrenching challenges when, after his mother was sent to a concentration camp, he was left on the streets of wartime Italy to fend for himself at age four.

Other notable examples of mentors include Carl and Gerty Cori, who collaborated in their research and welcomed all with appropriate training to their labs. Both husband and wife were recipients of the Nobel Prize in Physiology or Medicine, as did six of their trainees.

There are some notable feuds concerning rivalry that may have had a deleterious effect in keeping younger researchers from joining their labs. Robert Gallo and Luc Montagnier fought for years over precedence in finding the agent that caused AIDS. Their public animosity may have delayed finding a treatment for the disease.

There was a personal, professional, and public relations rivalry between Jonas Salk and Albert Sabin about whether the killed or live polio virus should be used in large scale immunization to prevent polio. While Salk and Sabin feuded, it is notable and admired that when John Enders was notified that he was awarded the Nobel Prize in Physiology or Medicine in 1954, he declined acceptance unless it was also awarded to his co-workers, Thomas Weller and Frederick Robbins.

Having recognized the nurture and support that she was given during her career, Rita Levi-Montalcini has supported the role of women in medicine and science in her native Italy. She and her twin sister have supported a foundation that provides mentors for teenagers. More than 6,000 African women have improved their chances of a scientific career through that foundation.

Having seen the value of collaboration and support, many professionals seek to develop it, rather than remain passive about discrimination and other drawbacks in professional settings. Many have welcomed the role of mentors to those still striving to find a place in professional life. Those who participate in mentor-mentee relationships see benefits on both sides, as well as to the academic field in general.
“Oughts”, “Cans” and Moral Demands: Remarks on Lichtenberg and the Importance of Moral Character
Joel Ballivian
Department of Philosophy
Western Michigan University

Abstract: In this presentation, I consider the claim that our moral responsibilities are highly demanding. As some have argued, we have to face up to the fact that morality demands what it demands, even when this demand requires great sacrifice on our part. Objecting to this, Judith Lichtenberg has recently argued that “If alleviating the suffering of others generally requires very significant sacrifice, that is a reason for thinking that people are not morally obligated to do so” (Lichtenberg, 2014). Call this Lichtenberg’s Principle (LP). I evaluate LP, arguing that Lichtenberg’s arguments for it face serious problems. Next, I consider some of Lichtenberg’s proposed strategies for promoting greater humanitarian action. These strategies tend to focus on psychological techniques that are effective in “nudging” people to give more towards the alleviation of suffering while, at the same time, reducing the burden of giving. One might wonder whether a moral strategy of this sort should neglect the role of moral character. Lichtenberg responds to this by claiming that, “in fact we care about both—human character and the alleviation of suffering...When these aims clash, I believe the alleviation of suffering should take priority” (2010, p. 138). Drawing from recent work in psychology and moral psychology, I argue that character formation tends not to clash with the goal of alleviating suffering with few costs to the individual; instead, it helps achieve that goal. If we want people to make significant contributions to the alleviation of suffering while incurring few losses in the process, we ought to pursue strategies that focus on cultivating moral character, as well as strategies that psychologically nudge people to give more.
Critical Communication: Addressing Inadequate Language Access in Healthcare
Antonio Bardawil
School of Professional Studies
New York University

Abstract: The unrelenting nature of globalization has resulted in an ever-growing number of progressively diverse societies across the world. Certain developed countries, such as the United States, are the recipients of an increasingly wide array of speakers of languages other than English (LOTE). The availability of culturally-appropriate language access in medical care has not kept pace with this demand.

While there are certain legal requirements (beginning at the federal level with Title VI of the Civil Rights Act of 1964 and occasionally enhanced at the state or municipal level) that are designed to provide culturally-appropriate and equal language access to speakers of LOTE, they are typically embodied in theory and on paper rather than in practice. This is true for several reasons: 1) Health service providers - both at institutional and personal - are ignorant of the requirements; 2) The realistic availability of well-trained, culturally aware, qualified interpreters is limited; 3) Ignorance on behalf of the service recipients as to their own rights; and 4) other logistical concerns.

Certain medical service providers are aware of the requirements regarding equal language access, and they have attempted to overcome relevant obstacles by hiring bilingual staff for the LOTE they most frequently encounter. This strategy is frequently damaging to patient health for several reasons, including (but not limited to): a lack of true equal access (and therefore dignity), ineffectiveness of treatment, and death. Interpretation does not simply involve repeating words from one language into another; it is a profession (comprehensive of its own codes of ethics, standards, and sets of best practices) that demands extensive training. Beyond linguistic skills themselves, interpreters must be aware of the kind of cultural and linguistic nuance to which most bilingual staff are not attuned. This cultural awareness is vital, as it allows the interpreter to provide physicians with a transparent understanding of the patient and ensures that culturally specific words, idioms, and beliefs are correctly relayed.

The damaging results of insufficient language access or the use of untrained interpreters in medicine are extremely well-documented. As such, it is imperative that we find a way to standardize language access for all patients in a way that provides them with fully trained interpreters while cooperating with health service practitioners to find cost-effective, but palpably beneficial, solutions. At present, the US (at the federal level) does not regulate the medical interpreting profession in any way despite the regulations it has set in place. While there are healthcare interpreting certifications that one may receive, many healthcare institutions do not require their interpreters be certified. It is our recommendation that legal regulation of interpreters (such as credentialing) be enacted at the governmental level to comply with the standards already in place, and that health service providers be made aware of these regulations and the options available to them for providing appropriate language access. Finally, changes must be made to ensure that the financial and other logistical realities allow healthcare providers to meet these standards without further endangering patient care.
Abstract: Charles Fried holds that physicians have a “duty of personal care” and must meet a “demand for undivided loyalty to the interests of the patient” (Fried, 1974, p. 148). Physicians have an absolute obligation to do what is best for their patients and cannot divide their loyalty between patients and future patients.

Randomized controlled tests (RCTs) present a problem for physicians who also act as researchers. It seems that researchers (physicians) cannot permissibly assign subjects (their patients) to test or control arms of an RCT unless they know that they will thereby receive the best available treatment.

The state of not knowing which treatment arm has more therapeutic value is called experimental equipoise. David Chambers says that “Equipoise is the position that subjects should not be randomized to treatment conditions where it is reasonable to believe better alternatives exist” (Chambers, 2011, p. 133).

This insight weakens the case against RCTs. At the start of the RCT, Doctor does not know which arm offers a better treatment. Thus, she is morally permitted to let chance decide which treatment Patient gets. As results come in, however, she may come to have an informed opinion that Therapy B, for example, is less effective. In that case, she ought not to expose her patient to the bad luck of being randomly selected for Therapy B.

As Don Marquis points out (Marquis, 1983), however, if Doctor discontinues the study on preliminary results, Therapy A has no chance of getting to market, since the medical community will never accept Therapy A merely on preliminary results.

Benjamin Freedman acknowledges that a study has to stop as soon as Doctor knows which treatment is best, but until then the research can continue (Freedman, 1987). A study may continue so long as Doctor’s opinions amount to something less than conviction, according to Freedman.

Winston Chiong rejects this absolute fidelity to Patient, and argues for a limited obligation to Patient that leaves room for some obligation to Future Patient. Chiong recognizes some contexts in which it is morally permissible to provide care that is less than the best, but which still meets a standard of being good enough (Chiong, 2006, p. 44), for example, in teaching hospitals. Voluntary informed consent requires that patients be informed that they may receive care that is merely good enough and respect for autonomy requires that patients be able to give some weight to the good of future patients at the expense of their good.

I endorse Chiong’s limited range of suboptimal treatment (though reject his Kantian endorsement of it, and argue for a veil of ignorance conception). In addition, RTCs require that Patient be a satisficer about her own care. Informed consent thus requires that Doctor assess Patient for what Patient believes is good enough care and drop Patient from the study if either arm falls below that threshold. This may threaten the viability of some studies, especially where the level of risk is great.
Heteronormativity is a Practice of Medicalization of Intersex People
Aleksander Berezkin
Independent Researcher
Founder of the Association of Russian Speaking Intersex People

Abstract: Heteronormativity is a common problem for such groups as transgender and intersex people in the health care system. Heteronormative practices are usually implemented by social workers and/or medical staff without understanding that many medical care standards are irrelevant for making decisions for the various sexual and gender minorities, and especially for intersex people, who are still invisible in the LGBTQI community. For example, some experts use standards of medical care, such as hormones treatment, and psycho-social support from the binary system without reference to the understanding of intersex as a variation of sex and not as pathology in the system of only male and female characteristics. The consequences of such practices can be very diverse, from disorders in the hormonal balance of the bodies of intersex people to psychological deterioration in gender identity and intersex transgender transition. Such practices often result in the objectification intersex people without consideration of their unique physiological and individual context.

In this presentation, I will describe heteronormativity as a part of medicalization of intersex people based on an analysis of selected medical standards and personal experiences of intersex people. The other aim is to attempt to make some recommendations for organizations and providers of socio-medical and psycho-social support for intersex people against the pathologization of intersex people.
Consent and Communication for Patients with Dementia
Andria Bianchi
Department of Philosophy
University of Waterloo

Abstract: By the year 2050, it is estimated that over 3.5 million people will be diagnosed with dementia in the United States of America. There are many influential consequences that result from having dementia, one of which is individuals’ inability to contribute to their care and treatment decisions. The lack of decision-making capacity that persons with dementia often have is due to their cognitive decline and increase of functional dependence.

As noted in Frontera et al.’s 2008 description of persons with dementia, “obviously, the patient should participate as much as he or she can in the decision-making process and treatment” regarding their condition. But how can individuals participate if they are incapable of providing informed consent? The importance of obtaining informed consent from patients when making any decisions about their care is regarded as essential, but because patients with dementia are often unable to provide informed consent, they are frequently dismissed from discussions about their care.

If patients with dementia should participate as much as possible in their care decisions, then how should their participation be enabled and facilitated? What type of communication is required in order to include persons in their care decisions when they cannot provide informed consent? Should the requirement of obtaining informed consent be altered when working with this patient demographic? This seems to be an important, yet challenging component to providing adequate care for those who are incapable of consenting, which this presentation attempts to address. The conclusions from this presentation will draw from qualitative data that has been gained through in-person interviews with health-care professionals.
Abstract: Advance directives are “documents written by patients to help direct their care if they become incapable of making their own health care decisions. . .” It is claimed that these directives are intended to preserve and promote patient autonomy in difficult medical situations where the patient may be incompetent or unresponsive. However, advance directives are notorious for having difficulties in being executed for a wide variety of reasons. In some cases, the directive is too broad or too narrow to be applied to a specific case properly. In others, the patient’s family simply overrides (or ignores) the directive, claiming the authority of a “substituted judgment.” These problems (and others) are widely familiar and have been broadly covered in the literature. In this presentation, I wish to explore a further problem with advance directives (specifically living wills), namely in the rational capabilities of an agent to make hypothetical future judgments about situations to which the epistemic information is limited or even inaccessible.

When a person creates an advance directive, they project into the future what their interests and desires will be in order to formulate the directive. However, due to the nature of major medical events, these hypothetical projections are suspect because these medical events can be considered transformative experiences. They are experiences which alter an agent in deep and fundamental ways so that whatever beliefs and desires were held prior to the medical event may drastically shift or change altogether. Therefore, whatever hypotheticals are used to create these directives can be questioned, primarily because the interests that are being promoted are those of the patient prior to the medical event, which in all likelihood will drastically change on the other side of (or during) the transformative experience. This question then becomes pertinent: Whose autonomy is being preserved in an advance directive? Do we privilege the patient with all of their beliefs and desires prior to the medical event, or the patient who has had their core beliefs and desires altered after (or during) the medical event? If the epistemic information of what it is like for any particular individual to have gone through the medical event is inaccessible, and therefore whatever judgments about what a person would or would not want done will be questionable, then this places the goal of such a directive, stated as preserving a patient’s autonomy, in question.

Here is how the presentation will proceed. First, I will introduce the key concepts of L. A. Paul’s conception of what she calls transformative experiences to provide the tools for this discussion. Then, I will examine whether the case of Alzheimer’s classifies as a case of a transformative experience. Finally, I will consider a hypothetical case (that occurs frequently in reality) where an advance directive is formed prior to the onset of Alzheimer’s disease, and show how this advance directive may not preserve patient autonomy (at least, not in the way we think it does) in these kinds of cases.
The Axes of Ego (Psychology): French Resistance to the DSM III in the Treatment of Autism in the 1980s

Jonathyne Briggs, PhD
Department of History
Indiana University Northwest

Abstract: The publication of the DSM III in 1980 was revolutionary in its redefinition of autism as a developmental disorder distinct from childhood schizophrenia, a distinction that would open the door to new methods of treatment and even understanding of the disorder within the psycho-medical community and its adjunct industries. However, the DSM III was distinct not only from its predecessor from 1968 but also from other international organizations' definition of autism, especially that of the Classification française des troubles mentaux de l’enfant et l’adolescent (CFTMEA). This difference led to a reaction from psychologists and psychoanalysts in France, the latter of which had become leaders in the treatment of autism by 1980. Psychoanalysts pushed back against the DSM’s definition and the American-style treatment of ego and behavioral psychology as not useful for understanding the family drama of autism. The reaction against the DSM III reveals how the emergence of more globalized definitions of health led to resistance from local practitioners and critiques of the ability of specific groups (such as the American Psychiatric Association) to determine how autism should be treated despite the wide variance in its exhibition. This presentation will look at that reaction to illuminate how the French deviated from the American model to formulate their own version of treatment for autism, a deviation that shows how the globalization of medicine was met with critical responses from those who continued to believe in the efficacy and validity of other methods that themselves were developed from intersections of medical culture.
The Artworld’s Phenomenology of Illness, Health, and Medicine

Jeffrey Byrnes, PhD
Department of Philosophy
Grand Valley State University

Abstract: In her book *Illness*, Havi Carel argues for the importance of having a phenomenology of human illness. She explains that the standard mode of scientific observation is essentially objectifying, that is to say it presumes to treat human beings as objects. While this mode of examining human beings has its place, this form of scientific observation will always omit and overlook an important aspect of illness, namely the human part, what it means for a person to be ill. If Carel is correct, and I think she is, then artworks can provide a glimpse into the history of the phenomenology of both illness and the contemporary treatment of that illness. In this presentation I provide a phenomenological reading of that artistic engagement with illness and medicine — including Vesalius illustrations, medicine in Dutch Golden Age, and Felix Gonzalez-Torres’ “Untitled” Portrait of Ross in L.A. This phenomenological reading will have an eye toward recalling and reviving understandings of what it means to be ill, to be healthy, and to seek out health through medicine. The fruits of such a reading may serve to flesh out our current understanding of illness, and may provide valuable support for those who are being educated in various areas of health care provision.
Abstract: This panel will address and critically evaluate issues related to the creation of Bioart from several professional perspectives, including the standpoints of working artists, medical and research professionals, bioethicists, and creative writers drawing on representations found in literature, while remaining cognizant of disparate challenges raised by “mainstream” science, religious and moral codes, and marginalized populations. The panel will address issues such as:

- The moral implications of artists using their own bodies, and potentially risking their own health, for their creations
- The use of blood, aborted tissue, and foreskins from circumcisions in Bioart
- Art and Bioart as a catalyst for innovation in medicine
- Giving voice to vulnerable and marginalized populations (from the standpoint of mainstream Western medicine) through Bioart
- The use of morally suspect samples in order to draw attention to morally suspect medical and research practices
- The lack of regulations in Bioart as opposed to the strict regulations of research and medicine
- Artistic expression vs. patent and copyright infringement

Panelists will employ numerous examples from Bioart and medical research to illustrate the medical, research, and moral implications of Bioart, both in the U.S. and other countries.
An Unforgettable, Unforgivable Tragedy in Marriage: Marital Rape in the 1970s
Donna Castelblanco, MBE
Department of Medical Ethics and Health Policy
University of Pennsylvania

Abstract: Social justice issues like equal education and employment opportunities were public and relevant to most women (The Seventies). Marital rape, on the other hand, was hidden within the home. That is to say, this social justice issue was often neglected and overlooked due to its private nature. My analysis of marital rape will question the way in which we perceive and understand this very serious issue. The first part is divided into 1) the origins of the sexual violence in marriage and 2) the feminist foundation for reforming this idea. Several areas of society including culture, law, medicine, and religion made it possible for the husband to rape his wife; and several movements within the second wave (namely, anti-rape, battered women’s, and women’s health) initiated the path towards eliminating the tragedy that is marital rape. Then, in the second part, there is a shift from silence to articulation for all forms of rape. These early discussions on rape occurred within and outside of the second wave. The final part of the presentation illustrates the spike in concern for marital rape victims. Feminist activism, the law, the media, and medicine all contributed to marital rape awareness, education, and/or prevention in the 1970s. I argue that the very serious issue of the husband raping the wife manifests the ultimate consent to patriarchy and acceptance of the unethical, unjust norms of rape culture in the United States.
Abstract: This project investigated the effect that medical student made films based on medical narratives have on medical students’ understanding of illness. While a few papers have examined the effects of creative activities and art making on medical students’ empathy skills, there is a lack of research on the utilization of cinematographic techniques by medical students to render subjects and their stories of illness—and the effect that this type of creative work has on their fellow classmates’ development into medical professionals.

