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Does Race and Ethnicity Influence Decisions of Medical School Admissions Committees: A Grounded Theory Study
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Abraham Flexner’s initial report on medical education gave the nation a greater understanding toward a balanced and streamlined standardization of medical education. Over the years, the curricular components of medicine have gone through many evolutions of science, research and experiment in order to advance itself through time. What has not advanced is the number of African American students that apply and/or matriculate into medical schools and residency programs.

The grounded theory methodology was used in this study to examine the role race and ethnicity played in the selection of applicants within southern regional medical schools (SRMS). SRMS admissions committee members were approached using the snowball recruitment method. Participants were interviewed and described their experiences of serving on the admissions committee. Through the constant comparative method used in this qualitative research methodology, a formal theory that explained the relationship between the themes and the research question emerged.

The theory, The Confounding Loop, shows the relationship between four themes experienced by members of the admissions committee: powerlessness, the responsibility to do something, evaluating ideologies and institutional awareness. The theoretical categories along with the bidirectional linkages that are used to propel this loop, indicate a cycle of status quo, which is evidenced by the challenges in creating a systematic and systemic shift at increasing diversity. As medical schools look to advance their mission with respect to diversity, there is a conflict that exists within the standard system that is created to evaluate applicants. This system is rooted in “more of the same” creating the circular pattern that many times committee members are not even aware that they are a part of.

Further research is recommended to understand the systematic and systemic institutional designs that continue to pose challenges and concerns to advance diversity missions in medical schools. There is also a need to describe methods of breaking through this circular pattern to affect and influence recruitment and selection for a more diverse group of applicants.
In this session, the emotional territory of loss will be explored through poetry. Facing the end of life and losing a loved one are among the most wrenching of human experiences and healthcare providers, by profession, must deal with supporting individuals through these difficult transitions. Poetry offers light and healing as it expresses in words what is deeply felt.
According to Arnold Van Gennep, there are three stages of transition that accompany a change of state, place, position, or age. They are separation, marked by a person being stripped of status and thereby detached from the social structure; limen, where the person enters an ambiguous period of transition; and aggregation, in which a subject is given a new status. This state of liminality, primarily found in the second stage, can be perceived either first-personally or third-personally. From the subjective perspective, this kind of description can be given when a person becomes aware (either through diagnosis or otherwise) of an illness condition within themselves. For example, when Dr. Devan Stahl was informed by a neurologist that she had MS at age 23 (after looking at her MRI for mere moments), Stahl says, “I am speechless. MS? I did not see this coming … All the energy leaves my body. I have no more questions. I curl up into the fetal position and a large needle is inserted into my spine; my diagnosis is confirmed. I have multiple sclerosis.” Stahl finds herself unable to properly grasp her own identity, and cannot even formulate the questions necessary to begin rebuilding her image as a person with MS. She experiences a separation from her previous self, and thereby a separation of her previous place in the social order, entering a state of limen. Upon further processing and reflection, it is hoped that patients like Stahl will eventually come to understand and accept their new role and status, and experience aggregation, though this is by no means guaranteed by the mere concept of liminality. Indeed, there are numerous stages of liminality, and even if Stahl comes to accept her identity as a person with MS, she would still be liminal in the sense that she has learn how to live with it and interact with society and family as a person with MS. This is why, third-personally, the story is similar. Using the same example, Stahl’s family began to perceive her differently and, by her sister’s own admission, did not know how to properly interact with her immediately following her diagnosis. These stages of liminality often overlap or run into each other, so examining how they effect something like the advance directive debate ought to bear fruit, in my estimation.

Therefore, in this presentation I will examine the concept of liminality in relation to a person with dementia. First, I will offer an exposition of liminality as a concept and attempt to explain its importance in social functioning and the structuring of society. Second, I will argue that the concept of liminality applies to the person with dementia and show how this alters the ways in which society understands and interacts with that person. Finally, I will use this application of liminality to the person with dementia to undermine arguments for the authority of advance directives in the care of such patients. It is my aim to challenge the prevailing picture of advance directives as the solution to most end-of-life care debates by casting doubt, even theoretically, on when they should be applied to patients.
Infants Feel No Pain and Don’t Remember
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Until the Anand-Hickey paper of 1987 (Pain and its effects in the human neonate and fetus, NEJM 317 (21): 1321-1329) it was widely taught in US Medical Schools that infants do not feel pain. This belief, which persists today among many physicians, was the basis for operating on children even over one year old without anesthesia; in fact, it was a parental complaint which inspired Anand and Hickey's research. Routine infant circumcision continues in the US, in many cases without anesthesia, in all cases without fully effective anesthesia.

The widespread belief among US physicians that infants feel no pain may be related to the unique prevalence of infant circumcision for medical reasons in the USA. The work of developmental psychologists such as Ronald Goldman and Darcia Narvaez has documented not only the mistaken nature of this belief, but its traumatic consequences for human development. In the face of overwhelming evidence that has led other English-speaking countries to abandon the practice of circumcision, it is striking that the practice continues to be routine in many parts of the USA.

A parallel and complementary belief, often repeated by physicians, is that adults do not remember the pain they suffered as infants. This belief has also been amply refuted by scientific literature in recent decades, notably in the research on PTSD developed by Bessel van der Kolk, Stephen Porges, and others.

This presentation will first document the prevalence of the beliefs that infants feel no pain and don’t remember; it will then cite the scientific literature establishing the contrary; and then raise the question of how and why these beliefs arose and remain widespread. I will argue that the beliefs may in some cases be a manifestation of PTSD, and more generally reflect a dehumanization of infants implicit in the medicalization of childbirth and the commercialization of infant care especially since WWII. The authority of the practice of medicine in the United States is related to these widespread beliefs, which raise questions both about medicine’s self-understanding, its influence on the larger society, and its role in the economy of commodification of human life.
The leadership of a hospital has significant responsibilities to the patients, employees, and broader communities they serve. These responsibilities include creating policies, setting in place processes among their healthcare providers, and educating its staff and community. All of these should aim at providing quality healthcare to their communities broadly and reaching the best decisions in individual cases. Furthermore, it is the supposition of this presentation that all of these responsibilities require hospital leadership to have the best available conceptual understanding of their profession and role in the community. We can see that problematic epochs of medical history were grounded in flawed understandings of the key concepts of medicine—to wit, the superstitious medicine of the middle ages and the paternalistic medicine of nineteenth and twentieth centuries. Are our conceptual understandings of medicine better today? Two recent studies by Rathert et al. and Houston et al. seem to indicate that the vast majority of cases do not leave caregivers confused about what to do. Thus, the majority of cases appear to be ones in which no intractable conflict arises among healthcare professionals and families. This frequent agreement among involved parties means that most decisions in healthcare are resolved without strife—in other words, there is no breakdown.