Methods: Two short films based on reflective essays written for the internal medicine clerkship were made by the author with medical students as actors. The author attempted to transmit non-coercive images/ideas/suggestions to viewers through cinematography, defined by filmmaker Robert Bresson as “writing with images in movement and with sounds . . . creative filmmaking which thoroughly exploits the nature of film as such.” UF medical students were asked to attend a film screening and complete a qualitative survey afterwards. Themes in the survey data were identified and analyzed using a relational content analysis method.

Results: Thirty seven students participated in the study, with the majority (60%) from the third year class. The films enhanced the participants’ understanding of illness through their depiction of the patients’ and providers’ emotions and interactions. The majority of participants appreciated the cinematographic techniques utilized, but the style of filmmaking was not a universal medium for communication of medical narratives to medical students. Most participants found the films effective at engaging them and making them reflect on their own experiences of illness and their future actions as care providers without forcing them to converge their thoughts on one perspective. The films provided a unique and valuable artistic and educational experience for the medical students involved that was consistent with previous medical humanities films that some had seen. The data were limited by the small sample size and presence of selection bias.

Conclusions: This project demonstrated that medical student generated art can enhance medical students’ understanding of illness from both the patient and provider point of view and promote internal reflection.
Health Reconstruction in the U.S. Society
Meifang Chen, MPH
Department of Health Behavior
University of Alabama at Birmingham

Abstract: The dominant cultural understanding of health is a limited and negative one: health is the absence of (typically physical) infirmities. This is reflected not only in the way individuals think and speak about health, but in the dispositions of our healthcare practice and research. Our current health care system actively and enthusiastically develops and employs programs to treat and cure disease, but consistently fails to support disease prevention and health promotion efforts.

We argue that this understanding of health is toxic, and must be replaced by a holistic and positive conception of health. Such a conception is adopted by the World Health Organization when it defines health as a state of “[…] complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO 1946), but has not been successfully communicated to the populace. This discordance results in a lack of funding for important preventative and promotional programs, encourages popular resistance to health-improving measures, and contributes to global health crises.

We propose three definitive policy adjustments to ameliorate these challenges:

1. Reorient public health messaging to the pursuit of health rather than the avoidance of infirmity. The current image of health is partially sustained by the tendency of public health advertising to focus on the negative elements of illness rather than the positive elements of healthfulness, but recent research suggests this is not the ideal approach.

2. Increase spending on preventive and promotional health. The United States spent $3.0 trillion on health care in 2014 – more than any other nation. A large percentage of that was spent on the treatment of preventable illnesses. There is strong evidence that preventative and promotional methods are both economically and medically effective, but less than four cents out of every dollar spent on health care in the United States today goes towards public health promotion and prevention.

3. Improve funding for preventative and promotional health research. Funding for health research is disproportionately awarded to the treatment of illness, but little investment has been put in health prevention and promotion by comparison.

It is urgent to create a culture of health that requires a commitment to promoting optimal wellbeing. As Hippocrates said, “the function of protecting and developing health must rank even above that of restoring it when it is impaired”. By moving from a narrow and negative model of health to a holistic and positive one, we can better accomplish that function.
Abstract: There is growing interest in the field of mental health to deliver patient-centered care. This care model moves beyond a passive role in healthcare decisions to a model in which the patients'/clients’ feelings, needs and preferences are central to the shared decision making that must ensue. The mental health professional learns from their patient/client about the impact of illness on their lives, and incorporates this into the treatment plan that is developed by a better understanding of the patients'/clients’ individual perspectives and values and by sharing the information needed for them to participate actively in their own care.

In this part of the theme session on “What Mental Health Patients have to teach their Providers” three psychiatrists will present a brief videotape of an interview with a person who has been involved in the mental health system as a recipient of care, both inpatient and outpatient, and who provides some recommendations to providers; a first person memoir narrative will also be used that provides a patient perspective of two different mental health care systems (US and UK), allowing a look at ways in which approach to patients can be adapted to provide more patient-centered care.
Abstract: This talk will describe and demonstrate Graphic Medicine, the interface between the medium of comics and the discourse of health and illness. Lecture attendees will be exposed to graphic narratives on relevant medical themes, and become familiar with the reasoning behind, and benefits of, reading and creating comics in the health care context. Attendees will also learn to make practical use of their own visual representations in thinking and communicating about health care experiences.
Silence and Oppression in Narrative Bio/Ethics
Charles Dalrymple-Fraser
Department of Philosophy
University of Toronto

Abstract: The stories we tell about ourselves shape our self-concepts and inform our decision making processes. Perhaps unsurprisingly, some ethicists have come to argue that, in order to make ethical decisions concerning the lives and well-being of others, we must also consider those persons’ stories, histories, and characters as an important part of the decision making process. Narrative ethics, in its many flavours, attempts to develop frameworks for ethical decision making that center around narratives and lived experiences, and which recognize the important roles that people play as the authors of their own life stories. The importance of narrative analysis been increasingly recognized in medical spaces as a means for understanding the complexities and the humanity of health and illness.

However, there are problems with taking patient narratives at face-value: sometimes we tell false stories, stories which are misleading, stories which are irrelevant to the care being provided, or which perpetuate harmful self-narratives. In general, it can be difficult to identify how and when to attend to particular narratives, and how to allocate time to listening. Yet, whereas many have written on the difficulties with analyzing the stories we are given, few have discussed the issues with calling for stories in the first place. That is, what are the upstream concerns with asking and listening for patient narratives in health practices?

In this presentation, I demonstrate some of the ways in which systems of oppression and inequalities can manifest in silence, and open a dialogue on how an uncritical adoption of narrative ethics may therefore contribute to the oppression and unequal treatment of “vulnerable” populations in medical care. By focusing on how to listen to and interpret patient stories, we may unknowingly overlook those systems which prevent voices from being heard, and thus fail to treat “vulnerable” patients in the just the ways a narrative ethics hopes to achieve.

To better illustrate these concerns, I introduce and explore a working typology of silences as they relate to systems of oppression, building on work in social epistemology Miranda Fricker and Jose Medina. In doing so, I argue, we can better identify specific spaces in narrative bio/ethics practices which allow for oppression and inequality, as well as identify where our current attempts to break these silences may fail. I conclude by arguing that we need a multi-modal approach to breaking these silences, with an important emphasis on the importance of listening in addressing shortcomings of “coming to voice” paradigms. For, by coming to understanding the types and causes of silences in medical practice, we better move toward promoting a more inclusive narrative bioethical practice.
Taxonomizing Risk in Genomic Sequencing
Michael J. Deem, PhD
Department of Multidisciplinary Studies & The Center for Genomic Advocacy
Indiana State University

Abstract: Much has been written about the potential risks of genomic sequencing (GS). Studies have documented fears about privacy, genetic discrimination, anxiety, depression, costs, medical complications from unnecessary testing, violation of a child’s fundamental right to an open future, and infringements on personal autonomy. The purpose of this presentation is to develop a taxonomy of risks and to review the evidence for the likelihood of each of these risks in the different contexts in which GS might be performed. The ultimate value of GS will require an accurate understanding of both the potential risks and the potential benefits. In this presentation, however, we will not discuss the benefits. Instead, we will only try to bring some conceptual clarity to the discussion of risks.

To create our taxonomy, we reviewed the literature in genetics, social science, economics, bioethics, and psychology. We analyze risks across three domains (clinical care, clinical research, and population-level biobank research) and organize these risks under four categories of harm (physical harm, psychological harm, medical harm, and social harm).

The purpose of this taxonomy is (a) to help clinicians and researchers to conceptualize and explain harms associated with GS, (b) to assist IRB review of protocols involving GS, (c) to aid patients and research subjects in deliberation during consent processes, and (d) to assist regulators and policy-makers with regard to health policy affecting the implementation and use of GS in clinical and research contexts.
The Ableist Physician?: A Study of Perceived Quality of Life for Disabled Patients
Katherine Fahy
Department of Medical Humanities
University of Florida College of Medicine

Abstract: In a 1999 study, 54.3% of people with moderate to severe disabilities rated their quality of life as good to excellent despite discrimination and difficulties with daily activities. By contrast, the general populace (including physicians and other health care workers) predicted people with disabilities had an unsatisfactory quality of life (Albrecht and Devlieger 982). This disparity in perspectives was defined as the disability paradox.

The purpose of this study was to further examine the disability paradox. A literature search yielded no studies asking physicians to compare quality of life for a male disabled patient versus a female disabled patient. Furthermore, the study aimed to assess how physicians view their disabled patients’ ability to have sexual relationships and to determine if there was a discrepancy based on the gender of the patient. As patient counselors with medical educations, it was hypothesized that physicians would recognize that disabled patients may not have a normative sexual life by able-bodied standards yet their sexuality is in no way limited.

A survey was distributed to the faculty listserv at the University of Florida College of Medicine. The survey asked physicians to evaluate the quality of life for three patients: a nondisabled 25yo male, a 25yo male with an acquired physical disability in a wheelchair, and a 25yo female with an acquired physical disability in a wheelchair. Each case stated that the patient had no additional health problems and no socioeconomic concerns. The names were intentionally abbreviated to eliminate race and ethnicity as confounding variables.

The physicians were asked to evaluate expected quality of life on a scale of 1 to 10 along several parameters: 1) Expected physical quality of life, 2) Expected mental quality of life, 3) Ability to have a sexual relationship, 4) Ability to have a family, 5) Ability to have a fulfilling career and 6) Ability to perform everyday tasks and activities.

This project reaffirmed that there is a disparity in the way physicians view their disabled vs. nondisabled patients. This disparity applied to physical quality of life as well as social and emotional quality of life questions with physicians rating disabled patients lower on every parameter. In terms of gender, physicians rated physical quality of life lower for male disabled patients than for female disabled patients and also rated the males’ ability to have sexual relationship lower than the females’ ability. The scope of the survey was too limited to determine if physicians are interpreting sexual ability from an able-bodied normative viewpoint and disregarding other potential sexual experiences or if it is more a commentary on perceived ability to attract a partner. Exploration of physician views on disabled sexuality could be areas of future research as could the efficacy of disability studies training to adjust physicians’ evaluations of their disabled patients’ qualities of life.
Suicide and Forced Withdrawal: Addressing the Changing Face of Mental Health among University Students
Cheryl Frazier
Department of Philosophy
University of Oklahoma

Abstract: A 2011 American College Health Association–National College Health Assessment survey found that 30% of undergraduates reported experiencing serious depression during their college careers. Of these students, one in ten experience suicidal ideation, and one in 100 attempt suicide during their college careers. These statistics are staggering and troubling, and pose a difficult challenge to universities—how should they respond to suicide attempts and self-harming behaviors?

Many universities have enacted formal enforced withdrawal policies, or strongly encourage students to withdraw from classes following a suicide attempt. These mandated leaves of absence are ordered in an effort to protect students, manage rising healthcare costs, and mitigate legal risks. Leading universities like George Washington University and Yale University have stringent medical leave policies that have recently been contested, as opponents argue that those policies punish students for seeking help and discriminate against people with mental illnesses. In a recent article in The Atlantic, a Yale psychology student said, “I know students who have been hospitalized involuntarily, or asked to take medical leave. When it happens involuntarily, the assumption is that you’re not capable of protecting yourself, or handling yourself, or even evaluating the state of affairs [you find yourself in] reasonably.” However, universities often claim that their mandatory medical leave policies are enforced in the students’ best interests, trying to ensure that mental health is prioritized and that students are able to have a healthy, successful college experience.

Despite their good intentions, it seems as though universities are failing to meet the needs of students, disregarding their mental health and well-being in order to protect the university and manage limited resources. Opponents of forced withdrawal policies argue that that response to a suicide attempt does more harm than good, putting additional emotional and financial strain on students and making it more difficult to recover or seek future treatment. Although the purpose of a university has not typically been to treat illness (be it physical or mental), I will argue that the increased need for mental health services among college students requires a change in how universities respond to suicide attempts and mental health problems.

In order to more readily address this obligation, I will discuss several ways in which colleges can better meet the needs of their students. First and foremost, I will argue that universities need to reassess their understanding of mental illness and suicide, dispelling myths such as the thought that people who are suicidal are necessarily more dangerous to others. Second, I will argue that universities should avoid blanket forced withdrawal policies, instead opting for personalized responses to suicide attempts that take into account the needs and interests of students as individuals. Finally, I will argue that providing reasonable accommodations that enable students to stay at their universities following a suicide attempt are a viable alternative to mandatory medical leave, and can benefit both students and universities.
Josian’s Loathly Likeness: Leprosy as Artifice in Bevis of Hampton
Sarah Gillette
Department of English
Western Michigan University

Abstract: Within the narrative of the fourteenth-century Middle English romance, Bevis of Hampton, there is a great deal of diffusion, acceptance, and promotion of medical theory and attitudes on health and wellbeing. In fact, the narrator supplies Princess Josian, the female protagonist, with a background in Arabic-Christian academic culture: she has been trained in the seven liberal arts and by medical masters from Toledo and Bologna, two fundamental centers of learning where Muslim, Christian, and Jewish physicians and intellectuals were drawn together. Josian frequently uses her advanced medical training and knowledge to protect and heal herself and her husband, Bevis, from numerous ailments that occur during the narrative. However, Josian also uses her knowledge in an ingenuous manner when she is being kidnapped and taken to a Saracen king, Yvor, who wishes to nullify her vows to her husband so that he can wed and bed her instead. As Josian is being taken away, she manages to identify, gather, and self-administer a rare herb that will give her the appearance of leprosy. In her recent criticism, Faith Wallis notes that the distorted historical views surrounding this skin ailment have only recently begun to be reviewed; earlier historians “at one time treated leprosy as the quintessential medieval disease. It was presumed to be everywhere, and at almost epidemic levels. Medieval people were portrayed as obsessively afraid of leprosy, which they considered highly contagious” (339). Josian’s cunning act, which plays upon the supposed extreme fears and confusion surrounding leprosy in the late medieval period, is a powerful artifice that effectively wards off the unwanted advances of a determined suitor. She draws upon the fact that lepers were the most ostracized group of people in medieval society, and refashions the archetype of the outcast to fit her own needs. In this manner, Josian’s knowledge of herbs “both medicinal and poisonous” (l. 3676), allows her to successfully negotiate the tensions in the romance, using her medical background to protect, to postpone, and to neutralize the threat of violence from Yvor, until she can be safely rescued.
Re-thinking Disability’s Economic Value
Abraham Graber, PhD
Department of Philosophy and Classics
University of Texas—San Antonio

Abstract: The costs associated with treating and caring for individuals with disabilities have often been cited as a reason to avoid disability, whether through searching for a cure or terminating pregnancies (see, e.g., [Buchanan, Brock, Daniels, and Wikler 2000]). Furthermore, we are increasingly capable of preserving the lives of extremely premature neonates (Santos 2001); however, such patients are likely to have developmental disabilities and require lifelong care. Some have argued that the financial burden associated with such developmental disabilities are a reason to ration care to neonates whose prognosis includes development disabilities (see, e.g., [Wilkinson and Savulescu 2014]). The goal of this presentation is to challenge the apparent consensus that, from an economic perspective, we would be better off if we could eliminate disability.

Organizations looking to be at the forefront of innovation are faced with a paradox. Such organizations wish to be structured in a way that will lead to a valuable new innovation; however, because we have no way of knowing what the next big innovation will be, there is no way to predict what organizational structure will have the desired effect. Diversity is the solution. The more diversity a company has in its workforce, the more likely it is to innovate. On a grander scale, the more diversity our society has, the more likely we are to produce novel innovations. After illustrating this point via examples of innovations that exist because of disabilities, I will argue that the benefits of diversity for innovation undercut the claim that treating and caring for individuals with disabilities is economically disadvantageous. In order to make this judgment we would have to be in a position to predict the value of future innovations stemming from disability. We are not in a position to do so; the paradox of innovation forces us to be skeptics regarding claims about the potential economic contribution of individuals with disabilities. Consequently, we cannot confidently make judgments regarding the instrumental value of disabilities and decisions about avoiding disabilities must be made on something other than economic grounds.
A Revised Principiplist Framework
Tatiana Gracyk
Department of Philosophy
Bowling Green State University

Abstract: Bioethical principlism is a pluralistic ethical framework commonly used to guide decision making in medicine. Made famous by Tom Beauchamp and James Childress, bioethical principlism appeals to four fundamental principles - beneficence, non-maleficence, respect for autonomy, and justice to guide the ethical reasoning of healthcare providers in practice. The goal of principlism is to provide a framework through which the moral permissibility of a healthcare provider’s action may be assessed, with morally preferable actions being the actions that best respect the bioethical principles. However, many have objected that the traditional principlist framework put forward by Beauchamp and Childress fails to offer sufficient guidance in decision making, lacks a clear structure for conflict resolution, allows for post hoc justifications of questionable practices, and as such is rarely helpful in the healthcare setting. This presentation will briefly discuss these and other criticisms before presenting an argument in favor of a revised principlist framework, one which appeals to the four bioethical principles while avoiding the criticisms of the traditional framework.