As desirable as this broad agreement is, it has two less desirable side-effects. First, this surface agreement covers-over substantially deeper rifts in the conceptions of health as it is understood by the different parties. Secondly, the fact that agreement is so often reached without careful reflection can lead healthcare leadership to think that the foundation for a solid conception of healthcare is fully intuitive to caregivers. Occurring together, these two side effects can cause catastrophic breakdown in the minority of cases that are not resolved quickly. Even though the cases of catastrophic breakdown are the minority, they are common enough that they too have become normalized. This breakdown is often overcome by the exertion of institutional power, typically one medical professional exerting power over another, or the medical institution exerting power over patients. The consequences of this exertion of power is also normalized as “just part of the moral distress of the job” or “just part of participating in your own care.” Yet, the frequent agreement in medical decisions should not lead us to ignore the weak conceptual foundations at work in many aspects of healthcare today. Here I argue that serious effort to work-out a conception of health is of the first importance among these conceptual foundations in need of clarification. Differing and incompatible conceptions of health are often the root cause of both instances breakdown in medical decision making, and the normalized stresses of medical care. This presentation seeks to present the differing conceptions of health at work in contemporary healthcare, how they are the cause of some of the most intractable contemporary problems in healthcare, and the way in which continuing to suppress these differences exacerbates these problems. I close by suggesting ways this situation could be improved.
Photography on the Brain: The Harvey Cushing Brain Tumor Registry, 1902–1938
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This presentation explores the place and limitations of photography in medicine by examining the holdings of the Harvey Cushing Brain Tumor Registry at Yale University, which include over ten thousand photographic negatives. From its inception in 1839, photography was adopted by medicine for its exactitude of image and speed of production. Photographs were conceptualized as reproductions of reality rather than merely representations drawn by hand, endowing the medium with powers of objective truth and leading to its adoption as an epistemological tool providing empirical evidence for experimental and diagnostic purposes. The force binding photography and medicine is the desire to visualize illness in order to categorize, diagnose, treat, and educate—that is, to create knowledge by way of seeing.

Dr. Harvey Cushing, the founder of modern neurosurgery, relied upon photographic portraits of his patients to study their maladies and track their progress. The approach to creating the photographic portraits in the Registry descended methodologically from photographs of psychiatric patients created in the preceding decades, which employed the “science” of physiognomy undergirded by the dualistic belief that a person’s state of mind left physical traces on the face. For Cushing, however, mental disorders were symptoms of brain disorders, indicating his underlying conviction in a materialist philosophy of mind, in which the mind is a neurophysiological effect of the brain. With the impossibility of being able to directly see the invisible workings of the mind, Cushing adhered to photographic technologies to visualize the physical symptoms of neurological disorders and disease.

However, no single visual medium could encompass or reveal all of the connections among symptomatology that Cushing sought. X-rays, discovered in 1895 while Cushing was a student, provided a model of visual transparency to which he aspired. He brought radiographic photographs together with photographic portraits, perimetry, photomicrographs, histologic samples, and post-mortem documentation to create visual composites resembling collages. The composites rely upon juxtapositions of imagery and text to form taxonomies of illness and to create a story of diagnosis, treatment, and outcome for each patient. By juxtaposing radiographs revealing the body’s interior with photographs depicting the exterior, and by shifting scales between measurements of the full body and microscopic slides of histologic samples, Cushing was reaching for a simultaneity of vision that could encompass the living body’s interior and exterior that was unavailable within any single image or medium. The connections among internal and external, macro- and microscopic, as well as the phenomenological experiences of the patient recorded using perimetry and patient histories, strive for a comprehensive knowledge through visualizing illness. However, the gaps between images admit to gaps in knowledge, and uncertainties of diagnosis and etiology are admitted in the notes, with the seeming hope that the composites would prove useful for future study while also revealing the limitations of photography.
Recent research on placebos shows that they can have a positive therapeutic result even when the patient is fully informed of their inert content. This presents a new puzzle about the implications of placebo use. The traditional objection to placebos is that they involve deception, which is in straightforward violation of various professional codes of ethics in medicine. Yet these recent discoveries about non-blinded placebo use apparently indicate voluntary self-deception on the part of the patient. Codes of medical ethics typically classify deception as a violation of the principle of respect for the patient’s autonomy. The same reasoning may presumably apply to self-deception: it is consistent with deontological constraints to say that a moral agent can violate her own autonomy. The question this presentation pursues, though, is whether or not the use of non-blind placebos does in fact violate the patient’s autonomy. Does non-blind placebo use imply self-deception, and if so, is this ethically problematic? The presentation discusses possible analogies with self-aware deception, such as responses to films and other art-forms, to determine the ethical implications of the recent information about unblinded placebos. The presentation concludes by speculating about the implications of the relation between self-deception and autonomy for clinical medicine in general.
Susan Sontag famously argued that we should do away with metaphors for illness, insisting that “the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking.” Drawing on both research and her own experience as a cancer patient, Sontag pointed to ways that metaphors can cast a moral judgment on the ill through their excess of meaning, leaving the patient to contend not just with the illness but also the ideas (and stigma) about what it “means.”

Of course, and just as famously, Sontag herself extensively relied on a metaphor in that same book, presenting illness as citizenship in a different country. As Sontag’s larger conceit suggests, metaphors about illness may not just be inevitable but may also be a helpful tool for patients to make sense of their own experience. The linguist Elena Semino and her research team found that the common illness metaphors of “battle” and “journey” could be used in both empowering and disempowering ways. Similarly, in drawing on both the research and their own clinical experiences, physicians Gary Reisfield and George Wilson argue that finding the right metaphors can support the therapeutic relationship and “serve as the basis for the shared understanding of clinical reality.”