My revised principlist framework is pluralistic insofar as it utilizes the four bioethical principles, but it differs from traditional principlism by employing the principles within a modified structural framework. This framework consists of two conditions for the moral permissibility of action: the favorability condition and the enabling condition. The favorability condition is about promoting the patient’s health and appeals to the principles of beneficence and non-maleficence. The favorability condition requires that for an action to be morally permissible it must be favorable in terms of promoting the health of the patient; any possible risks must be outweighed by the foreseen likely benefits, and healthcare providers can only be required to perform actions that are foreseen to provide at least some health benefit. The enabling condition is about upholding the rights of patients, appealing to the principles of respect for autonomy and justice. The enabling condition requires that for an action to be morally permissible to perform, performing that action must (1) respect the rights of all relevant parties including a fair distribution of medical resources and (2) be authorized by the individual(s) directly concerned.

I argue that satisfying each condition is necessary and both conditions are jointly sufficient for the moral permissibility of an action. The aim of this project has been to take the best parts of bioethical principlism and place them into a more structured framework, allowing bioethical principlism to be significantly more practicable in a real-world healthcare context. In contrast to the traditional principlist framework, my revised principlist framework can offer judgements that more frequently align with common intuitions and current healthcare practices, bridging the gap between ethical theorizing and ethical decision-making in practice.
Abstract: Emerging technologies and hacker communities have disrupted old paradigms of access to knowledge and technology. With the advent of additive manufacturing (for instance, 3D printing) and distributed manufacturing (for instance, parts sourced on the internet and assembled at home) low-income women, transwomen, and others without reliable access to needed medical services have begun to create medical devices to engage in at-home gynecological exams and at-home labs to process tests and synthesize hormones (motherboard.vice.com, “Meet the GynePunks Pushing the Boundaries of DIY Gynecology,” 2015). “Gynepunks” claim to hit the “opt-out” button on major pharmaceutical companies and multi-national information technology and computer companies, even seeking to develop feminist servers to store and control information outside already-existing networks subject to censorship and monetary interests (calafou.org, “TransHackFeminist Convergence Report,” 2015). These activists no longer want to seek life-changing technology in traditional capitalist frameworks where they argue access is regulated by prejudice and political exclusion. An integral part of these and similar efforts is the lowered cost of access to sophisticated technology—including, for example, Raspberry Pi computers, highly-manipulable basic units which cost less than $50, and open-source access to relevant tools and knowledge. Disabled people, too, are benefiting from cell phone mapping services, inexpensive applications, and other personal technologies not necessarily intended to increase accessibility but easily hacked for those purposes. Indeed, access to technology has been radically disrupted.

Some may speculate that these radical engagements could herald the further disruption of the exclusionary hierarchies of the capitalist production of knowledge and technology. Yet, I propose that merely increasing access to and the proliferation of the means of production through additive and distributed manufacturing does not yet rise to the level of challenging the basic conditions of our capitalist patriarchal contexts. Crucially, the overarching neoliberal discourse of empowerment and happiness through the use of technology—a techno-optimism which yearns for an increasing array of options in an ever-wider field of choice—is perhaps even furthered as individuals clamor for personal, at-home access to physical change. Indeed, what does for disruption mean when expressed this way? Perhaps a troubling concession to the techno-optimists—without access to the products of masculinist capitalist production, we are worse off.

If increasing access to technology is to be meaningfully transformative (that is, liberating), I claim we must think around the imperative to chase after choice and the requirements to express ourselves and seek fulfillment through the tools of capitalist production. Classic Marxist analysis focused on collective ownership of the means of production may miss the problem, but contemporary critical theory and recent thinking from Louis Althusser (The Reproduction of Capitalism, 1995/2014), Nancy Fraser (Fortunes of Feminism, 2013), and Nick Srnicek and Alex Williams (Inventing the Future, 2015) can assist in viewing relevant issues differently through critiques of neoliberalism. Additive and distributive manufacturing brings the factory and the clinic home at just the time we might be able to take these social forces apart altogether. Increasing access and efficiency in the use of technology is not equivalent to democratizing science.
Abstract: Money drives the model is a commonly stated refrain. This presentation will argue that not only does money drive the medical care (business) model but also that money (and the business model) drive the patient – physician relationship. A relationship has loosely been defined as a byproduct of people spending time together whether on a personal or professional level. Trust is built when two individuals gain confidence in each other through shared experiences and challenges. The depth of the patient – physician relationship drives trust and depth of trust drives adherence to treatment regimens and plans of care.

I will attempt to demonstrate through a survey of the history of payment for medical services how the patient – physician relationship and the associated trust has eroded as physicians have become focused on the business model of medical practice as opposed to the patient. Concomitantly, throughout this evolution of the medical care delivery system, risk between the physician and patient has all but evaporated largely due to both parties becoming increasingly alienated from the cost of care. In order to restore this relationship to its flourishing past and the trust that accompanies it, innovative payment models are going to have to reward the assumption of risk by both parties and the development of a strong relationship. Sadly, though, the volumes required to maintain a financially viable and profitable practice will require that a new relationship be developed with the practice instead of the physician.
The Use of Photographic Images in Depicting Health and Disease

Joan Whitman Hoff, PhD
Department of Philosophy
Lock Haven University

Abstract: Photography is a powerful tool in communicating information about the world and how people live in the world. Images, truthful or not, can provide appearances of realities that might or might not reveal the nature of those realities, whether or not intended. While all people and things are suspect, health and disease are of particular concern since how people are depicted provides accurate or inaccurate (or somewhere in between) information about people, health, and illness. From the ‘haunting reality of what mental disorders look like’ (Patel, 2016) to the use of photo instruments in aiding patient communication about illness (Sitvast & Abma, 2012) the use of photography in understanding health and disease can foster a better understanding of people and how they live in the world at a very fundamental level. Likewise, it can stigmatize people and disease by depicting disease as other-worldly and people who have a disease as ‘dangerous’.

In this presentation, I will examine some of the ethical issues that arise in the use of photography in communicating information about people, health, and disease and I will argue in support of ‘ethical guidelines’ for such communication. Through an examination of codes of ethics of various photographers’ association and the health care professions, photographic images of people in various stages of health, and an examination of literature focusing on the value of photographic images for this purpose (intended or not), I will argue that communicating information about health and disease must be truthful, humane, and provide an opportunity for non-visual narratives, such as Patel’s, in order to aid in the understanding of health and disease and reduce stigma of what it means to have a disease.
Abstract: This session addresses the topic of loss related to dementia and death through the poetic voice. As an expression of emotions a person may feel but not be able to put words to, poetry can be a healing force. In poems, universal human concerns find their way into language.

We propose a presentation of poetry specifically addressing the topics of dementia and death. Carlton Johnson is the author of 12 poetry chapbooks and Chaplain for Aspirus Hospice Northern Michigan; Buchinger Bodwell, who teaches creative writing to students studying for careers in healthcare professions, is co-President of the New England Poetry Club, Cambridge Poetry Ambassador, and author of two books of poetry. Both of us have written poems that seek in some way to come to terms with progressive dementia and death. This presentation will be of particular interest to healthcare professionals caring for patients and their families who are struggling with dementia and facing the end of life. In a very real way, it is the humanities that make and keep us human when dealing with loss. This session of poetry is an exemplar of the interconnections among the humanities, illness, and healing. We welcome discussion following the presentation.
Violence against Women and the Public Health Implications of Legisrating Sex and Consent in Southern Texas

Cynthia Jones, PhD; Department of Philosophy and Director, Office for Victim Advocacy & Violence Prevention, University of Texas Rio Grande Valley

Anne Stachura, PhD; Department of Modern Languages and Literature, University of Texas Rio Grande Valley

Abstract: Border regions where a developed country abuts a less affluent or developing country can face unique challenges in confronting public health issues like violence against women. Challenges arise from immigration, from undocumented status, from language barriers, from cultural differences, and from mistrust or misunderstanding of the services available and the local and federal laws. In southern Texas and literally on the border of Mexico, the issues on our university campuses (in Brownsville and Edinburg, Texas) are further exacerbated by poverty, by population growth, by limited English proficiency, by the high rate of medical uninsurance (Hidalgo County’s rate is the highest in the country), and by levels of education, among other factors.

In the lower Rio Grande Valley, the limitations on women’s safety from violence due to immigration status have been acknowledged in the media. A Spanish-language newspaper based in McAllen, TX, El periódico USA, ran a story in August of 2011 entitled “No sea una víctima más”, (“Don’t be another victim”), with the goal of educating women of the recourse available to them under the federal Violence Against Women Act. While it educated the public about where to obtain the necessary I-360 form, it also called attention to the disparities in protections afforded to abused women based not only on their immigration status but also that of their abuser. It is essential to remain cognizant of the similarities and differences between disparate populations regarding violence against women as a public health issue in the U.S.

In southern Texas, significant underreporting on the part of victims and survivors, and more disturbingly, on the part of local law enforcement, creates unique challenges in attempting to collect data and develop appropriate and culturally sensitive advocacy, education, and prevention programming. This panel will discuss issues of violence against women arising in the border regions of southern Texas from public health challenges, new consent regulations, “laws” that apply to federally-funded institutions of higher education (like Title IX and Clery), local grassroots efforts, rampant and pervasive victim-blaming, and attempts to promote a victim-centered, research-based, and trauma-informed approach to addressing violence against women in southern Texas.
Why Bioethics Needs Evolution
Thomas Kiefer
Department of Philosophy
Fordham University

Abstract: As the study of moral issues in biomedical contexts, bioethics tends to focus on concrete examples and the application of particular principles for guiding ethical decision-making. However, many of the most pressing ethical issues arise precisely when a given example is deemed exceptional and the go-to principles come in to conflict with one another. Such cases of moral dilemma are not rare, but the movement to a metaethical level of analysis of morality to solve them currently is. In this presentation I argue that in these cases we must take a step back and consider the nature of morality and what it means to make ethical decisions as such. I propose that we must have some understanding of what morality allows us to do, and thus which principles for guiding ethical decision-making should be prioritized in general, if we are to address the most controversial bioethical issues in particular. I argue that this requires reference to the evolution of morality, which provides an account of the nature of morality as a biological adaptation oriented toward social cooperation. If morality is understood as an adaptation that functions by enabling a human being to cooperate by helping or not harming other members of her social group, we can understand bioethics as the specific concern with cooperation in medical contexts, wherein physicians have great ability to help or harm a patient who is comparatively unable to do so by herself. Bioethical principles then can be understood as conditions for making other-regarding decisions that ensure the patient is helped and not unduly harmed, as if the hospital were a social group in its own right. I conclude that these considerations can be used to solve moral dilemmas in bioethical contexts by clarifying the conditions in which such dilemmas arise, providing guidelines for prioritizing or limiting the application of particular ethical principles, and supplying objective criteria by which to judge the moral value of an act.
Using the Health Humanities and Disability Studies to Teach Health Professionals about Disability
Kristi L. Kirschner, MD; Department of Medical Education, University of Illinois College of Medicine; Department of Disability and Human Development, UIC
Sandra M. Sufian PhD, MPH; Department of Medical Education, University of Illinois College of Medicine; Department of Disability and Human Development, UIC

Abstract: Most health care professionals do not understand the lives of people with disabilities. Historian Paul Longmore declared this a “clash of cultures” in 1995. Indeed, people with disabilities, despite being high users of health care services, experience significant health disparities and are often dissatisfied with the care they receive. Many describe being misunderstood, excluded, and stigmatized by the very people they need as partners in health care. As a result, people with disabilities may delay seeking care, or grow weary of having to fight such barriers. Though there has been some progress since the passage of the ADA in 1990, the health care culture has been slow to change.

In 2005, The US Surgeon General issued a Call to Action to Improve the Health and Wellness of Persons with Disabilities and challenged the health professions to educate professionals to “treat the whole person with a disability with dignity.” The 2009 National Council on Disability report, The Current State of Health Care for People with Disabilities, charged that “the absence of professional training on disability competency issues for health care practitioners is one of the most significant barriers preventing people with disabilities from receiving appropriate and effective health care,” and recommended that “all health care provider training programs must have a disability competency requirement that produces student comprehension and understanding of the principles of accessibility, accommodation, cultural competency, and awareness of community and other resources for people with disabilities.”

But how? Actualizing these aspirational goals has proven to be a challenge. In this workshop we will argue that the health humanities provide a powerful method in which the lived experience of disability can be incorporated into health professional training programs. Patient stories, films and artistic expressions will be explored, and paired with critical readings about stigma, apperception, models of disabilities, implicit ableism, etc., accompanied by scholarly humanities drawing upon disability studies scholarship. Specific curricular examples will be discussed such as:

1. The historical (mis)treatment of people with disabilities in health care and society.
2. Medical texts about disability to uncover implicit assumptions and “frames” about disability, the narrative structures inherent in such texts, the goals of medicine (such as medical model, social model) and the reification of health. What would a different lens tell us? How could the goals of the healthcare system be reframed if we apply a different lens? (such as the biopsychosocial model grounded in the WHO the International Classification of Functioning, Disability and Health)
3. Narratives about the lived experience of disability. What do people tell us about their lives and what they want from the health care system?
4. Popular literature and films about disability (e.g., the book and movie Me Before You or Academy Award Winner Million Dollar Baby) and how the arts shape our perceptions and attitudes about life with disability. How do these perceptions compare to studies about the lived experience, quality of life of people with these conditions?
5. Bioethical debates about health care decisions and the lives of people with disability
Abstract: This address will be a critical perspective on the field of bioethics. Beginning with its start in the mid-20th century, I will look at the forces that shaped this field focusing on its prominent role in the public arena. Moving out of the ivory tower made fans of bioethics as well as those concerned with the role of bioethics in society. Critics have suggested that bioethics has taken on too much power and too central a role in public health and medical policy. What do these varied perspectives hold for the future of bioethics and where should we go from here?

According to the varied accounts of the beginning of bioethics, the field comes together in the late 1960s/early 1970s as a response to the growing awareness of human subjects research abuse, the rise of complex medical technology, and the civil rights movement. After the Nuremberg trials of 1947 and after the medical ethics debates among theologians in the 1950s and 60s, a more secular bioethics began to arise. Scholars in medicine, law, philosophy and the humanities found themselves interested in similar questions—the effect of medicine and health on the human condition and society. Perhaps the most distinguishing feature of this new field was its willingness to engage with the public through government panels and the media. The very first bioethics commission was created in 1974 as the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Since this beginning bioethics has grown in scale and scope. Bioethics is seen in popular media such as films and television, in news reports where bioethicists are frequently quoted, and in the proliferation of blogs and independent media run by bioethicists.

Some have argued that bioethics has gained too much power in the public arena. Consider Steven Pinker’s August 2015 Boston Globe OpEd that bioethicists were slowing down the progress of medical research. He claims that bioethicists are viewed as moral experts—a mantle that most people in bioethics explicitly deny. Wesley Smith feels that we put forth a decidedly liberal agenda that diminishes the value of human life and creates a culture of death where the bioethicist makes decisions over life and death. Others claim that philosophers and others have grabbed on to the medical and STEM fields in order to be seen as relevant in today’s world.

As bioethics has reached an uneasy adolescence, questions about its future hang heavy. Many debates about the field from its beginnings remain unsettled such as who can call him/herself a bioethicist, who should be under the tent, what is the core skills and literature of this field, is it a field or discipline or something else, should we be more applied or more theoretical. Some like Ruth Macklin and Steven Miles hold that we should focus less on the latest news or most recent technology and instead move toward social justice such as poverty, torture and war. Others like Mark Kuzciewski and Bob Baker are bent on professionalizing clinical ethics on line with medicine and nursing.
The Right to Reproduce: Infertility, Insurance, and the Commodification of Gametes

Tonia Kohal
Oakland University William Beaumont School of Medicine

Abstract: We live in an era where medicine is racing forward at an exponentially faster rate than policy and law, riding the coattails of technology and the internet’s ability to provide instantaneous information. There are many areas in the art and practice of medicine where bioethics aims to bridge this gap, but none as close to the roots of humanity and evolution as the rights of reproduction. In 2011, 1.5% of US births resulted from assisted reproductive technology (ART). ART offers a host of ethical conundrums that begin even before a birther, sperm donor, and egg donor decide to bring the products of conception to fruition. In this talk, I discuss that there is a need to view infertility as a medical condition requiring treatment and that insurance companies should pay for those treatments. Furthermore, I contest that these principles are substantiated by an appeal to ethical principles in conjunction with discourse surrounding ART.