Starting from the premise that metaphors can be both damaging and empowering, this sixty-minute interactive workshop engages participates in the work of generating new possible metaphors for experiences of common illnesses. After briefly discussing Sontag’s argument, we will focus on military metaphors in the context of cancer, analyzing their implications for how we might understand what it means to be a patient, caregiver, and physician. Then, we will explore alternate possibilities, e.g., cancer as a “judo match,” as presented by poet James Dickey, and as citizenship or immigration as described by Sontag and poet Anya Silver.

The bulk of the workshop time will be spent in teams generating additional possibilities of metaphors that describe various kinds of illnesses (e.g., addiction, depression, cancer, infectious diseases) and then examining their implication for how those metaphors present the role of the patient, the physician and medical team, and the caregiver.
Is There a ‘Medical Student Personality’?
Hidden Diversity Among Students Pursuing Healthcare Professions
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Some educators of students who intend to pursue medical or nursing careers recognize some fundamental forms of homogeneity among them, e.g. attribution of certain behaviors to having a ‘medical student personality.’ Certainly, meaningful commonalities and acknowledged forms of diversity exist among students in the same institutional and programmatic setting. However, research by the 4C Project, sponsored by the National Science Foundation, reveals that there are hidden forms of diversity in the STEM classroom, even among those who share cultural and demographic factors as well as an intent to pursue a career in, or related to, healthcare. A composite survey consisting of validated scales and subscales probing personality and moral values was offered to STEM students in four distinct higher education institutions, and our project team collected over 200 responses from students in ‘care’ majors such as nursing and biology/pre-med. While some statistically significant differences were identified based on readily identifiable distinctions between participants, our results demonstrate high levels of less-apparent diversity, such as differences in values and personality traits, within groupings that may otherwise appear to represent a high level of commonality. Our methods include Latent Class Analysis (LCA) to explore non-linear relationships in the survey data. Using LCA, we have examined each major section of the survey and created profiles based on how respondents answered the questions. With our mixed-methods approach, analysis of these LCA profiles can be combined with prompted writing assignments by study participants as well as demographic data. This ‘hidden diversity’ finding has major implications for STEM education, particularly when content related to the humanities, social science, and/or ethics is integrated into classroom learning. Educators may take a ‘one size fits all’ approach that assumes a common starting point for learning if they do not recognize the varying manifestations and prevalence of hidden diversity among STEM students. As a result, some student subpopulations may be inadequately supported in their learning about STEM-related humanities or social sciences, which are increasingly emphasized for their contribution toward the early professional development of compassionate health caregivers and ethical biomedical scientists.

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The Second World War, widely understood to be the deadliest conflict in human history, challenged every institution in every nation involved: socioeconomic, military, and political systems were subjected to unprecedented levels of pressure, and these systems were forced to adapt to this climate with varying degrees of success. The medical establishment was no different, and the field of trauma surgery was of special importance due to new collections of increasingly deadly and accurate weaponry and the amount of mass casualties that often characterized the war’s battles. The field of neurosurgery, specifically, advanced rapidly in conjunction with trauma surgery and grew into a more distinct, focused, and practical subspecialty. This presentation asserts that, through wartime improvements in surgical interventions for traumatic injury to the brain and spinal cord, not only did the organic structure of the brain become more understood, but an acknowledgement of the need for a neurosurgical subspecialty also arose.

In this presentation, I argue that the distinction of neurosurgery as a subspecialty arose in large part due to the wartime necessity of efficient diagnosis, rapid triage, and appropriate surgical intervention in the treatment of trauma; as trauma surgery advanced, the need for supplementary training in brain and spinal cord surgery became increasingly apparent. Mobile neurosurgery units, or MNSUs, represented a crucial part of this field’s conception, marking brain and spinal trauma as an especially challenging and complicated casualty requiring a different level of expertise. Additionally, vast improvements in prevention and treatment of infections greatly improved survivability in patients undergoing neurosurgery, leading to a unique need for a restructuring of the bones and tissues of the head. As a result, the practice of cranioplasty was necessary much more often, leading to notable advancements in that component of neurosurgery. As a whole, this presentation asserts that while the Second World War challenged and affected almost all facets of medical care, it was an especially transformative period for the neurosurgical subspecialty, and as a result the field became a more distinct part of the international medical establishment while its practice improved out of necessity in the treatment of victims of brain and spinal trauma during the war. This coexistence of tragedy and medical advancement is a hallmark of war, and 16th-century surgeon Hieronymus Brunschwig is cited in *Journal of Neurosurgery* as having once remarked, “I would remind you again how large and various was the experience of the battlefield, and how fertile the blood of warriors in rearing good surgeons.”
Members of marginalized communities often experience harm from not being able to make their experiences intelligible to members of privileged, dominant groups. A woman who does not have the support to take care of her baby and experiences being shamed for being pregnant and unmarried may have a hard time communicating her reasons for wanting an abortion to a male physician. An immigrant woman who has had bad experiences with healthcare professionals in the past may have trouble communicating to her physician why she has been avoiding getting a necessary procedure. A transgender man may avoid going to see a physician for hormone therapy out of fear of judgment and instead take black market hormones. What is common across different marginalized communities' experience with healthcare is a lack of trust and a fear of judgment.

While there has been much progress in developing effective models of the physician-patient relationship, the common models fall short in demonstrating how to navigate a physician-patient relationship where there is an unbalanced power dynamic as is the case with patients who are members of marginalized communities. I seek to fill this gap by demonstrating how allyship can strengthen a common model of the physician-patient relationship.