Do we have a right to reproduce? This question is fundamental to two broader ethical issues examined in this talk. First, I explore the role, and interrogate the responsibility, of physicians and insurers for treating infertility. The practice of medicine often relies on screening tests and assessments as a tool for early intervention and preventative healthcare, but their use can be controversial in the context of ART. Considerations of socioeconomics, health status and the age of patients as well as the personal beliefs of physicians can influence how screening is conducted. Moreover, the average cycle cost per delivery of $36,417 is prohibitively expensive for some and for those who can afford it, is a motivator for multiple embryo implantations so as to maximize the chances of conceiving a viable offspring. This creates an environment where implantation of the most number of embryos can be a metric for success. I will therefore, also examine the role insurance companies play in ART and how their approach to infertility as a medical issue or lack thereof, creates the conditions where the usage of gametes and embryos becomes a contentious issue.

Secondly, I elaborate on the commodification of gametes and embryos. The 1992 case Davis v. Davis decided in the Tennessee Supreme Court offers a starting point for the discussion of the ownership of gametes and embryos. One of the key issues that arose from the discourse of this case was the usage of contracts by agencies providing ART procedures and the enforceability of these contracts. Michigan law has not made clear delineations of who has ownership of embryos and so relies on the aforementioned contracts. If there is dispute over the original contract, do we have practical and reasonable mechanisms of resolving the ethical conundrums that arise? The door is open to questions about which donor, egg or sperm, has the rights to use embryos to which they have contributed genetic material. Uses could be reproductive purposes either self or donation, research purposes, or for the purpose of destruction. A comparison could be drawn between donating embryos and donating organs, the latter of which has had substantial ethical discussion devoted to it already, but questions of personhood arise with embryos, which can change the nature of discussion.

The physician is often a source of trusted information and patients will seek their physician for advice in making potentially life changing decisions, which infertility and its treatment certainly can be. Infertility and its treatment options are not only primary concerns that PCPs, Ob/Gyns and reproductive medicine physicians face, but are issues that can arise in any field of medicine as a consideration for patients. As healthcare providers, it is necessary, in addition to guiding patients on all available options, to also make patients aware of the implications of different options.

The issue of reproductive rights is immense in scope and complexity. As ART becomes more prevalent and more accessible to a larger population, clinicians will have to field questions from patients regarding infertility and available ART options. Through discourse in the ethical issues surrounding ART, physicians and other healthcare providers can understand patient rights and beliefs as well as reconcile personal beliefs. This allows us to be prepared to advise patients about treatment options as well as the potential consequences, medical or legal, of these choices. The intent of this talk is to foster discussion about this multi-faceted topic through the bioethical lens, and also remind us how the discussion of ART can be a discussion on fundamental beliefs of ownership, rights, and life.
Melody Meets Malady
Stepfanie Lam; Department of Molecular Genetics & Microbiology, University of Florida
Virginia Lane; School of Music, University of Florida

Abstract: This musical composition is a collaboration between the Department of Molecular Genetics & Microbiology and the School of Music at the University of Florida. Scored for cello, this work was derived from the genetic code and of both malignant and benign Neurofibromatosis 1 tumors. Neurofibromatosis 1 is an autosomal dominant disease characterized by benign tumors in the body. While these tumors are symptomatically benign, a mutation in the tumor suppressor gene, PTEN, leads to their transformation into cancerous Malignant Peripheral Nerve Sheath Tumors. It has been found that DNA samples of these malignant tumors often exhibit a loss of heterozygosity in their alleles. Benign tumors are characterized by the inactivation of only one allele, whereas their malignant counterparts show an inactivation of both alleles. The goal of this project was to show the possibility of analyzing data using an interdisciplinary approach in order to increase the understanding and dissemination of this research across a wide range of disciplines.

The loss of heterozygosity used to differentiate malignant from benign tumors can be visualized when DNA samples are run on a Polyacrylamide Gel. The appearance of DNA bands seen on these gels is reminiscent of a musical program called Synthesia, which uses a Musical Instrument Digital Interface (MIDI) file to generate notes that appear in a banding pattern. This synergy between a Polyacrylamide gel and the Synthesia program was the inspiration behind the composition. A musical staff was superimposed on pictures of Polyacrylamide gels to directly transcribe their genotype into music. Each DNA band became an individual note, and the ensuing musical pattern was developed into two movements. In the first movement, notes are played one at a time, congruent with how they appear on the original gel. Each beat represents a DNA sample, and the beats are divided evenly among the bands visible in that sample. The second movement builds off the already present chordal structure found in the Polyacrylamide gel. DNA samples containing multiple notes were structured into chords, and additional harmony was developed off of their preexisting pitches. Since malignant tumors show an inactivation of both alleles, they only contain one note and are represented by a lack of harmony. Because of this, harmony in the second movement is only associated with the presence of benign samples. When signified in this way, the stark contrast between malignant and benign tumors becomes easily discernible.

The similarities between musical notation and the genetic code are often overlooked. The creation of melodies from notes in the diatonic scale is analogous to the way A, C, G, and T nucleotides make up the genetic code. Overall, this project highlighted some of those similarities.
Anatomical Body Donation Under Ill-Informed Consent May be Harmful to the Dead
Samantha Mahon, MS
Florida State University College of Medicine

Abstract: It is unarguable that the medical community has an obligation to patients to minimize harm and respect their autonomy. It should then follow that when a living person is making the decision to donate their body to the scientific-medical community, there is a duty to inform that person of each relevant scenario their body could undergo. When this is not done, and consent is not obtained appropriately, it is possible that events occurring through anatomical body donation may harm the dead.

Priorism, a view concerning posthumous harm, holds that an event after death may harm the person prior to death, even prior to the event itself. Preferentialism, a view on well-being, holds that well-being should be assessed by examining the extent to which preferences or desires are thwarted, or fulfilled. Using both viewpoints, I argue that the prospective donor’s interests can be thwarted at a time, after death, separate from when the interest was held, before death, and thus anatomical body donation has the potential to cause posthumous harm to the donor.

In the future, healthcare teams and the scientific community should ensure donors are properly informed of each relevant scenario surrounding body donation. Like other medical procedures, knowledge of values and wishes would be best obtained through an advance directive. Not only would this ensure a respectful burial for the dead, but this would answer questions regarding their former preferences so posthumous harm does not occur.
Visual Arts as a Way of Expression for Mental Illness Patients
Gina Maki, DO
Henry Ford Hospital - Wayne State University

Abstract: When art is the point of discussion, one can approach it through three main perspectives. First as a historical document that describes daily life in several moments and places. Then as a manifestation of individual attitudes towards life, being a way of sharing ideas. Lastly, artistic creation is conceived as a therapeutic activity, a way the patient finds to face their emotions and express them. So, the questioning about the use of visual arts to soften human suffering arises. The one disease which has been most often depicted to coexist with fine arts expression is schizophrenia, with Alzheimer’s disease following behind in second place.

Objective: To discuss the role of visual arts as a palliative care in patients with Schizophrenia and Alzheimer’s disease.

Discussion: Doctor Karl Jaspers related an “abyss” that separates non patients from those with schizophrenia that puts the first ones beyond the understanding of the feeling of seeing the empty “shell of a person”. Reinterpretation of schizophrenia has shown that much of what has been passed off as primitive form of art made by patients is far more complex and interesting—and self-aware—than is usually acknowledged. Establishing the link between the “abyss” and the exhaust valve called art. It is said that Van Gogh for instance did not paint due to his madness, on the contrary, he painted to keep his mental sanity because it was one of the few aspects he was successful with despite his illness. For Antonin Arnaud, also diagnosed and treated as a schizophrenic, theater was a refuge to say and listen to content he couldn’t express daily. Also, Jung and Nise da Silveira agreed on their correspondence that if there is a high degree of limitation of consciousness, often only the hands are capable of fantasy. This leads us to another portrayed illness: Alzheimer’s disease. William Utermohlen through self portraits depicted the gradual decay of his mind due to this crippling disease revealing an urge on expressing his impressions of the disease.

Conclusion: There is a therapeutic potential in art. This does not, however, eliminate suffering, but instead gives the possibility of manifesting demands that words sometimes can’t help expressing anymore. Humans need to recreate reality in art to express a channel that brings them emotional relief. Thus, art is an attempt for each to make sense of their inner experiences that identify them as a human being.
Ethical Applications of Neuroscientific Evidence in the Criminal Justice System
Joseph P. Mandala, MPA, JD
Institute for the Medical Humanities
Graduate School of Biomedical Sciences
The University of Texas Medical Branch

Abstract: A neurolaw debate continues raging at the bioethical intersection of neuroscience, medicine, and law as neuroscientific discoveries over the past twenty-five years have spurred significant advances in brain studies that implicate the judicial system. Many scholars agree that cognitive dysfunction predisposes people to criminal misconduct, but there is no consensus on how to ethically allocate criminal responsibility to offenders. Some argue that people, not brains, commit crimes because personal responsibility stems from rules of social interactions, not the brain. Others counter that the brain, not people, commits crimes. As a center of free will, they argue based on the seminal experiment of Benjamin Libet and colleagues that the brain makes unconscious choices incapable of voluntary preconditioning before producing conscious thoughts capable of deciding to veto all antisocial, deviant behaviors and bad acts. Both arguments have merits based on our present technological advances, but are also not without negative public policy, legal, and ethical consequences. Whereas the application of the former argument led to mass incarceration, unmitigated death sentences, and recidivism, the latter contention introduced mandatory drug provision (e.g. Sertraline or Zoloft) to offenders in prison and on probation not for rehabilitative treatment or therapeutic justice, but as retributive punishment to the brain. Although each argument refines the debate, none of them makes a persuasive case for ethical application of brain science to medicine and law in order to properly allocate criminal responsibility to offenders. This presentation seeks to do so for neurolaw to advance the ends of justice.
Bribery, Conflict of Interest, and a Physician’s Fiduciary Duty to Patients
Michele Martinho, MD

Abstract: In September 2010, my decision to accept cash bribes for referring office blood work to a laboratory in New Jersey violated not only my place in society as a law abiding citizen but also my oath to my profession and to my patients. Initially, I did not understand how my actions were so deeply criminal. I saw the cash as simply a referral fee for sending my bloodwork to a particular lab. At the very worst, I feared that my decision would pose a tax issue with the IRS, and I would be required to pay taxes on this money at some point. I now understand the true definition of the word bribe and how I violated a basic principle of health care ethics by engaging in a conflict of interest. Bribery does not mean accepting money to do something “bad” which I interpreted as ordering or drawing unnecessary blood tests, which I did not do. In fact, bribery means accepting money to induce a desired behavior which was simply sending the blood work to the lab. The results of my crime are deeper than the obvious criminal and financial aspects. As a physician, by engaging in the conflict of interest, I violated my fiduciary responsibility to my patients. I violated their trust in me by forcing them to question whether the bloods that I had drawn were truly necessary or whether I was simply drawing them because I was being paid a fee from the lab. The magnitude of the crime that I have committed has devastated all aspects of my personal and professional life. All that I have worked to achieve is now comprised: my freedom, my medical license, my reputation, and my ability as a single parent to provide for my children. In understanding my violation of the principles of health care ethics and truly accepting responsibility for the crime that I have committed, I am focusing on the concept of restorative justice. I acknowledge responsibility for what I have done, I want to make amends, and my goal is to accomplish that by educating and deterring others from ever committing similar crimes.
Neurophenomenology: What it can Explain about Traumatic Memory
Kate Mehuron, PhD
Department of History and Philosophy
Eastern Michigan University

Abstract: This presentation asks: is cognitive-behavioral memory manipulation primarily a discourse of mechanistic control over human subjectivity? To get an answer, the hermeneutic niche of the discourse of traumatic memory is examined, drawing from philosopher of science Ruth Hibbert’s notion of “epistemic niche” and her intuition that by a conceptual examination of the epistemic ecology of a scientific concept, the normative legitimacy or illegitimacy of the concept can be assessed. This presentation shows how the cognitive behavioral research program of memory manipulation is part of the hermeneutic niche of the discourse of traumatic memory. Neurophenomenology is introduced as a significant discourse in the hermeneutic niche of the concept of traumatic memory. Recent interdisciplinary research in neurophenomenology is presented as a new explanatory framework to understand how traumatic memory functions and why certain cognitive behavioral interventions into traumatic memory are effective for addressing problems such as arachnophobia. The hypothetical findings of neurophenomenology are evaluated in the context of these interventions, to consider the normative implications of cognitive behavioral memory manipulation.
Abstract: There is a common view that science can only give us facts, and can say nothing about ethics or other value-laden fields. This ‘is/ought gap’ is starting to face challenges from developments in neuroscience. Close study of the human brain is starting to reveal novel insights into the nature of how moral reasoning works, and what makes it break down.

In this presentation I will argue for two central conclusions. First, that the ‘is/ought gap’ is not as capacious as it may seem; science can indeed help us derive a (moral) ought from a (neural) is. Second, an Aristotelian eudemonistic ethics offers a promising, but underappreciated framework from which to understand both the methods and the substance of neuroethics.

To the first point: moral reasoning is something that the brain does. It is a function that has evolved over time as the result of a variety of evolutionary pressures. Our brains have numerous moral ‘centers’ that operate in different ways, sometimes cooperatively, sometimes combatively. We understand that when the somatosensory cortex is damaged a variety of perceptual impairments result; why should we not, by parity of reasoning, understand that when these moral ‘centers’ are damaged, a variety of ‘moral impairments’ result?

Such a naturalistic approach to neuroethics fits comfortably a broadly Aristotelian approach to moral thinking, both methodologically, and substantively. Methodologically, Aristotle championed an approach that was pluralistic and pragmatic, rather than principled. Aristotle would no doubt find himself right at home using neuroimaging to better understand moral reasoning and the good life.

The substance of Aristotle’s moral thinking brings us to our second point: a eudemonistic theory of ethics offers a promising framework for thinking about many recent findings in neuroscience and cognitive science more broadly. There has been an Aristotelian vein running through psychology for over a century; Jung, Maslow, and Frankl all had decidedly Aristotelian affinities. More recently the positive psychology of Seligman and Csikszentmihalyi have also stressed ‘flourishing’ as a core concept in their work, and neuroscience is starting to follow suit. (e.g., work by Gary Lewis; Britta Holzel). Such work implies a neuroscientifically objective framework for understanding human wellbeing that is based in a pluralistic value system that is broadly Aristotelian in nature.

In closing, I suggest that the over-emphasis on ‘trolleyology’ cases in neuroethics may lead to a neglect of broader questions of ‘living-well.’ Given that human beings with healthy, functioning brains flourish best when they are responsive to a plurality of moral values, we should be skeptical of theories that offer straightforward solutions to complex moral dilemmas.
Taking Patient Virtue Seriously
Jonathan Miles, PhD
Department of Philosophy
Quincy University

Abstract: The title of this presentation implies that we do not currently take patient virtue seriously. Scholars have noted that there is an asymmetry in philosophizing about patient/professional relationship with emphasis on the latter. For better and worse, the moral obligations and virtues of medical professionals have dominated the ethics of healthcare. This presentation pulls together previous ethical discussion about patient virtue, critiques them, and offers a framework for taking patient virtue seriously.

Just as medical professionals should have certain character traits and philosophizing about these traits is useful to clinical design and education; the same is true for patients. Patients can be identified by certain character traits that make them good at dealing with illness and the medical professionals they encounter. It is fruitful to talk about patient virtues and to let virtue theory inform the design of patient advocacy and education. This is especially true as healthcare institutions themselves are seeking ways to minimize costs by emphasizing patient self-management of their disease.

This presentation proceeds in three sections. Section 1 pulls together the threads of the isolated work on patient virtues and offers suggestions as to why patient virtue has not been taken seriously. I argue none of these reasons should make us abandon philosophical work on patient virtue. In section 2, I argue that in order to take patient virtue seriously, first we need a coherent concept of flourishing in the midst of illness. Second, we need distinction between self-regarding virtues centered on self-management and other-regarding virtues centered on interacting with medical professionals. One way to do this is to apply the four cardinal virtues of prudence, courage, temperance, and justice to patient flourishing.
Memory Dampening and the Avoidable Consequences Doctrine  
Jonathan Milgrim  
Department of Philosophy  
Western Michigan University  

Abstract: Advances in neuroscience and new understandings of brain chemistry have allowed the development and use of drugs that offer the chance to dampen or possibly erase damaging memories. These advances hold the potential to offer treatment to those affected by PTSD. Soldiers returning from war, EMT and medical personnel that routinely deal with terrible tragedies, and victims of assault or similar forms of trauma could benefit from either having the damaging memories removed, or having them dulled to the point that they no longer cause damage. While these potential benefits are praiseworthy, they do not come without some cost. One such cost is potential legal confusion relating to a victim’s duty to mitigate damage in order to be awarded full compensation.