In order to cultivate a sense of patient empowerment, I argue that the physician-patient relationship needs to be reimagined through the lens of allyship, where an ally broadly construed is a person in a position of power that aims to support a person in a position with less power. My argument will be as follows: First, I will give a brief overview of four different models of the physician-patient relationship as understood by Emanuel and Emanuel. I will show how the deliberative model is exemplary to the rest. Second, I will explain where the deliberative model falls short when it comes to patients in marginalized communities. For the purposes of this presentation, I will focus on trans-identified patients. Third, I will give an account of allyship and the need for autonomy-oriented help from physicians in order to cultivate a sense of patient empowerment. Fourth, I will explain how the obligations of a physician should be understood differently as an ally. To conclude, I will explain how the responsibilities of the patient will differ.
Conscientious Objection and a Moral Conviction to Provide Care
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Georgia has become the latest state to pass a “heartbeat” bill, outlawing abortion as soon as a fetal heartbeat can be detected and severely limiting access to abortion. Many physicians may be deeply morally opposed to such bills. Yet what moral recourse do they have? As Stahl and Emanuel note, “health care conscience clauses are one-sided, protecting only those who refuse to treat patients, not those whose conscience compels them to provide medically accepted but politically contested care.” I argue that this is a mistake; negative and positive conscience clauses stand or fall together.

Magelssen argues that conscientious objection ought to be accepted when:
1. Providing health care would seriously damage the health professional’s moral integrity by constituting a serious violation of a deeply held conviction
2. The objection has a plausible moral or religious rationale
3. The treatment is not considered an essential part of the health professional’s work
4. The burdens to the patient are acceptably small, and
5. The burdens to colleagues and healthcare institutions are acceptably small.

Magelssen’s purported jointly sufficient criteria are framed in terms of refusing medically accepted treatment that a patient desires. With minor adjustments, parallel criteria can be offered for providing medically accepted treatment that a patient desires. Because these adjustments don’t alter the spirit of these criteria in any morally significant way, we can conclude: If Magelssen’s criteria provide sufficient justification for a physician’s refusal of treatment, the parallel criteria provide sufficient justification for a physician’s provision of treatment. Thus, physicians with a conscientious objection to “heartbeat” bills would have a moral right to provide an abortion to patients who want them, provided they satisfy these parallel criteria.

One might object that a violation of one’s negative duty not to do something is worse than a violation of one’s positive duty to do something. Yet it’s not clear this is always true, especially regarding conscience provisions. Moral integrity can be just as damaged by not acting in a way one believes is required as it can be by acting in a way one believes is forbidden—especially if healthcare providers have special obligations to patients. One might instead press that refusing to engage in legal behavior is one thing, but acting contrary to the law is another. But what does this difference come to that isn’t question-begging? In the refusal case, the patient is legally entitled to treatment. In denying that treatment, one would ordinarily violate the law if not for one-sided conscience clauses—the very issue at hand.

Nevertheless, allowing physicians to act contrary to the law is ripe for abuse. I do not take a stand on whether conscience clauses ought to be accepted. My conditional conclusion is more modest: if we are to recognize a physician’s right to refuse medically accepted treatment that’s contrary to her conscience, we similarly ought to recognize a physician’s right to provide medically accepted treatment demanded by her conscience. Ultimately, perhaps we ought to recognize neither.
Comics as a Tool to Improve Health and Science Literacy: A Course for Undergraduates, Medical Students, and Community Public Health Organizations

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Throughout life, we confront challenging health-related issues: how not to catch that nasty bug going around; how to convince our friends that vaccines are safe; and how to better support our aunt through cancer treatment. With this in mind, one goal of college science courses is to prepare students to use science to make more informed decisions in their everyday lives beyond the classroom—especially about their health.

In this talk, I present an innovative course in which undergraduate students study comics in order to learn about infertility, cancer, and HIV/AIDS. Reading comics about patients’ emotional experiences in traversing these illnesses sparked students’ “need to know”—an entryway into learning the complex medical science behind each illness. Students related to the comics, seeing themselves or friends and family as potential patients in the future. Then, students studied the biology behind each illness. Finally, students did research to answer their own questions about these health conditions. Students created their own comics communicating what they learned from their reading. In this talk, I explain how the course was structured to support discussions about the comics we read, as well as students’ health information-seeking and their biology learning.

The course was taught at Gallaudet University, which serves deaf and hard-of-hearing students, a population that faces health disparities. This course has the potential to make health information more accessible to groups such as the Deaf community.

Comics are a fantastic medium to communicate about health issues. Using a mix of science journalism, personal narrative, and comics art to illustrate compelling “science stories,” science and medicine can come alive for folks without a science or medical degree. Comics explain complicated concepts in everyday, plain English, with engaging illustrations. Research published in medical journals is rarely read by the general public. However, through comics in this course, medical science became accessible, relatable, and of interest to students. Used in this way, comics can reach a large, diverse, audience—and impact the general population’s science and health literacy.

I share strategies for making this course applicable for medical students and public health community organizations—with the goal of making science and medicine more approachable for patients—and improving patients’ participation in decision-making about their care.
Humanists and social scientists believe that race is a social construction. Genetics and genomics researchers sometimes agree, but end up reifying race anyway. Is there a way to reframe the genetics and race debate so that there is not such an evident divide over the question of the reality of race?

We think we may have found a way. We are an ELSI scholar and research ethicist, a cultural theorist, and a geneticist who have come together to develop an intensive short course to teach scientists about debates in the social sciences and the humanities concerning race as a social construction. Our goal is not to transform scientists into social constructionists, but to create a context in which exploring the debate about race as a social construction occurs. Our concern is that the stalemated divide between many scientists (on the one hand) and social scientists and humanists (on the other hand) has created a situation in which lip service is paid to race categories as historical artifacts but research continues to confirm race as a real fact. Thus, our purpose is to show, through humanistic approaches, how exposure to the intellectual controversy and engagement with the debate itself may open science to new ways of thinking and conducting research about group phenotypical differences and hereditary patterns in human populations.

This panel presentation will introduce audience members to the social science and humanities debates about the social construction of race and ethnicity as categories defining human groups. We will then discuss the debates within genetics and genomics—played out in scholarly contexts as well as news reporting and op-ed pages—concerning appropriate and inappropriate uses of these categories in defining populations and describing hereditary patterns. In particular, we will focus on how race is concretized or reified as a category describing real genetic and/or genomic differences, and what scholarship critical of these approaches suggest about the limitations of such research. We will also include discussions of how race as a factor in doing science—requirements from the NIH, for example, to include diverse populations in research projects—influences research results in this area. We are especially concerned that flawed use of racial categories leads to problems in translation of research from bench to bedside. Finally, we will consider how stalemated debates about race in scientific research leads to silences among researchers and the perpetuation of discriminatory experiences for scientists of color.

This panel’s topic falls within the ELSI theme (ethical, legal, and social implications of genomic research) as well as health humanities. Situated in a College of Medicine and affiliated with the Department of Humanities, we seek to provide an intellectual context in which difficult conversations can occur, to improve translational science and integrate humanities approaches within both basic and clinical science contexts.
A Narrative Approach to the “Difficult” Patient
Margot Hedlin, MD, Department of Medicine, New York University School of Medicine
Jafar Al-Mondhiry, MD, MA, Department of Hematology/Oncology, UCLA David Geffen School of Medicine

Narrative medicine is a practice in which the power of stories is harnessed for self-reflection and healing. The practice of narrative medicine enables healthcare practitioners to better understand their patients, examine their own emotional response to challenging situations, and promote meaning-making in medicine. In this workshop, we will focus on narrative medicine as a tool for self-reflection, with a specific focus on understanding counter-transference and moral distress. We will lead participants through an exercise in which a narrative approach is used to explore one aspect of clinical care that can induce feelings of frustration, moral distress, and burnout in clinicians: the care of the “difficult” patient. The workshop will conclude with a discussion of narrative medicine as a “toolkit” which can be utilized in applied to other challenging situations in clinical care.

Timeframe
1. Introductions (10 min): Workshop leaders discuss medical narrative and its role in understanding counter-transference, commonly-encountered ethical dilemmas in clinical care, and moral distress. Introduce topic of workshop: the “difficult” patient. Break into groups of 4.
2. Writing Exercise #1 (10 min): Participants spend 10 minutes freewriting in response to two prompts: 1. What kind of patients do you struggle to take care of, and why? 2. Write about one patient you found “difficult.”
3. Group Discussion #1 (15 minutes): Small groups discuss their answers. Then the room regroups and one participant from each group summarizes the group’s discussion. Workshop leaders will define counter-transference, and discuss instances in which it arose in the group’s answers.
4. Writing Exercise #2 (10 minutes): Participants spend 10 minutes freewriting in response to two prompts: 1. What would be a good outcome for these patients? 2. What have you learned from your difficult patients?
5. Group discussion #2 (15 minutes): Small groups discuss their answers. Then the room regroups and one participant from each group summarizes the group’s discussion.
In his famous Sanger lecture in 1970, Dr. Edmund Pellegrino (1920 – 2013), one of the founding fathers of bioethics as a formal academic pursuit, observed that “Medicine is the most scientific of the humanities, the most empiric of the arts, and the most humane of the sciences.” A world-renowned innovator in the medical humanities, Dr. Pellegrino spent his career championing the need for the humanities in medical education and practice and arguing that a liberal arts education is good for medicine. As H. Tristram Engelhardt, Jr. said of him: “Bioethics and the medical humanities, especially their emergence in the latter part of the twentieth century, cannot be understood apart from Edmund D. Pellegrino.”

Dr. Pellegrino logged almost 70 years in medicine as a clinician, teacher, bioethicist, research-scholar, and administrator, serving as departmental chairman, dean, vice chancellor, and president. Author of over 600 articles and 23 books, as well as the founding editor of *The Journal of Medicine and Philosophy*, Dr. Pellegrino served nationally as Chairman of the President’s Council of Bioethics in Washington, DC, from 2005-2009.

However, it is in his life, and not just in his academic writings or research, that Dr. Pellegrino made, perhaps, the strongest case that the humanities and medicine should not be separated from one another. This presentation will explore how the medical humanities are exemplified in life—in the life of Dr. Edmund Pellegrino.
Conspiracy theories are now a common feature of American public life and discourse. However, conspiracy theories are far from unique to America. There is a plethora of conspiracy theories throughout the world that range from 9/11 conspiracy theories to the topic at hand: viruses.

In this part of the panel, I will do several things. First, I will briefly give a summary of some of the academic work done on conspiracy theories, especially in the realm of philosophy. Second, I will discuss my recent analysis (Int. Journal of Applied Phil., 2019) of the vice epistemological notion of a conspiracist mentality. I will, in turn, combine that with an understanding of blame in order to establish a framework to examine conspiracy theorizing about viruses. Finally, I will use the developed framework to discuss specific examples pulled from historical and ethnographic studies of virus conspiracy theories in different parts of the world.
Moral Dilemmas of CRISPR Babies: Revisiting Arguments for Non-Medical
Sex Selection in Global Commercial Surrogacy
Asmat Ara Islam
Centre for Healthcare Ethics
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The ethics of global commercial surrogacy in the era of genetic testing for detecting diseases such as Down Syndrome, single gene disorders like cystic fibrosis, and inherited cancer syndromes is highly complex. Although researchers are divided on whether commercial surrogacy can be morally justified, they agree that sex selection based on medical grounds is ethically defensible. Such justification of sex selection in this context, may also defend editing the gene of a possible child by CRISPR technologies from the perspectives of procreative beneficence and the ethics of enhancement. Hence, this presentation explores whether commissioning parents should aim at buying the best babies through advanced biomedical technologies and argues that aiming to have perfect babies may distribute burdens disproportionately to some stakeholders.