Such a duty to mitigate relies on the avoidable consequences doctrine. This doctrine states that when some harm is done to a victim, the victim can only receive damages for those harms that could not otherwise be mitigated by taking some preventive action. As such, a person is expected to receive medical treatment and cannot receive damages for harms that are a result of not seeking treatment. Precedence is set in such cases, with notable objections from religious victims that had their compensation lessened due to failure to seek treatment. In the case of assault victims, it seems that the avoidable consequences doctrine might suggest that they must take memory dampening drugs to prevent PTSD or similar severe emotion distress, or else not be due compensation for the harm. However, taking the drugs might reduce the harm, and damages cannot be awarded for nonexistent harms.

In this presentation I will explore the emergence of memory dampening drugs, as well as the potential interplay between the emergence of these drugs and current laws requiring mitigation. I will then argue that despite the seeming similarities between cases involving religious belief and memory dampening drugs, the availability of such drugs should not reduce the monetary compensation for pain and suffering on the part of the victim.
“What are they going to do to me?”: Surgical Spectacle and Reproductive Agency in *Tomorrow’s Children* (1934) and *Men in White* (1934)
Megan Minarich, PhD
Department of Language, Literature, and Philosophy, Tennessee State University
Department of English, Vanderbilt University

**Abstract:** During the climax of Crane Wilbur’s exploitation film *Tomorrow’s Children* (1934), the film’s protagonist, Alice Mason, lies inert upon an operating table, about to undergo a court-mandated hysterectomy due to incorrect, eugenically-based assumptions. We see close ups of Alice staring, unable to escape, before losing consciousness. These shots are cross cut with those of the surgeons’ preparations as well as with Dr. Brooks, “conscientious objector” and Alice’s advocate, rushing to obtain a court order halting the operation. Back in the operating room, an audience has gathered for Alice’s hysterectomy: several members of the medical commission have come to observe, and we see them surrounding Alice, anonymous in their white coats and masks. Just as the chief surgeon, Dr. MacIntosh, receives word from Judge Beakin to not go through with the procedure, the camera stalls on a close up of Alice’s exposed abdomen: the surgeon’s gloved hands menacingly hold a scalpel poised to make the first incision as the surgical tools of MacIntosh’s assistants advance, seemingly disembodied, seemingly of their own volition, against Alice’s will.

For Barbara Denham in Richard Boleslawski’s melodrama *Men in White* (1934), however, surgery—and surgical abortion specifically—is her choice. Barbara, a nursing student, is pregnant by a doctor at her research hospital and decides to terminate her pregnancy—unbeknownst to her lover. While much of the setting, staging and cinematography in this surgical scene bear a striking resemblance to that of Alice in *Tomorrow’s Children*, there are a few key distinctions: Barbara’s surgery is not halted, and Barbara dies not long after her surgery.

In this presentation, I first examine the visual similarities between these two surgical scenes in order to argue for a shared use of reproductive surgical spectacle: moments that put the reproductive female body on both medical and sexual display. While feminist film theorist Laure Mulvey contends in her classic essay “Visual Pleasure and Narrative Cinema” that female spectacle “tends to work against the development of a storyline, to freeze the flow of action in moments of erotic contemplation,” I argue here that reproductive surgical spectacle fuels the narrative instead by interrupting, if not redirecting, the male gaze (Mulvey 11).

The stark difference between these two women, however, is the extent to which they have the agency to affect their own reproductive choices. Although it may seem that Alice Mason possesses a greater sense of reproductive agency, the revocation of her court-ordered hysterectomy is achieved not by her, but by Dr. Brooks with the aid of other male authority figures: a move that undercuts Alice’s own desire and personal health knowledge in favor of male medical authority. Barbara Denham, however, has made her own choices all along: she chose to have sex, she chose abortion, and she carried through with this decision despite knowledge of the possible consequences. Barbara dies, but her reproductive choices are entirely her own. Given the parameters of film censorship under the Production Code at this time, it is unsurprising that a woman with reproductive agency who eschews male medical authority must also face punishment—even by death. *Tomorrow’s Children* and *Men in White* use reproductive surgical spectacle to suggest that until women’s self-health knowledge and health decisions are honored and accepted as valid—at all, but additionally as something that can exist as decoupled from male medical authority—women have no real privacy or choice.
Empathy, Asymmetrical Reciprocity, and the Ethics of Mental Health Care
Andrew Molas
Department of Philosophy
York University

Abstract: In “Seeing Oneself Through the Eyes of the Other,” Marguerite La Caze defends Iris Marion Young’s position of asymmetrical reciprocity as a way to understand the experiences of others. In this presentation, I explore Young and La Caze’s understanding of asymmetrical reciprocity, I examine how asymmetrical reciprocity compares to modern understandings of empathy, and I demonstrate why I believe asymmetrical reciprocity can serve as an appropriate framework for an ethics of mental health care.

I begin by outlining some of the differences between symmetrical reciprocity and asymmetrical reciprocity and demonstrate why an asymmetrical approach is useful for meaningful, respectful engagement with persons living with mental health issues. According to Young and La Caze, symmetrical reciprocity is a view which claims that moral respect consists in a “symmetrical relation of reversibility” where we take the perspective of the other person by “imaginatively representing their perspective to ourselves” (La Caze 2008, 119). This “mirroring” approach assumes that both sides are equally capable of being known and understood by the other person. Although the motivation behind symmetrical reciprocity’s idea of “putting yourself in someone else’s shoes” demonstrates a willingness to engage with others, and it is an attempt to bridge distances between various groups by trying to dissolve, or at least minimize, superficial differences which divide us and are sources of discrimination and injustice (e.g. race, gender, ability, health), Young and La Caze maintain that symmetrical reciprocity is problematic because it obscures difference, it is impossible to reverse positions, and it is “politically suspect” for one person/group to identify with the experiences of others (119).

Empathy is an important component of good mental health care because the cultivation of empathy can be helpful for engaging with others and develop trust between patients and their caregivers. However, if empathy is practiced irresponsibly, one potential worry is that caregivers may appropriate the experiences of persons living with mental health issues which can result in them feeling alienated and distanced from the therapeutic process. That said, unlike symmetrical reciprocity, an asymmetrical approach is one which attempts to understand others across differences without reversing perspectives or identifying with each other (119). The motivation behind this is that we can take others’ views into account “without imaginatively occupying their position” or “putting ourselves in their place” (119). Asymmetrical reciprocity does not try to understand the experiences of others from their perspective; rather, I understand asymmetrical reciprocity as the acknowledgement that there are differences between individuals and that there is a willingness to engage with others on their own terms. Asymmetrical reciprocity is a powerful and useful concept for understanding the experiences of others because we are not trying to take over their perspectives, or mold their experiences, to fit our own conceptual frameworks. Instead we are trying to recognize and respect difference and diversity. This view, I argue, can be an appropriate framework for an ethics of mental health care.
Health as Growth: A Deweyan Perspective on Evolutionary Medicine
Cody Moore, MS
Baylor College of Medicine

Abstract: Despite the repeated assertion of the centrality of evolutionary thought in the biological sciences, evolution fails to make an impression on the practice of medicine. Even the relatively young field of “evolutionary medicine” has—as of yet—made little impact on medical education or clinical reasoning. Why this disconnect? What insights into health and clinical care could an evolutionary perspective give to clinicians in their daily interaction with patients? In this presentation, I will examine the current state of evolutionary medicine and show why its adherence to strict reductionism has prevented it from influencing medical care. Having done so, I will then introduce John Dewey’s philosophical naturalism—as laid out in the first chapter of Art as Experience—as an alternative and ultimately superior understanding of the implications of evolutionary thought. Finally, I will dedicate the remainder of the presentation to reimagining medical practice through the Deweyan perspective. This will include a discussion of current and potential medical practices, as well as a new conceptualization of health.

I will first explore what has kept evolution at the periphery of medical practice. Thus far evolutionary medicine has largely confined itself to the study of infectious diseases, organisms’ interaction with hosts, and the impact of anti-microbials on these organisms. This artificial limitation is a direct result of strict reductionism. Evolution, as an explanatory force, is conceived of in terms of “lower order” phenomena such as biochemistry and molecular genetics. Medicine, however, mostly operates in the realm of “higher order” phenomena such as organ systems or mental states. The consequence of this limitation of perspective is that important determinants of patient health are either lost or ignored by clinicians.

To remedy this deficiency in evolutionary medicine, I propose an alternative take on evolutionary theory—that of John Dewey. In Art as Experience, Dewey provides a rich metaphor for describing human existence, that of a live creature transacting with its environment. He uses this metaphor to develop his concept of growth—a central concept to his philosophical naturalism. I will briefly elaborate on Dewey’s discussion in this text, showing how this discussion fits into his philosophical pragmatism. I will conclude by showing how Dewey offers a more robust interpretation of evolution that is more useful to clinicians.

Finally, I will offer concrete examples of how a Deweyan perspective on evolution can and—in some ways—already has improved clinical care. For example, primary care physicians have already begun to embrace the concept of the Patient Centered Medical Home (PCMH), which I will demonstrate fits seamlessly into a Deweyan perspective. Additionally, I will consider how other cultures approach mental illness, showing that our reductionist view can be broadened with a Deweyan approach. I will conclude by showing that health can be reimagined through an evolutionary perspective by understanding through Dewey’s concept of growth.
Art Saves Lives
Andrea Morgan
Grand Rapids Art Museum

Abstract: Developed in collaboration between the Grand Rapids Art Museum and the College of Human Medicine at Michigan State University, Art Saves Lives was launched as a pilot in 2014 on the Grand Rapids campus and expanded to East Lansing and the Eli and Edythe Broad Museum in 2015. This course aims to help first and second year medical students build observation skills, develop strong communication skills, and become comfortable with ambiguity. Art Saves Lives reinforces and helps expand the competencies of service, care of patients, rationality, integration, professionalism, and transformation.

This interactive workshop will include discussion about the development and implementation of this medical humanities elective that places students in a “non-medicine” environment, as well as demonstrations of hands on activities students experience throughout the course.
Fixing Children Who Are Not Broken: The Dangers of Internalized Prejudice
Tabitha Moses, MS
Wayne State University School of Medicine
National Core for Neuroethics, University of British Columbia

Abstract: Over the past half-century, our abilities to treat and cure diseases and disabilities have progressed dramatically. More recently, researchers and scientists have developed new prosthetic devices to be used as treatments and have the potential to be used as enhancements. The development of these devices has led to numerous ethical concerns about whether individuals should be able to enhance themselves physically or mentally. Embedded in these concerns surrounding enhancement is a deeper question as to what it really means to enhance an individual and how exactly one is able to distinguish treatment from enhancement.

This discussion becomes increasingly important when it regards children. Previously uncontroversial treatment devices — such as cochlear implants — are now entrenched in significant debate. It is therefore important to understand our own motivations for pursuing cures for disorders that those with the disorders do not view necessary. As medical professionals work to treat disorders and disabilities as early in childhood as possible, it is important for us to understand whether these disorders really do require treatment. Many members of communities that are considered to be disabled (such as the Deaf) are coming together to defend their communities (and by extension, their defining features) and fight against the need for treatment of their so-called disability. As a result, it is important to reevaluate what we consider to be "normal" and whose job it is to decide what is normal and decide who needs to be treated.

Until recently, this was not a question that would be considered. Medical professionals viewed it as their duty to fix any person deemed as abnormal wherein “normal” encompassed a specific phenotype, five senses functioning in a specific way, and a mind that responds to external and internal stimuli in a specific manner. If a child was born outside of this normal range and the physician had a way in which he could “fix” the child, then there was no doubt that the doctor should do whatever he could to do so. However, recent developments in our views as to what is normal and the backlash from groups such as the Deaf community against certain treatments like the cochlear implant are forcing us to re-evaluate this apparent medical paternalism. While it is easy to debate the merits of enhancement and treatment of certain disorders in adults, this question becomes more difficult when it is focused on life altering treatments in children. There is an ever-diminishing divide between whether something is viewed as a treatment or enhancement and whether its use may in fact disrespect a person’s identity and destroy a community. We need to be fully aware of these differences and our own motivations for pursuing certain treatments before assuming that they are necessary in a child who does not have the capacity to consent to such a life-altering surgery. We should never be in a situation where the medical profession is fixing individuals who may not be deemed as broken, before they have the capacity to consent.
QALYs Cannot Represent the Value of Health States
Dane Muckler
Department of Philosophy
Saint Louis University

Abstract: The Quality Adjusted Life Year (QALY) is a way of quantifying the impact a medical condition has on a life. Despite increased use of QALYs by healthcare economists in recent years, many have raised concerns about whether the QALY can adequately represent the value of diverse health states. Nord (1999) maintains that a value representation is adequate for use in policy analysis only if its accuracy can be demonstrated and decision-makers can easily understand what it represents. Following Nord, I discuss two ways of interpreting what the QALY represents and argue that neither is verifiable. Therefore, the QALY is not an adequate value representation. I conclude by outlining how hedonic measures of health states have the potential to overcome the deficiencies of the QALY.
Combating Medical Conspiracy Theories with Cognitive Infiltration

Peter Murphy, PhD
Department of Philosophy & Religion
University of Indianapolis

Abstract: Almost half of all Americans believe in at least one medical conspiracy theory. A few of the most popular are theories about vaccines, water fluoridation, harmful effects of cell phones, and the origin of AIDS. These beliefs can undermine important public health initiatives and lead to significant harms to innocent people. My goal is to explore an under-discussed strategy for combating harmful medical conspiracy theories: cognitive infiltration.

I begin with two background items. I first review the latest research on the popularity of medical conspiracy theories. Since conspiracy theories are designed in part to be immune from standard forms of refutation, we should be pessimistic about relying on education as the sole means for curtailing the spread of such theories. The second piece of background spells out Sunstein and Vermeule’s idea of cognitive infiltration. I then highlight a few examples of cognitive infiltration strategies that might be used to curtail the spread of harmful medical conspiracy theories. One involves posing, and gaining credibility, as a true believer, in some theory, and then later renouncing that theory. Another is to sound so far-fetched that people who are considering the relevant conspiracy theory will be turned off. And a third involves arguing for some less harmful version of a popular conspiracy theory. Along the way, I highlight how each of these examples crucially depends on lying as well as other forms of deception.

This sets up my central question: when, if ever, are these strategies morally permissible given their heavy reliance on lying and deception? To answer, I start with a case of morally permissible lying: the murderer at the door. I then proceed to consider a series of variants on this case that are more and more similar in their morally relevant features to a sample case of cognitive infiltration, one that targets anti-vaccination conspiracy theories. First, I adjust the parties from three in the simple murderer at the door case (namely the person who answers the door, the murderer, and the person hiding in the house) to four in the sample cognitive infiltration case (namely, the person who deploys cognitive infiltration aimed at the parent who is considering not vaccinating their child, that parent, that parent’s child, and another child who might be harmed if the first child is not vaccinated). Second, I adjust the number of deceptive acts (including lies), the number of people who are deceived, and the number of people who deceive. Third, I adjust the intentions of the malevolent murderer in the murderer at the door case to the well-meaning intentions of the anti-vaccination parent. Fourth, I adjust the other options available to the party that is trying to prevent harm (namely the person at the door and those who are engaging in cognitive infiltration). Last, I make the probabilities of being caught deceiving, and the harms that will be result from being caught, comparable in the two cases.

None of these adjustments, I argue, makes for a difference in moral status between the two cases. So under circumstances that emerge in the discussion, it is morally permissible to use cognitive infiltration to combat harmful medical conspiracy theories.
Why Care about Parental Permission in Pediatric Treatment?
Mark Navin, PhD; Department of Philosophy, Oakland University
Jason Adam Wasserman, PhD; Department of Biomedical Sciences, Oakland University William Beaumont School of Medicine

Abstract: The Committee on Bioethics for the American Academy of Pediatrics (AAP) suggests that parental autonomy is valuable only for promoting the best interests of the child. This situates parental autonomy in an exceedingly narrow instrumental view that presupposes the physician and health care team know what is best, leaving parental consent to treatment as merely a conduit in the pursuit of those ends. In this presentation, we criticize this view and defend a larger set of reasons to care about parental permission in pediatric treatment. Importantly, we argue that the expansion of the concept of parental autonomy can be undertaken without justifying its more problematic forms (e.g. vaccine refusal), which the current AAP position rightly was crafted to oppose.

By positioning the role of parental autonomy as merely a gateway to a treatment goal, decided, in advance, or in absence of parental input, to be in the child’s best interest, the AAP overlooks at least three highly significant ways in which parental autonomy matters for pediatric patients, for clinical relationships, and for parents and families themselves.

First, parental autonomy contributes to a child’s best interest over and above the influence and input of the medical team. In certain cases, parental autonomy can serve as a correction to misguided aims that are not on target with this best interest standard. Also, in cases of children with conditions or characteristics outside norms and expectations (or even experience) of the health care team, parental autonomy brings critical diagnostic and treatment information into the fray.

Second, parental autonomy is valuable as more than a conduit for the goals of the medical team because cultivating it promotes stronger clinical relationships and otherwise benefits children. When physicians seek parental consent, this may cultivate parents’ ability to engage in autonomous decision-making. This kind of parental autonomy can be good for children, because parents may be more likely to complete treatment protocols when those protocols are self-imposed. Autonomy can be a good motivator. Also, it may be good for children if their parents model autonomous interactions with (relatively) powerful people. There is abundant empirical evidence that children have better outcomes for education, employment, income, etc., if their parents show them how to exercise authority in their social worlds, rather than encouraging children to be subservient and compliant.