First, I identify the moral problems of non-medical sex selection in commercial surrogacy by examining the argument of exploitation, reproductive justice, natural sex selection, and reproductive autonomy. Next, I examine the question of the extent to which the ethics of procreative beneficence can be incorporated in the ethics of gene-edited babies. Finally, having identified the problem that the CRISPR babies may introduce a new layer of ethical dilemma, I conclude that non-medical sex selection in global commercial surrogacy is not morally justified. Such ethical dilemmas may promote unjust inequality, hence, an interdisciplinary study is significant which involves ethical analysis regarding global commercial surrogacy in the age of advanced biomedical technologies.
This presentation traces the concept of medical liberty from 19c Britain to its contemporary manifestations in Anglo-American culture in order to illuminate the liberal underpinnings of our understanding of health. I examine how the concept was formulated as a plebian reaction against the rise of professional medicine in the 19c. Criticizing medical professionals as an interest group complicit with state authority, proponents of alternative medicine, such as hydropathy, vegetarianism, and anti-vaccinationism, emphasized individual autonomy over one’s body by promoting individual hygiene such as abstaining from meat and alcohol as the only means to cultivate health. In tune with the liberal virtue of self-reliance, such individualist understandings of health persist to this day, from anti-vaccination and free-birth movements to the ableist culture of wellbeing, and even in the rhetoric of pro-choice arguments. By contextualizing the concept of medical liberty in relation to the historical formulation of the liberal individual, this presentation complicates the way health is imagined in a (neo)liberal society.
Bedside Education in the Art of Medicine (BEAM): Shining a Light on Arts-Based Teaching
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Much of clinical communication today is sanctioned: templated write-ups like the HPI, while efficient, herald a formulaic approach to patient narratives that leave little room for detail or continuity. Our contemporary ethos of bioscience further stunts attempts at nuanced connection in medicine, in which the digitized sterility of EMRs or metrics-driven workups can promote the mechanized or technocratic at the expense of authentic intimacy and engagement. The resulting compression of narrative freezes out many chances to personalize, or truly honor, these patient stories that doctors make their life’s work. Such essentially enacts burnout, or the formation of negative identity conclusions (inadequacy, incompetence, guilt, etc.) and compromised value systems due to an unexpressed, unorganized stock of lived experience. The inarticulacy of burnout is mostly owed to the fact that many are inadequately equipped with the narrative devices to accommodate such damage.

Human narrative—whether it be the narrative of words, images, or sound—not only facilitates the communal transaction of understanding from person to person, but also achieves this through an outward triangulation onto some mediating focal point. The externalized narrative does work in threes; whereas a conversation between two persons might prove too emotionally charged to get a message across, the introduction of a tertiary variable allows our focus to pour into a singular, “safe” space. A concretized subject, like a poem, photograph, or painting, can thus act as a scaffold for proliferate meaning making.

This was the basis for BEAM (Bedside Education in the Art of Medicine), an educational research initiative at the Johns Hopkins School of Medicine that pushes the importance of arts-based curricula in the medical training of humanistic physicians. Currently a mobile interactive app of “third things” like visual art and poetry thematically linked to common patient concerns, BEAM aims to embattle clinician burnout and moral injury through reflective practice, empathy, and reciprocal learning. Each module is tagged with specific keywords that vary depending on the nature of the artwork, and can range from terms like “depression” to “bereavement” to “family”; the inclusion of these metrics allows users to target and navigate to desired content more quickly. While BEAM can be deployed individually in care settings, ideal engagement with the app incurs group input; by receiving the impressions and interpretations of others, we illumine avenues of difference and compatibility in thinking, and in so doing are afforded a chance to deconstruct, process, and vocalize personal experiences.

This presentation will expand upon the project’s background and current progress in beta-testing within both inpatient and outpatient settings, as well as the methods used to select for and organize humanistic content into modules. It will provide representative cases of certain artworks and examples of how each can impact the clinical dialogue.
Pathos or Active Resistance: Asexuality Reclaimed
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In the Western world, the trend of “sex positivity” and its accompanying proliferation of ways to understand or identify one’s own sexuality (i.e., as “pansexual,” “demisexual,” “polyamorous,” etc.) is pervasive in academia, the “psy” medical community, and the lived world. While interest, both expert and otherwise, has increased with respect to non-heterosexuality, despite some exceptions, asexuality is largely overlooked. Broadly, the term ‘asexual’ refers to persons who do not experience sexual arousal or who, despite sexual arousal, choose not to engage in sexual activity. These people may or may not experience romantic feelings for others. Asexuality remains a relatively unknown, and perhaps worse, a largely misunderstood phenomenon across all contexts (professional and otherwise). Some typical overgeneralizing misconceptions, though indeed, these conceptions are sometimes true, include the notion that an asexual is someone who is a “closeted” homosexual, a person who “has yet to find the right person,” or person whose libido can be “returned to normal” via psychological or chemical intervention. When asexual persons are misunderstood, constraints placed upon them can be not only epistemically unwarranted, but unethical and oppressive. Perhaps best described in the works of Foucault, Western society emphasizes “compulsory sexuality”—the idea that human beings are “naturally sexual.” This idea, coupled with the current trend of “sex positivity” and its accompanying proliferation of ways to understand or identify one’s sexuality (i.e., as “‘into’ BDSM,” “bi-curious,” etc.), while considered emancipatory by some, can serve to reinforce the notion that there is something wrong with asexual people. In Ian Hacking’s terms, asexual people are also subject to the looping effect. Being characterized as asexual by oneself or by others, an individual has some capacity to negotiate the meaning of that characterization—to accept, reject, or alter it. A main theme of Beauvoir’s The Second Sex (1949) is to underscore the social undergirding of much of what woman is. Though I will not restrict my attention to whom Beauvoir refers to as the “frigid” woman, her analysis is useful in providing a lens through which to reconceptualize asexuality by means of ideology critique. Beauvoir reconstructs “frigidity” as sometimes indicative of an active resistance to one’s situation rather than a passive pathology. I hope to further underscore this important rearticulation and to buttress Beauvoir’s reading with Catherine MacKinnon’s work on pornography, and Sally Haslanger’s work in Resisting Reality (2012) on ameliorative social constructionist programs (programs that ask what do “we” want the concept of, in this case, “asexual” to represent or do?).
Art and Medicine; Increasing Empathy and Skills of Observation in Medical Students
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The level of burnout and depression is on the rise in medical students. The lack of social life, the stressful and competitive environment, and the overwhelming amount of information contribute to this. In response, medical schools continue to develop courses for their students in the convergence of art and medicine.