Finally, parental permission matters because parental autonomy can be good for parents, for parent-child relationships, and for the family. Of course, physicians have a primary responsibility to their child patients, but there is no reason to think that in some situations, benefiting parents even at some expense to the child is unethical or unreasonable.

Each stage of our analysis goes beyond the problematical limitations of the current AAP conception of the value of parental autonomy. Pediatric ethics needs a robust conception of the ethical terrain in which parents participate in decision-making.
Manipulation, Salience, and Nudging People to Healthier Behaviors

Robert Noggle, PhD
Department of Philosophy and Religion
Central Michigan University

Abstract: Cass Sunstein and Richard Thaler recommend helping people make better decisions by employing “nudges,” which they define as non-coercive methods of influencing choice for the better. Although “nudging” sometimes refers to interventions that improve conscious critical thinking (e.g., providing information in a more user-friendly format), a subset of nudges involves non-informational methods of influencing choice. A common example involves a cafeteria placing healthy foods at eye level, a practice which is thought to increase the extent to which people choose healthy over unhealthy foods. Proponents of nudging maintain that such influences can help people make better decisions without constraining their freedom. Not surprisingly, then, healthcare practitioners and public policy professionals have become interested in whether nudges (both informational and non-informational) might be a promising method of improving health-related behaviors without resorting to heavy-handed government regulation. However, critics question whether non-informational nudging is as morally benign as its advocate suggest. One criticism of non-informational nudges is that they are manipulative.

This presentation will focus on one kind of non-informational nudges—those that operate by changing the salience of various options. It will survey two approaches to understanding manipulation, one which sees manipulation as a kind of pressure, and one that sees it as a kind of trickery. On the pressure view, salience nudges do not appear to be manipulative. However, on the trickery view (which the author favors), salience nudges will be manipulative if they increase the salience so that it is disproportionate to that fact’s true relevance and importance for the decision at hand. By contrast, salience nudges will not be manipulative if they merely highlight some fact that is true and important for the decision at hand.
Neurodiversity and Inclusivity: Ethical Challenges of Transition for Adolescents and Young Adults with Autism Spectrum Disorder

Kayhan Parsi, JD, PhD; Director, Graduate Program in Bioethics, Neiswanger Institute for Bioethics, Loyola University Chicago Stritch School of Medicine

Nanette Elster, JD, MPH; Neiswanger Institute for Bioethics, Department of Bioethics and Health Policy Loyola University Chicago Stritch School of Medicine

Abstract: The challenges of healthcare transition for adolescents with autism spectrum disorders (ASD) are well documented. Ethical challenges exist for adolescents transitioning to adulthood related to making important health care decisions. There also exist a range of other key milestones in the transition to adulthood for adolescents with ASD. In this presentation, we will explore the following areas that are garnering more attention:

1. employment challenges for young adults with ASD and their effect on health outcomes
2. post-secondary education
3. housing challenges
4. health and reproductive decision-making.

Many of these issues are related to social justice, as young people with ASD are vastly underemployed or unemployed compared to their neurotypical peers (and even other young people with special health care needs). Moreover, these other challenges illustrate the contrast between the way we support children with ASD compared to young adults with ASD. What was once considered an entitlement or right (e.g. education) is now a privilege. Moving beyond a strictly biomedical model to a public health model is important. Such a model is well suited to addressing the above challenges.
Abstract: Since the 1960s, the most predominant form of school-based sex education actually covered puberty, and took place in gender-segregated classes with a film, a presentation, and a booklet produced by a hygiene product company and sample products. My presentation seeks to investigate the changing historical connections between puberty education and sex education. Reexamining the periodization of puberty education emphasizes the ways in which puberty education emerged and changed in historical contexts and became increasingly connected to sexuality, particularly female sexuality. Critically examining puberty education illuminates the importance of sources of funding, particularly the roles of religious groups, commercial interest and governmental faculties. Of particular note, a growing consumer culture of feminine hygiene promoted puberty education and a willingness to talk about puberty and sexuality outside of the context of disease.

My presentation will examine the curricula for American puberty education through case studies from Indiana. These four short historical examples highlight the contingencies, continuities, and discontinuities across place and time. The growing national consensus around sex education belied deep internal contradictions where sex education was not part of the regular school health curriculum and outside of schools’ control. These examples illustrate the richness of this area for future study.

1940s—AMA and the Sex Education Campaigns—A national eugenic leader, Indiana University’s Thurman Rice helped form national puberty education texts through his work with the American Medical Association Sex Education campaigns and the AMA-NEA Health Education texts.

1970s—Feminism and Puberty Education—In elementary-school, lessons focused on families and the biological and emotional changes occurring at puberty. In gender-segregated classrooms, students watched a short film followed by discussions led by a SHA teacher. To generate discussion and build rapport with the students, teachers used a question box for students to submit anonymous questions, or if students felt comfortable, they would ask their own questions. This question-asking and discussion was central to SHA’s pedagogical approach as it undermined older ideas of expertise and promoted open dialog.

1990s—In Indiana, new federal revenue streams for abstinence-only sex education would have required changes to SHA programming that limited the money’s use to puberty education, and perhaps more significantly introduced competition, particularly in the middle school environment.

2000s—With the challenge to abstinence-only education and evidence-based education, SHA found that the focus on puberty education was now a difficult area to attract donors and grants. Puberty education did not lead to social change, as everyone will go through puberty with or without education, and after more than fifty years in schools funders would argue that schools should cover this topic anyway. More destabilizing, universal language advocated argue that puberty education should not focus on gender binaries and the conflation of biological changes of puberty to expressions of sexuality.
Coercive Threats to Public Health: Funding the Fight Against Food Deserts
Keagan Potts
Department of Philosophy
Western Michigan University

Abstract: Proper health starts with proper nutrition. Americans often picture malnutrition as a distant problem restricted to developing countries, but this association ignores the immediate threat that hunger poses to millions in the US every day, and one of the largest unrecognized public health crises in our country. Across the US, poor and disadvantaged communities struggle to survive in food deserts. Food deserts arise from a complex amalgamation of social, economic, and racial inequalities which prevent access to fresh produce. Negative health resulting from food deserts is exhibited by higher rates of hypertension, diabetes, and cardiovascular disease amongst low income populations.

In this presentation, I begin by outlining the public health threat introduced by food deserts, then focus on cases of urban food deserts. Next, I identify the presence of coercion in determining the shopping and eating practices of those stranded in food deserts, and suggest that aid should be guided by Rawlsian principles of distributive justice in counteracting current market forces. I assert that distributive justice balances market forces in a way that does not introduce further coercion into an already oppressive system. Finally I provide a few examples of efforts that adhere to Rawls, and evaluate these projects’ effectiveness in combating health problems posed by food deserts. In order to fight coercive factors creating food deserts, we must restore autonomy to those most affected by barriers to access.

Food deserts result from an insidious form of governmental coercion. Cost and distance pose the two largest barriers to access faced by low income communities. This coercion is systemic and operates by making healthy dietary choices less desirable, thus keeping poor people across the US from accessing the crucial nutrients essential for preventing disease and promoting their own well-being. I draw upon Robert Nozick’s account of corruption as he accurately captures the insidious and systemic nature of economic coercion that must be combated in order to restore agency to those stranded in food deserts. Any threats to alter the functioning of the free market are denounced, and so my argument must be careful to adequately defend itself against the claim that government funding to prevent food deserts would constitute interference, and as such exercises coercion. All interference must be enacted while keeping maximal liberty for all as the end goal. This shifts the terms of the debate so that my argument is not introducing coercion into a system, but rather channeling funds to combat coercion and restore autonomy to those in food deserts.

I utilize Rawlsian distributive justice in ensuring that all in society stand to benefit from efforts to ameliorate food deserts and close out the presentation by surveying measures that fight food deserts and do not infringe upon liberty. No matter how much progress is made in combating food deserts, people will always have to choose between healthy and unhealthy dietary practices. However, as things stand coercive market forces create inequalities that contribute to food deserts. The government must act now to restore agency to low-income communities.
Abstract: On October 3, 1994, an American family, while driving in Italy, came under gunfire from masked robbers. While the family escaped from robbery with their material possessions, they lost their 7-year-old son, Nicholas Green, who was shot in head by the robbers. As heart wrenching as the story is, it becomes more so when the family decided to donate Nicholas’s organs.

In 2009, a Gallup poll showed that while 90% of Americans agreed to be donor at death, only 40% had a donor card and most of them had not shared their desire for organ donation with their family members, thus defeating the purpose. The low rate of organ donation, seen in other counties such as India, can be improved by increasing awareness about brain death. An increase in the awareness of organ donation after death and how it can benefit multiple patients can solve the problems of organ scarcity.

Organ donation is extreme altruism for loved ones, and more so for an unknown recipient. Do a counselor and physician have the ethical responsibility to warn a related living donor of the potential of suffering the same disease due to an inherited risk? Is the responsibility towards their own patient, who is in need of the transplant now, greater than that of the wiling donor as there is no doctor-patient relationship yet established?

The ethical and humanistic question is what is a fair distribution of altruism and finances? Any system of living donor will exploit the poor as opposed to organ donation after death. After brain death, organs are well perfused and oxygenated and donor does not suffer any consequences in so far as the dead donor rule is applied.

This presentation will highlight the importance of altruism, communication, and diversity to provide a humanitarian, ethical, and legal solution for organ donation.
The Third Leading Cause of Death in the United States: Hospitalization
Wade Robison, PhD
Department of Philosophy
Rochester Institute of Technology

Abstract: Mistakes in hospitals are now the third leading cause of death in the United States. You now have at least two reasons not to want to need to go the hospital — a concern about the prognosis of the condition that requires you to go there and a concern about dying once you get there because of a mistake by medical personnel. It is harder to make a mistake regarding something when there are a variety of ways of identifying it. The denominations of the euro thus come in different sizes with different predominant colors — red for the 127 x 67 millimeter €10, blue for the 133 x 72 millimeter €20, and so on. The ink can be felt, and the different denominations have different tactile patterns, with smooth bands and holograms in different locations. Electrical wiring is marked with the gauge number for the different sizes and comes in a different color for each gauge — yellow for #12, for instance. These multiple modes of identification are standard for situations where harm could come from a mistake — a loss of money, a fire from an overheated wire.

Standard — except in medical practice. A number of infants have died and others put at grave risk because hospital personnel have mistaken Heparin for Hep-Lock, the former a blood thinner for adults, the latter for infants. The story hit the national news when the twin newborns of Kimberly and Dennis Quaid almost died because of the mistake. The mistake was all the more tragic because a year before six infants in Indianapolis were given the wrong medication, three dying. The containers for Heparin and Hep-Lock are the same shape and size with their similar names in the same font, only the labels differently slightly in color. Anyone could readily mistake one for the other — let alone someone in a stressful situation working against time and taking medication from a cabinet that was supposed to be dedicated to medications for infants.

A 24-year-old woman lost her 35-week-old fetus and then her life because a feeding tube was coupled to a tube entering a vein. The tubes and connecting links were not color-coded and were not of different sizes. We may want to fault the nurse in such a case, but we ought to fault the system that fails to provide multiple ways of identifying an object so that mistakes are less likely. The medical profession has a lot to learn, and a lot it ought to learn, from other professions about how to minimize error.

The optimal solution would be a complete and thorough cataloguing of all the ways in which mistakes can occur in medical practice and a redesign of all the artifacts of medicine to ensure that the designs themselves do not provoke errors — with continual monitoring of new artifacts to ensure they do not introduce new ways in which mistakes can occur. This solution should include the following pedagogical initiatives:

- All those entering into medical practice — nurses, physicians, administrators, accountants, orderlies, and so on — ought to be taught to look for ways in which things could go wrong and, in particular, how things could go wrong through no real fault of those involved.
- A set of procedures ought to be in place in every medical facility to work with its practitioners — from nurses to orderlies and everyone in between — to check for ways in which harm could mistakenly occur.
The Ethics of Hippocampal Prosthesis as a Potential Future Treatment for Alzheimer’s Patients
Matt Schuler
Department of Philosophy
University of Arizona

Abstract: Research in neuroprosthesis appears to be reaching a critical mass: Yu, et al. (2016) have created “cyborg” rats (rats with chips implanted in the medial forebrain and somatosensory cortices) who demonstrate enhanced cognitive performance; Luo, et al. (2016) have utilized a silicon version of the cerebellum to demonstrate improved sensorimotor control and learning; Ochsner, et al. (2015) have made advances in cochlear implants to repair hearing (which involves bypassing the ear altogether – the implant sends sound signals directly to the brain rather than amplifying sounds, as hearing aids do); and perhaps most peculiar of all, Hartmann, et al. (2016) have shown that it is possible to create new sensory modalities via neuroprosthesis (in their case, this involved implanting a chip in the somatosensory cortices of rats enabling them to discriminate infrared light).

These developments are all tremendously fascinating. One not mentioned above, however, is particularly important and challenging both for the medical community and for philosophers and cognitive scientists. As many are now familiar, Hampson, et al. (2013) have shown that it is possible – in primates, no less – to create an artificial hippocampus such that the subject can read from, and write information back to, the chip component of this hybrid brain – and to do so at the individual neuron level; it is this finding I wish to explore in this presentation.

While I shall not be focusing on the possible philosophical implications of this research, it is worth flagging here that these implications are potentially quite significant. First, such findings provide strong prima facie (though defeasible) empirical support for “multiple realizability” and (physicalist) functionalism about mind, and they simultaneously tell convincingly against most varieties of dualism and some physicalist alternatives to functionalism (e.g., the Mind-Brain Identity Theory, especially as propounded by John Bickle, who maintains a radical anti-realizability view according to which memory always depends upon the CREB cycle). Second, Hampson and his colleagues have furnished philosophers with important empirical data that can be used to test theories on the nature of personal identity and its potential dependence upon memory. Third, when Hampson et al.’s findings are combined with the other recent findings in neuroprosthesis mentioned above, it looks as though we may be able to say something meaningful about the possibility of artificial intelligence – and, of particular interest, the surprising form it might end up taking.

But I save these latter ruminations for another occasion. What I am particularly concerned to address is the findings of Hampson and his colleagues in their work on hippocampal prosthesis, and the complex moral issues such findings raise for medical practitioners – and, indeed, for the medical community at large. Researchers working on hippocampal prosthesis are doing so, evidently, because they think it may eventually prove useful in the treatment of Alzheimer’s and related conditions. However, even if Hampson et al.’s findings with primates can be replicated in humans, it is not at all clear, as I shall argue, that such surgical procedures should actually be undertaken – even in cases of advanced Alzheimer’s.
The Political Illegitimacy of Biomedical Animal Experimentation

Marcus Schultz-Bergin
Department of Philosophy
Bowling Green State University

Abstract: Biomedical animal experimentation is a big industry and is getting bigger. Despite industry claims, recent findings published in *The Journal of Medical Ethics* found that the number of animals used in federally funded experimentation rose by 72% between 1997 and 2012 (Goodman et al. 2015). This increase has occurred despite a supposed commitment to reducing animal experimentation, a rise in public opposition to animal experimentation, mounting evidence of the inefficacy of animal experimentation, and the availability of alternatives to animal experimentation.

Much of this research – at least $12 billion per year – is federally funded through the National Institutes for Health. That means a great deal of animal research is funded by *us*, whether we support animal experimentation or not. I argue that such use of funds is *politically illegitimate* in a diverse and pluralistic society such as the United States.

I approach this topic first by introducing the Principle of Public Justification (PPJ), a principle which constrains legitimate State action by appeal to the commitment we all share to the freedom and equality of all citizens. According to the PPJ, a law is publicly justified (and so legitimate) only when every member of the public has sufficient reason of their own to endorse the law. My core suggestion is that many members of the US public do not have sufficient reason to endorse animal experimentation, and so the use of taxpayer funds for such purposes amounts to authoritarianism.

In order to defend the core argument, I will sketch and motivate the Principle of Public Justification as a general principle of legitimate State action, argue that many citizens have *defeaters* for animal experimentation and thus do not have sufficient reason to endorse it, and then consider what this means for the future of federally funded animal experimentation.
Abstract: Over the last ten years, reproducibility has been demonstrated to be a serious concern for psychological science and medical science. Attempts to reproduce their published conclusions have produced mixed and sometimes dismal results. This chapter begins to answer an important practical and epistemological question raised by these results. How does the reproducibility problem for medical science, and to a lesser degree psychological science, affect the confidence medical practitioners should have in their recommendations for patient care?

This presentation uses a 1991 study of oncology practitioners’ overconfidence in their recommendations to illustrate how the reproducibility problem affects how we should approach the risk of overconfidence in medical practitioners’ recommendations. In short, the reproducibility problem exacerbates difficulties in addressing overconfidence among medical practitioners. A previously published taxonomy of epistemically humble medical judgments (Schwab 2012) attempted to address practitioner overconfidence by focusing on the distinction between the intuitive judgments of practitioners and the direct application of medical science’s conclusions. But, this Epistemic Humility Taxonomy paid inadequate attention to the quality of medical science’s conclusions. The reproducibility problem illustrates that an adequate taxonomy should reference the robustness of these conclusions as a means to distinguish among medical science’s conclusions.
Toward a Humanistic Medical Education: An Analysis of Pre-Med Advising and Curriculum in Ohio Colleges and Universities

Daniel Skinner, PhD, Department of Social Medicine, Ohio University, Heritage College of Osteopathic Medicine
Kyle Rosenberger, MEd, Instructional Innovations, Ohio University

Abstract: Faculty, curriculum designers, and scholars alike have long noted the challenges of infusing humanistic perspectives into medical school education. Oftentimes, stakeholders point to a lack of flexible time within undergraduate medical education for humanistic topics in light of the demands of basic science and clinical training, and the looming presence of board exams. At the same time, the cultivation of physicians’ humanistic dimensions is increasingly being recognized as a keystone for meeting 21st century health care needs. These needs include cultural and linguistic competency, the ability to work in professionally expansive and diverse teams, flexible communication skills, and basic competency in health policy and politics. If medical school curriculum does not allow for a sustained and intentional focus on these perspectives, then what is to be done? Instead of engaging medical school curriculum debates, this presentation focuses on pre-medical education and advising. Considering time limitations within medical programs, but also noting changes in the MCAT, which now emphasizes competencies in the social and behavioral sciences, we suggest that the humanization of medical education calls for a renewed investment in the liberal arts in pre-medical education. Though many pre-med programs emphasize biochemistry, anatomy, and other science courses, often at the expense of liberal arts and humanities training, what are the prospects of working with pre-medical advisors to encourage students to nourish their critical thinking, cultural, and humanistic dimensions if those dimensions are, in fact, the key not to being doctors, but—increasingly—“great doctors”?

To understand the prospects of such a development, we will interview pre-medical advisors at Ohio colleges and universities in the summer and fall of 2016. Using qualitative the research software Dedoose, we will code the interviews to identify themes and trends. We will supplement these interviews with an analysis of pre-medical tracks, as available on institution web sites.
Abstract: One of the sources of the word medicine is the Greek word medomai. It means to be mindful of. The course I created in the past year called The Skilled Observer in Art and Science is precisely about that: being mindful.

Art, and science as a whole (and medicine in particular), are chronically misunderstood. People distrust scientists and doctors, and mystify artists. Doctors come in for more than their share of mystification as well. We need to educate ourselves as to how artists and scientists are natural allies; and how fluency with the arts and sciences empowers us.

What can art teach the scientist? How can art be a valuable ally to medicine? In recent years, the arts have been found to be highly effective adjuncts to the practice of medicine. This presentation will approach the intersection between the arts and medicine by discussing ways in which we can better understand science and medicine.
Abstract: Trust is an essential element in successful medical care. The patient must trust her doctors and other care-providers if she is to submit to their procedures and follow their instructions and recommendations both in and outside of the clinical setting. Patient trust is a complex phenomenon in at least two ways. First, it has both an epistemic and a moral dimension. Epistemically, patients must take themselves to have reason to believe in the informedness and practical competence of their doctors and other medical care providers. Morally, patients must take their care providers to have at least some genuine concern for them and for their condition, and in particular for the successful resolution of their medical condition. Second, patient trust involves a balancing act of the patient’s moral and epistemic appraisals of at least three relevant parties: her doctors/care providers, her family/intimate friends who are playing a role of support and assistance in her treatment (especially outside the clinical setting), and also, importantly, of herself and her own grasp of her medical and life situation. It is possible for a patient to evaluate any one of these parties as epistemically but not morally trustworthy, as morally but not epistemically trustworthy, as trustworthy in both senses, and as trustworthy in neither. Significantly, how the patient evaluates the trustworthiness of any one of these parties is likely to have an effect on how she evaluates the others (e.g. a patient may determine that, notwithstanding her doctor’s expertise, she is in a better position to understand and respond to her condition than he is, and so trust herself or her family/friends more than her doctor). In this presentation I articulate the foregoing distinctions and explore the different ways in which patient trust (moral and/or epistemic) can vacillate using Tolstoy’s description of the terminal illness and death of a patient in *The Death of Ivan Ilyich* for purposes of illustration. In light of recent discussions of epistemic and moral trust and the conditions under which it is legitimate or rational for an agent to place or withhold such trust, I then consider the question of under what conditions it is reasonable for a patient, especially one undergoing treatment for a serious or terminal illness, to have or withhold trust in the various parties (doctors/caretakers, family/close friends, and self). A significant conclusion of the presentation is that, while doctors in general are and should be taken to warrant a high degree of epistemic and moral trust, given the division of labor and lack of regular patient contact with a single family doctor or practitioner in much of contemporary medicine, the actual relationship that a patient has with any given doctor or caretaker is one where, from the standpoint of moral and epistemic criteria for trust themselves, there are cases where it is not unreasonable (and indeed may often be quite reasonable) for the patient to lose or give significantly less weight to her trust in her doctor or other care provider.
The American YMCA and Prisoner-of-War Health Problems during World War I
Kenneth Steuer, PhD
Department of History
Western Michigan University

Abstract: While the International Red Cross was primarily responsible for the inspection of health care in belligerent prison camps during the First World War, under the terms of the Geneva Convention of 1863, the American YMCA played an important role in addressing the health needs of sick and wounded prisoners. The Red Cross visited and reported on POW conditions in military hospitals, in lazarettes in prison camps, and maintained a war prisoner information database which was designed to locate and identify prisoner of war wounds and sicknesses to their respective governments. The International Red Cross also served as a supervising organization that worked closely with national Red Cross agencies. The International Red Cross did not assign personnel to prison camps but made regular visits.

On the other hand, the American YMCA sent welfare workers, known as secretaries, under the War Prisoners’ Aid program, who spent a great deal of time in prison camps across Europe and Siberia. One of the four major missions of the Association was to provide POW’s with physical relief. To keep men fit and healthy, the YMCA provided sports equipment and organized leagues for a wide range of sports. These athletic contests also attracted spectators who enjoyed watching these matches.

Another YMCA goal was education, which included vocational training, especially for wounded POW’s. Once out of serious danger, authorities transferred wounded men to prison camps, where they received the last stages of their treatment. The loss of a limb was a serious liability for wounded soldiers, since they often lost their livelihood, especially if they were craftsmen or were involved in heavy work. Secretaries obtained prosthetic limbs for soldiers who had lost arms and legs and provided them with the training which allowed them to learn new skills so they could support themselves and their families. This physical therapy was critical as a source of hope for seriously wounded prisoners.

As the war dragged on, adequate food supplies for POW’s fell precipitously in most countries. British, French, Belgian, and American prisoners received generous food parcels from home on a regular basis, so the reduction of rations was not a problem. However, Russian, Serbian, Romanian, Italian, German, and Austro-Hungarian POW’s did not receive food packets, due to foreign occupation, limited transportation facilities, or government decision, and therefore had to subsist on poor POW fare. Many prisoners succumbed to tuberculosis, dysentery, and other diseases associated with these poor diets. The first response of the YMCA was to provide POW’s with seeds so they could plant gardens to supplement their diets. However, as destitute prisoners began to eat grass, fight over food, or dig through garbage heaps, secretaries took the initiative. While the YMCA was not supposed to supply food to war prisoners, they arranged for special bread and food supplies to be sent to prison camps where POW’s were starving.

Probably one of the most important services the YMCA offered was to address the problem of “barbed-wire disease,” which was a form of debilitating mental illness. Prisoners arrived in prison camps, happy to have survived the fighting and eagerly joined camp activities, such as education and sports. But slowly over time, prisoners lost interest and simply isolated themselves from their comrades. Criminals in civilian prisons knew how much time they would spend behind bars and could look forward to their eventual release. However, POW’s sat in prison camps with no idea when the war would end and when they would be repatriated home. Secretaries recognized this mental disease and took steps to provide prisoners with stimulation. In addition to sports and education, the YMCA sought to provide entertainment as a third goal by organizing bands and orchestras, promoting theatricals, encouraging art work, and other activities that were designed not only to keep the participants happy, but to also encourage crowds to attend performances. The YMCA’s fourth goal, providing spiritual support for POW’s, this was also brought by the threat of “barbed-wire disease.” For many POW’s, the Christmas and Easter holidays were difficult, especially emotionally, since these men were separated from their friends and families. The Association made a great effort to provide religious services and decorations (especially Christmas trees and trimming) to help prisoners enjoy important holiday seasons.
Abstract: Music has long been recognized as a healing modality, just as it has long been an instrument for social change indeed revolution. Although these roles are described for centuries formal roles may be more in the 19th and 20th centuries. For instance, formal music therapy was established in 1950, and in general it is a long recognized and respected means of addressing specific deficits with carefully developed and targeted therapeutic interventions focused on a particular goal. Nigerian musician Fela Anikulapo Kuti used his music to critique imperialism and post-colonial society and stated that, “Music cannot be for enjoyment, music must be for revolution.”

Recognition of music’s power in healing, providing connection, building community, tying together civilizations has been longer in coming. Too, knowledge of the means by which music can accomplish this by engaging numerous regions of the brain has lagged behind understanding of brain regions facilitating use of spoken and written language. Oliver Sacks suggested that the slower response to investigating music’s impact came because musical deficits are less obvious the language deficits. Whatever the reasons, there recently has been an upsurge in the study of music, the brain, and healing, including discovery of brain regions that process music, and purposeful use of music to promote peace, community, reconciliation, global connection, and economic/educational opportunity. Of course, the use of music as a means to inspire, unite and ignite globally also is long established- the life histories of musicians such as Woody Guthrie and Pete Seeger show how they used their music to promote revolution.

Today, their impact is recognized- and popular media show how their message translates into a contemporary language of healing, “While Seeger is best known for using music for social change, an important part of his legacy is the potential of music to affect change on a personal level. When Seeger said, ‘This machine surrounds hate and forces it to surrender,’ he was throwing down the gauntlet. Music can heal.” (https://www.psychologytoday.com/blog/brick-brick/201402/does-music-have-healing-powers) Too, recognizing that community created by music—studies show, for instance, that inherent lack of empathy toward strangers vanishes after a brief interval of playing Rock Band—can promote change has translated into creation of organizations such as Playing for Change and Silk Road Ensemble.

The talk will provide an overview of developments in brain and music science, as well as a more in depth look at scholarship, movements and organizations that attempt to provide connection and global healing- in essence the use of music to foster healing social change. It will incorporate examples of this music-audio and audiovisual- while exploring how groups and individuals globally use their music to advocate for peace, women’s rights, reconciliation, healing, and connection.
Community Voices: Mental Health Research Needs by Consumers and Non-consumers of Mental Health Services
Lisa A. Szymecko, JD, PhD
General Medicine
University of Michigan

Abstract: The DECIDERS project (Deliberately Engaging Communities in DEcisions about Research Spending) aimed to develop and evaluate a method to engage communities in deliberations about health research funding priorities, emphasizing the voices of minority and medically underserved communities in the state of Michigan. For DECIDERS (NIA 1R01AG040138-01) academic-community partnerships adapted the simulation exercise CHAT (Choosing All Together) for research priority-setting using existing research agendas and interviews with community leaders, clinicians and key informants. Forty-seven groups (n=519) of community members from minority and underserved communities throughout the state of Michigan deliberated about health research priorities using CHAT in English and Spanish. Data collection included pre- and post-deliberation surveys measuring participants’ experiences with deliberations, and individual and group priorities. Within-participant changes in priorities from pre- to post-deliberation used a mixed-effect logistic regression model accounting for within-participant repeated assessment nested within groups.

Participants ranged from 18 to 88 years old (Mean 48.3); about 2/3 were women. Half of participants self-identified as white, 1/3 African-American, 7% Hispanic, 5% Native American, and 3% Arab, Arab-American or Chaldean. Most had incomes <$35,000/year, and 17% reported poor or fair health status.

Before deliberation, individual participants most commonly prioritized research about Mental Health (90.6%), Child Health (89.3%), Causes of Disease (85.6%), Promote Health (82.7%), Healthcare Quality (82.7%), Aging (81.1%), and Environment (81.1%). Access was the only type of research more likely to be selected after than before deliberation (77.2 vs. 84.0%, OR 1.63, p=.005). Improving Research (67.5→53.6%, OR .51), Policy Research (64.5→51.5%, OR .52) and Culture and Beliefs (55.6→46.0, OR .58) each became less likely to be selected after group deliberations (all, p<.001).

Groups overwhelmingly prioritized Child Health and Mental Health. Not only did nearly all groups (93.6% and 95.7%, respectively) select these types of research at some level of investment, a majority of groups chose the highest level of investment for these two categories. Deliberations provide some reasons why mental health research should be funded. However, reasoning was commonly based on secondhand knowledge or media exposure. In contrast, a focus group comprised of consumers of mental health and substance use disorder services prioritized mental health research but also access research. They offered reasons based on personal experiences and detailed stories that were just not captured in the larger population. This insight is particularly interesting as mental health consumers can be a difficult population to engage for a variety of reasons including lack of trust, poor alliances with providers, not being listened to, and not being given the opportunity to make decisions and collaborate in treatment. Cultural reasons including stigma, power, and limited exposure to research can also impact choices for engaging in mental health research.

This presentation looks at this deliberation process as a method for gathering voices, especially from minorities, underserved populations, and from consumers of mental health services. Analysis also includes the reasoning in the selection of mental health as a category for funding and compares input from consumers and non-consumers of mental health services.
Pulling Out: How the Oldest, Most Primitive Form of Contraception Might Be Just What the Doctor Should Order

Ruth Tallman, PhD
Department of Philosophy
Barry University

Abstract: Patient non-compliance is one of the most vexing problems health care providers face. Well-meaning physicians, therapists, nurses, and dieticians strive to prescribe the medically best drugs, therapies, and lifestyle behaviors to their patients. They are understandably frustrated in finding that their patients often appear to blatantly ignore their recommendations. It’s easy to blame the problem on a patient’s weakness of will or lack of interest in health. However, I will argue that patient noncompliance may often be the result of radically different value sets butting up against each other. The health care provider, looking through a relatively narrow lens whereby health is always given primacy, sees one clearly best recommendation. Yet the patient’s lens is almost always going to be much more broad, and may well see the physician’s recommendation as not even close to the best option.

I will consider the withdrawal method of contraception, widely regarded as “not a method” by health care professionals, but used by one in three women at some point in their lives. Executed perfectly, withdrawal has a 4% failure rate, only one percent higher than condoms. Yet actual, imperfect use of withdrawal has a whopping 27% rate of failure! In light of these statistics, some argue that health care practitioners do their patients a great disservice in failing to even discuss withdrawal as a form of contraception.

A woman and her health care provider might share the same end-goal – to avoid pregnancy. To that end, the health care provider recommends the most effective methods of contraception, while spurning less effective ones, like withdrawal. But the patient, for reasons of her own, knows she is not going to use those most effective methods. Being counseled against withdrawal is not going to stop her from using this method, but it may inhibit her from using it maximally effectively. When she ends up with an unwanted pregnancy, the health care provider’s belief that withdrawal is “not a method” is confirmed, the patient is labeled noncompliant for failing to follow the health care provider’s contraceptive advice, and the desired health outcome – remaining pregnancy-free – has not been met.
Awareness: How Mindfulness can be used Within Health Professionals
Melanie Tsesler
Humanities Department
York University

Abstract: “Job-related chronic distress is an occupational hazard for healthcare professionals affecting around 38% of primary care personnel, and has been linked to burnout, low health status levels, and outcomes such as worse patient safety and poorer quality of care” wrote the Frontiers in Psychology journal. The healthcare industry is under pressure to cut costs and improve quality but at what costs to the practitioners’ and patients’ overall health? We are in need of delving into new innovative management processes and organizational strategies that can be implemented to deliver better value for money, not only in terms of reduced wait times and costs, but also in terms of better care from healthcare practitioners leading to overall improved quality of services to patients.

I am interested in humanizing medicine by delving into the actual delivery of health care by considering long-term policy changes by looking at the effects of incorporating mindfulness into the training of healthcare professionals to improve the way they practice as oppose to providing “band-aid” solutions that prove only to be short-term answers. The increasing awareness of burnout and stress among physicians and how this subsequently affects patient care might explain the growing interest in mindfulness (the mental state achieved by focusing one’s awareness on the present moment).