The goals of teaching art in medical schools are: 1) to explore the interplay of art and medicine; 2) to provide a better understanding of human anatomy and of neuro-visual perception; 3) to open horizons by better appreciating beauty; 4) to increase empathy and the skills of observation; and, 5) to get used to ambiguity. These goals are accomplished by group museum visits, short didactic presentations, drawing and sculpting. The issues of art, illness and genius provide for discussions about the mental and physical adaptation to illness and the society’s views on disability.

Artists and scientists are similar because they work with the same substrate—the visible world—and are able to analyze and re-interpret the received information. Both art and science require a lifetime of dedication, knowledge and skills. The students give positive feedback on this course, bringing up its social and relaxing aspect and stating that their level of empathy and skills of observation have increased. This presentation aims to discuss the interplay of art and medicine. It will start with a short presentation about artists with physical and mental illness. It will continue with the audience being asked to draw an experience that had a deep impact in their lives, an event that they were not able to express otherwise. The sharing of the actual experience is voluntary and the audience will discuss the art work.
The clinical discourse of schizophrenia is one that carries with it an implicit assumption of a diminished life course. Core to the diagnostic criteria for schizophrenia is the concept of decline in functioning: the idea that an individual has experienced a level of functioning that is “markedly below the level achieved prior to the onset” of illness. No other categories within the Diagnostic and Statistical Manual of Mental Disorders, the classification manual that writes the diagnostic criteria and thus sets the parameters for officially recognized mental illness specify a similar decline as a core criterion. However, for schizophrenia, diminished life course and diagnosis are almost inextricably entwined: in mainstream accounts of schizophrenia, discussion of long-term prognosis is guarded, and at diagnosis individuals are frequently given a prognosis involving diminished life expectations and little hope of full recovery. Accordingly, schizophrenia confers not only diminished expectations, but a highly stigmatized identity category. In clinical discourse, individuals’ relation to this stigmatized identity category has been the topic of academic inquiry. However, the space of this inquiry has generally elided an analysis of the liminal space in the discourse: individuals pushing back against standard conceptualizations of psychosis and their relationship to schizophrenia as a diagnostic category.

At present, there is a growing movement pushing back against standard understanding of narratives of psychosis, and explicitly pushing back against the damaged identity inherent to both the DSM categorization and much of the professional discourse and research literature on experiences commonly understood as psychosis. This presentation will critically analyze relationship to (and understanding of) a schizophrenia diagnosis from the perspective of individuals critically pushing back against standard models of psychosis. In particular, it will look at relationship to a schizophrenic identity from three points of contact within critical approaches to experiences commonly understood as psychosis: the Hearing Voices Movement (a service-user run movement that seeks to “normalize” the experience of voice hearing by explicitly disavowing the viewpoint of schizophrenia as a damaged identity), professional organizations that are themselves critical of standard approaches to psychosis, and recent work within critical psychiatry arguing for a more nuanced approach to experiences commonly understood as psychosis.

In particular, this presentation will analyze the way in which schizophrenic identity is understood and managed within these discourses, critically unpacking whether individuals themselves understand it as something that can be salvaged as a form of pride (such as “queer” in LGBTQ circles) in tension with arguments for the label’s abolition based on its highly stigmatized history. In so doing, it will interrogate the unarticulated tension in discussion of schizophrenia as both a diagnostic and identity category, asking whether troubling madness is possible or if the longstanding categorization of schizophrenia as madness itself places it as a category incommensurate with any possibility of recovery.
“Everyone was hopeful when the [communist] regime fell in December 1989, but nothing changed on the ground, in the hospitals, on January 1st, 1990,” says Mioara Popescu, a very experienced nurse, in an interview for the National Television. She describes how the political changes in 1989 impacted the Romanian medical system and its ongoing collapse, the physicians’ code of conduct and the relationship between doctors and their patients. I take Popescu’s words as the background for this presentation and focus on Cristi Puiu’s *The Death of Mr. Lăzărescu* and Cristian Mungiu’s *Graduation* to analyze the dynamics between the collapse of the medical system and the interactions between patients, physicians and nurses in emergency care units. The films follow Mr. Lăzărescu’s journey in an ambulance from one hospital to another in Bucharest, and Romeo’s dissociation from his profession as a physician in Cluj-Napoca. I argue that, in the films, care is negotiated through verbal abuse and structural violence. The doctors work through their disappointment with the lack of change and resources and withhold or delay care in a continuous expansion of the ethical boundaries inherent to the medical profession. I contend that the minimalist cinematic approach adopted by Puiu and Mungiu highlights the politics and mechanics of abandonment as abusive or delayed care. The films show how reverberations of political turmoil modify the concept of *care* and its ethical dimensions and open up a space for critical conversations about modalities of representing and enacting care during periods of crisis beyond the Romanian context.
“Universal healthcare,” “Medicare for All,” “Healthcare as a human right.” These buzzwords fill our airwaves and generate emotions along a spectrum from visceral disgust to ecstatic optimism. Let’s not get the cart too far before the horse. Before the politicians and policy-makers promise America this panacea, we should understand what this promise means for the patients and providers who will live within this construct. What about the business interests that gain (and lose) from the current healthcare delivery system in the U.S? What about the business interests that would gain and lose in a new system of care? Have we considered the unintended consequences of making such a policy shift? Have we taken the time to understand what must happen to deliver on the promise of healthcare as a human right?

Starting with a viewpoint from within the exam room, I will discuss “the good, the bad, and the ugly” parts of the doctor-patient relationship as it plays out in the current healthcare delivery system. How could things change for the better (or the worse) under a new system? Drawing on the body of international experience with universal healthcare and the traditional priorities of the American people, he’ll talk about what healthcare as a human right might “look like” in America? Are we ready to accept both the risks and benefits of that transition? If so, what will be required of patients? Doctors? Hospitals? Communities? Businesses? Universities?