I intend to use scholarly work to investigate how preventative measures can increase overall well-being and medical care.
Human-Nonhuman Chimeras, Ontology, and Dignity: A Constructivist Approach to the Ethics of Conducting Research on Cross Species Hybrids

Jonathan Michael Vajda
Department of Philosophy
Western Michigan University

Abstract: Developments in biological technology in the last few decades highlight the surprisingly ever-expanding practical benefits of stem cells. With this progress, the possibility of combining human and nonhuman organisms is a reality, with ethical boundaries that are not readily obvious. These inter-species hybrids are of a larger class of biological entities called “chimeras.” As the concept of a human-nonhuman creature is conjured in our minds, either incredulous wonder or grotesque horror is likely to follow. This presentation seeks to mitigate those worries and demotivate reasonable concerns raised against chimeras research, all the while pressing current ethical positions toward their plausible conclusions.

In service of this overall aim, first, I intend to show that chimeras are far less foreign and fantastic in light of recent research in the lab; second, I intend to show that anti-realist (so-called “constructivist”) commitments regarding species ontology render the species distinction (i.e., the divide between human and nonhuman) superfluous as a basis for ethical practice; and third, I discuss some prevailing dignity accounts regarding the practical ethics of the creation, research, and treatment of chimeras. Consequently, I intend to show that the adoption of a particular set of views (constructivist ontology, capacity-based ethics) in conjunction with recent research ought to justify a parallel with what we accord to humans persons, and that trajectory allows for cases of moral permissibility.
Religious and Cultural Diversity: A Catalyst for Structural Changes in Health Care Chaplaincy
Cindy Visscher, PhD
Department of Comparative Religion
Western Michigan University

Abstract: The potential effects of increases in religious and cultural diversity on social structures in the United States is an ongoing topic of discussion in the sociology of religion. One aspect of the discussion is the question of how religious and cultural diversity may shape public policy, regulation and organizational structures, and; conversely, how public policy and regulations that address diversity may affect American civic life. That broad question remains an open topic of study, but there are social microcosms and cases that indicate the kinds of social change that may happen.

The health care system is one of the social structures where public regulation has affected policy and practice through the Patient Protection and Affordable Care Act, which requires health care systems to measure and address disparities in the quality of care for racial and ethnic minorities. Additionally, The Joint Commission on the Accreditation of Health Care Organizations has, in effect, provided a formal foundation for de-secularization of the hospital as a public space through accrediting standards requiring that diverse religious and spiritual needs of patients are assessed and cared for.

All health care professionals increasingly need to demonstrate competencies in providing patient centered care that meets diverse cultural and religious/spiritual needs. Health care chaplains, who serve patients and their families in some of the most traumatic health care situations, demonstrate these competencies as well. Chaplains serve two constituencies: their patients/health care organization and their denominational source of religious training and authority. A third group of organizations also affect the career of a chaplain. In order to obtain qualifying credentials, of which the highest is a Board Certified Chaplain, chaplains work through chaplaincy associations that offer Clinical Pastoral Education (CPE) and verify educational and other requirements for certification. Accreditation for organizations that provide CPE is offered by the Association for Clinical Pastoral Education and CPE is carried out at health care organizations where chaplains can also meet patient contact requirements.

Chaplaincy practice and training is a cross-religious or interfaith endeavor but historically, a Master of Divinity degree based in Christian theology has been the standard educational path to certification. An aspiring chaplain may request an examination of educational equivalencies, however equivalencies still tend to be organized to align with the content of a Master of Divinity degree. The historical structure of chaplaincy associations and the barriers to entry in the field for religiously diverse chaplains has been a topic of concern among the organizations in recent years, though significant change did not occur until April of 2016. At this point the Health Care Chaplaincy Network bypassed the collaborative model and established the Spiritual Care Association, making significant changes to educational requirements and CPE training that eliminated many of current barriers to a career in chaplaincy.

This presentation will take a case study approach and examine the impact of growing cultural and religious diversity on the profession of health care chaplaincy which may be secularizing, or like hospitals, may be creating a newly understood religious space.
A Buddhist Alternative: Mindfulness Meditation for Post-Traumatic Stress Disorder
Jordan Wadden
Department of Philosophy
Ryerson University

Abstract: Post-Traumatic Stress Disorder is a debilitating condition which affects a significant minority of individuals exposed to even a single traumatic event. Symptoms can persist throughout life, even with treatment, thus permanently altering the established flow of an individual’s daily routine. I am proposing that mindfulness meditation, abstracted from Tibetan Buddhism, could be utilized to add a more human element to treatment at the neurological level. The combination of meditative practices with neuroscientific analysis is a growing sub-field with the potential for many interesting and enlightening solutions to current problems. This presentation combines neuroscientific studies, Buddhist religious teachings, and Eastern philosophy to demonstrate that we may want to spend more time on humanistic approaches either alone or, better still, in tandem with medication and therapy.

The first section of this presentation addresses neurobiological factors of note in patients with PTSD. First, a reduction in hippocampal volume, proposed to be through pre-existing genetic factors or from neurotoxic effects from trauma, has been reported in adult patients with PTSD. When Villarreal et al. underwent their 2002 study to their knowledge no study had examined total volumes of white matter in PTSD. What their results showed was that there is a significant white matter reduction in PTSD patients which is not connected to hippocampal volume and is therefore an independent result of PTSD. This unexpected result is the second focus for this section. Nearly ten years later, Fani et al. conducted a study to compare the effects of trauma on white matter in patients that developed PTSD against trauma that did not result in PTSD. They found that PTSD sufferers demonstrated significantly lower white matter integrity in the posterior regions of the cingulum bundle than non-PTSD patients. As both hippocampal volume and white matter fibres participate in the retrieval of trauma-related memories, they need to be addressed in treatment.

The second section of this presentation addresses mindfulness meditation and how it is being employed in other detrimental psychic ailments (most notably, depression). Zindel Segal has suggested that mindfulness training can play a role in preventing depression from returning. He and his colleagues have developed a Buddhism-inspired mindfulness-based therapy focused on body-scans and awareness to thoughts. Hözel et al. have found that the anterior cingulated cortex plays a significant role in the development of mindfulness meditation as it enables executive attention. It appears that, even in relatively short periods of time, mindfulness meditation can increase white matter integrity in the anterior cingulated cortex. Tang et al. have proposed that the change in white matter efficiency influences the functionality of white matter neuroplasticity. Thus, any meditation that increases white matter integrity could provide means for prevention and treatment.

It is not a leap to translate these findings to PTSD patients, who have been found to have reduced white matter integrity, thus leading to non-medicative resolutions for the disorder. I then conclude by briefly addressing whether the spiritual aspect of the Buddhist tradition is a necessary element for the full impact of this treatment.
Experiencing Symptoms of Mental Illness
Ashley Walker, MD
Department of Psychiatry
The University of Oklahoma Health Science Center

Abstract: It is generally easy for health care providers and others to empathize with patients who experience various medical problems but appreciating and understanding the experience of persons with mental illnesses can be more challenging. Mental illnesses continue to be imbued with stigma, and the experience of symptoms such as hallucinations, severe depression or difficulty integrating sensory input is somewhat foreign to many. Mental illnesses are often referred to as “invisible disabilities” – those that are not always obvious to the onlooker, but cause impairment in function. In addition, some people including health care providers may feel that symptoms of mental health problems are things people should be able to “get over” if they only tried hard enough.

The purpose of the exercises that will be introduced at the start of the theme session on “What Mental Health Patients have to Teach Health Care Providers” is to have the participants engage in simulations of what it is like to deal with some of the symptoms of mental illnesses in an effort to raise awareness and empathy, and to set the stage for the remainder of the theme session.
Voices of Life but Not of This World: The Use of ‘Impossible Illness Narratives’ in Health Education
Rosemary Weatherston, PhD
Department of English
University of Detroit Mercy

Abstract: Illness narratives—“constructed representations of the interior experience” of sickness or impairment—are a common fixture in health care and health humanities classrooms. Non-fiction illness narratives, in particular, are used promote a wide range of pedagogical goals including but not limited to: bringing “the voice of the life world” into conversation with “the voice of medicine;” demonstrating distinctions between subjective experiences of illness and categorical diagnoses of disease; enabling students to practice perspective taking; providing focal points for students’ reflection on their own beliefs and practices; making concrete the abstract concepts of professionalism; illustrating healthcare inequities; stimulating discussions of ethical quandaries; developing students’ ability to conduct narrative analysis; and adding to students’ “stores of imaginative vision.” Instructors incorporate many different types of narratives towards these ends, such as oral histories, interviews, essays, books, videographies, and graphic memoirs.

Despite its pervasiveness, however, the use of non-fiction illness narratives in health education is not without its controversies. Some detractors blanketly condemn the privileging of narrative in medicine while others are wary of the ways in which illness narratives may promote culturally-bound, normative models of selfhood.

Other critics are less concerned about the use of illness narratives than their potential misuse. They warn against consuming illness narratives as if they provided access to the authentic subjectivities of others unmediated by genre conventions or representational strategies. They are troubled by “celebratory” readings of illness narratives that position voices of the life world is strictly antagonistic relationships with a monolithic, oppressive voice of medicine.

In contrast, other critics are more concerned about some readers’ tendency to reduce illness narratives to case studies, mining the texts for diagnostic facts and ignoring the particularities of individual experience. Still other critics object to listening and reading practices that focus exclusively on the narrating individual, eliding both content and conditions of production that point to the social nature of illness and narratives about illness.

Rather than trying to resolve these controversies, in this presentation I reframe the issues driving them by making a case for incorporating “impossible illness narratives” into health care and health humanities classrooms.

Impossible illness narratives are fictional first-person accounts of sickness or impairment that, by means of their point of view or content, could never be produced in the real world. Carolyn Barbier’s “Nighthawks,” for example, purports to be the real-time first-person narration of a ventilator-dependent patient as she decides to die. In Octavia Butler’s classic short story “Bloodchild” a young man struggles with his status as a breeding host within complex familial and social relations entwining terran and alien species.

Deeply defamiliarizing, impossible illness narratives resist conventional frames of reference and interpretation. Instead, they require readers to employ unique reading strategies grounded simultaneously in narrative humility and structural awareness. Rather than sidestepping the thorny issues of representation, production, and consumption involved with the use of non-fictional illness narratives, however, I contend that impossible illness narratives offer students and instructors a unique vehicle through which to directly engage them.
Health as Virtue: Self-Cultivation and Self-Care
Daniel Weissglass, MA
Department of Philosophy
The City University of New York College of Staten Island

Abstract: A fundamental and universal right to health is articulated in the constitution of the World Health Organization’s (WHO) and the United Nation’s Universal Declaration of Human Rights (UN). While these documents differ somewhat on what this right constitutes – with the WHO stipulating that humans are entitled to enjoy “the highest attainable standard of health” (WHO 1946) and the UN pressing for “a standard of living adequate for the health and well-being of himself and of his family” (UN 1948) – both take the maintenance of a basic standard of health for the citizenry as an obligation of the state. As these documents represent a wide range of cultural perspectives, and as health is essential to human well-being, it is certainly plausible that health is a non-trivial right.

While it is widely accepted that the freedom to pursue health is a right, it is much less clear whether there is any obligation to utilize that right. This presentation defends the controversial view that there is a moral obligation to pursue health as defined by the WHO – “complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO 1946). Our view is rooted in virtue ethics, a branch of ethical theories for which the primary moral obligation is the inculcation of virtues – traits the possession of which indicates, contributes to, or constitutes moral excellence. We cite work in moral theory as well as the health sciences to demonstrate that health is a virtue, and defend the consequent moral obligation of self-care.

We motivate the obligation to pursue health by reviewing empirical evidence that suggests that the pursuit of health contributes significantly to the well-being of the self, others, and society at large. The complex value of health shows the pursuit of health to qualify as self-regarding, other-regarding, and society-regarding duty. We further show that this intersection is characteristic of virtues more generally.

We consider objections to the normative demand to pursue health based on the association of this demand with prejudicial attitudes towards those who do not conform to the normative model, generally clustered together under the title ‘ableism’. We show that ableist attitudes are not a product of the treatment of health as a virtue, but rather a misconstruction of what a virtue is. We show that the model of health as virtue developed here is not vulnerable to this sort of misuse.
Philanthropy and Medicine in 17th Century France:
A Family Affair, Marie de Maupeou Fouquet and Sons
Leigh Whaley, PhD,
Department of History and Classics, Acadia University
School of Continuing Studies, University of Toronto

Abstract: This presentation is intended to introduce the multi-faceted medical philanthropic contributions made by members of the Fouquet family led by Marie de Maupeou Fouquet (1590-1681), named “la mère des pauvres” (mother of the poor)” by courtier and historian Louis de Rouvroy de Saint Simon (Vol. 5, 1958, 265). Born in 1590 and raised in a devout and privileged family, the life of Fouquet followed countless paths from that of wife and mother to serving the poor sick as a Lady of Charity. Perhaps her greatest contribution in terms of medical humanities was her compilation of a medical receipts text in conjunction with one of her sons (Louis Fouquet) and a medical doctor named Delescure from the University of Montpellier. The Recueil de receptes, choisies, experimentées & approuvées contre quantité de maux fort communs, tant internes qu’externes inveterés, & difficiles à guerir, first published in 1675, was circulated amongst dioceses in France in manuscript form for use in private homes and hospitals years before its publication. Once published, it was translated into major European languages and circulated on the continent well into the 19th century. Historian of medicine Matthew Ramsey has commented that, “The most prominent of the charitable handbooks and perhaps the most successful of its kind in early modern Europe was the Charitable Remedies of Madame Fouquet.” (Ramsey, 1992, 103) This text became the “vade mecum” for Vincent de Paul’s nursing Sisters of Charity and parish priests. (Brockliss and Jones, 1997, 271)

Although Madame Fouquet is the key figure in this story, medical philanthropy for the Fouquets was a family affair and thus any discussion of Madame Fouquet’s work would not be complete without the inclusion of her sons, both men of the church. Working with their mother, they engaged in a wide range of charitable works whose focus was the sick poor. As archbishop of Narbonne, François, (1611-1670) founded hospitals at Agde and at Pézenas. Louis (1633-1702), bishop of Agde, wrote the rules for general hospitals for the communities of Pézenas and Agde.

Marie de Maupeou Fouquet and her sons dedicated their lives to Christian piety and charity. Committed to and imbued with the new Catholic Christian piety, they sought to make a difference in the lives of the sick poor through diverse acts of medical philanthropy.
The Ethics of Patient Satisfaction Surveys
Andy Wible, PhD
Department of Arts and Humanities
Muskegon Community College

Abstract: Patient satisfaction surveys are frequently used to measure how well hospitals and clinics are serving patients. Medicare will even base 30 percent of reimbursements on such surveys. The reasoning is that if facilities are to provide high quality patient centered care, then it is imperative that patients’ experiences are carefully considered. Yet, many are concerned that such surveys are not good for medicine. They do not correlate to better patient outcomes, they lead to spending on frivolous things, and often harm good employees. Patients often do not know how to properly judge what is good for them or society. This presentation will examine the benefits and pitfalls of patient satisfaction surveys and offer morally appropriate ways for society to use them that defend public health and clinical outcomes while also protecting patient autonomy and satisfaction.
Disorder versus Difference: Does it Matter?
Sara Worley, PhD
Department of Philosophy
Bowling Green State University

Abstract: One of the problems bedeviling philosophy of psychiatry, and psychiatry itself, is arriving at a criterion which can distinguish disorder from mere difference. This problem most famously arose in the dispute over how homosexuality should be regarded, but has also been evident in the recent disputes about whether to continue to include a grief exception for depression, and also in the claims of some activists that some conditions, e.g., deafness and autism, should not be classified as disabilities or disorders, but as differences. There has, consequently, been a considerable literature focused on the question of just how we should distinguish disorder from mere difference. Some, however, have challenged this project, not only on the grounds that there is no principled way of making the distinction, but on the grounds that there is no need to make it. Whether some condition is a disorder seems to have no bearing on whether, or how, it should be treated. Someone who needs assistance coping with the terminal illness of a loved one, for instance, might benefit from and be deserving of therapy even though needing such assistance is not reflective of any disorder.

In this presentation, I argue that there is at least one important reason for continuing to make this distinction. That has to do with the ‘sick role’. As members of society, and as the occupants of particular social roles, we all have certain normative demands placed on us. As a citizen I’m expected to obey the law, as a parent I’m expected to care for my children, and as a professor I’m expected to teach and do research. But we do also sometimes exempt people from some of their responsibilities in virtue of their health status.

Someone who has the flu is not expected to go to work. It’s also the case that some of us have a harder time than others in satisfying certain responsibilities, because of cognitive, emotional, or motivational differences. For instance, people seem to vary in the amounts of self-control that they are capable of. Some people might find it especially difficult to obey certain laws, because they find it hard to resist certain impulses. But we don’t generally regard mere difficulty as an excuse for not obeying the law. But we do exempt some people. I argue that one of the important roles that a distinction between disorder and mere difference can make is precisely in helping us determine when such exemptions are appropriate. To put the point excessively crudely, someone who is disordered has grounds for such an exemption, whereas someone who is not, does not.

I argue further that the connection between exemption and disorder goes both ways. Not only do we use judgments of disorder to determine whether and when people should be exempted, but our normative judgments about when people should be exempted (should) enter into our judgments about which conditions count as disorders and which do not.