Moving from the buzzwords to reality generates more questions than answers, more unknowns than certainty, and more need for philosophical contemplation than is allowed by the pace of modern media. In this discussion we’ll explore the deeper meanings of “healthcare as a human right” from the perspective of a practicing physician who desires to be thoughtful about what his patients really want and need—past, present, and future.
This presentation addresses policy, uptake and women’s responses to the contraceptive pill (the Pill) in former East and West Germany, demonstrating how opposing political ideologies created different environments for engagement with women’s health. This presentation looks primarily at the 1960s and early 1970s, considering the impact of wider social developments during this period on uptake of the Pill, including the escalation of Cold War tensions and the development of second-wave feminism surrounding the student revolution of 1968. In analysing governmental policy towards the Pill, I will demonstrate how women’s healthcare was commodified to suit political agendas: where Christian conservatism was being established in the Federal Republic of Germany to cope with the Nazi past, whilst the German Democratic Republic needed to demonstrate ideals of equality to legitimise the founding of a socialist state. Through analysis of texts written by female authors from East and West Germany, including Häutungen by Verena Stefan (1975) and Leben und Abenteuer der Trobadora Beatriz nach Zeugnissen ihrer Spielfrau Laura by Irmtraud Morgner (1974), I will study women’s interactions with the Pill, demonstrating their dissatisfaction with the respective healthcare systems of East and West Germany.

Within this presentation, close attention will be given to the institutionalisation of male control over the female body, considering how (male) doctors’ personal views and prejudices influenced prescription rates and uptake of the Pill—in turn affecting how women perceived and interacted with the drug: often regarding it more as a means of control than empowerment. I will discuss to what extent women’s healthcare is informed by pre-existing power relations in society more broadly.

This presentation provides a unique look at a drug which has become integrated into Western society and still shapes the lives of many women, using an interdisciplinary approach to query how we interact with it and how this affects users. Such research comes at an important time as more and more women are starting to reject the Pill, turning instead to natural contraceptive methods. By studying the factors which affect women’s engagement with the drug, the field of women’s health may be improved to better serve women.
The college years are a critical time for the growth and development of emerging adults. Developmental tasks for college students often involve the discovery of and identification with various aspects of identity (social, sexual, occupational, etc.). What is often lacking in understanding the developmental experiences of college students is the focus on spirituality and spiritual development. Research indicates college students are actively seeking ways to enhance their spirituality through their undergraduate experiences. This has led to a resurgence of spirituality on college campuses, which comes with both benefits and challenges.

Faculty engagement, opportunities for reflection, living arrangements, and choice of major of study are all aspects of the college experience which subsequently impact students’ spiritual development. More specifically, Lindholm & Astin note that “faculty attitudes and behaviors are known to have important implications for student development.” However, higher education has historically failed to consistently meet the spiritual needs of both students and faculty members. How is spirituality being implemented on campuses to benefit students’ growth and development as well as increase connection with faculty?

The college classroom is an example of one avenue for students to explore and discuss spirituality, as well as apply spiritual practices to their everyday lives. Strategies for enhancing wellbeing stem from a student-centered pedagogical philosophy, which focuses on increasing students’ self-awareness through open dialogue, small group discussion, and an emphasis on understanding self and others from a holistic perspective. Faculty preparation is also an important aspect of teaching spirituality. Faculty preparations include an exploration of their own spiritual journey, active pursuit of contemplative practices, and openness to being vulnerable with students.

The 15-week undergraduate elective course focuses on understanding and developing students’ spiritual self. Housed within an academic program at a public university in the United States, the course inherently has a health and wellbeing focus. Course topics are varied but include: defining spirituality, spiritual diversity, understanding spirituality and health, spiritual self-care, overview of relevant research, as well as an exploration of spiritual journeys.

This presentation will discuss the course, which is specifically designed with the developmental needs of undergraduate students in mind. Faculty preparation on how to teach spirituality from a centered space will also be emphasized. A focus on how class activities, discussions, and assignments facilitate students’ overall wellbeing will be highlighted as well as future research suggestions.
Social conflict theory holds that not only will group folklore describe that group’s values and point of view, but that it will do so as defined against some other group with which the storytellers perceive themselves to be in conflict. In medical folklore, most stories either encode the point of view of the patient or the point of view of the institutional healthcare provider, two groups with sufficient mutual mistrust to generate legend and rumor. Virus legends—and indeed most legends of infection and contagion—reflect the point of view of a helpless patient upon whom sickness is suddenly imposed, a narrative structure reminiscent of those stories told by healthcare avoiders. After all, if one never goes to the doctor, is one ever truly “sick”? This panel discussion touches on identity formation, group values, and the rupture of illness narratives in order to analyze several key virus legends and discuss analogues among provider-oriented folklore.
Rethinking Obesity Through Canguilhem’s Conception of Pathology

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According to the World Health Organization, the global prevalence of obesity doubled between 1980 and 2008, a trend which has lead researchers and medical organizations to label obesity a “chronic disease” reaching the level of a “global epidemic.” In fact, the WHO identifies obesity as “one of the greatest public health challenges of the 21st century.” Although there is some disagreement about how to best conceive of obesity, the prevailing definitions are biostatistical, defining the condition in terms of deviation from (variously) average, desirable, acceptable, ideal, or health body weight, the principal measure of which is the Body Mass Index.

But perhaps this global epidemic is more apparent than real; perhaps the reason obesity seems to be a public health challenge is that it is understood as a function of an inadequate definition of the significance of having high levels of body fat. In this presentation I will briefly discuss the history of statistical definitions of obesity, including an overview of BMI calculations. I will then raise questions about the adequacy of such methods, drawing on the work of Georges Canguilhem, French medical doctor and philosopher of science. I will sketch Canguilhem’s account of normativity, normality, and pathology, and, by applying his insights that health and disease cannot be understood purely quantitatively, argue that obesity qua pathology involves a qualitative dimension that statistical methods like the BMI are ill-suited to capture. An adequate definition of obesity must be sensitive to individual differences and environmental variations, including social milieus, in addition to physiological facts. Thus, I argue that an individual is obese just in case that person experiences his or her body fat as a diminishment or hindrance relative to biological, natural, or social environmental conditions. Reconceived as contextually variable, I suggest that obesity not be treated as an “epidemic,” which may have negative effects on those who may be considered statistically or socially obese. Instead, it is my view that health care professionals concerned with obesity should abandon data-driven definitions and adopt a more holistic, patient-centered definition.
Beat Generation author William S. Burroughs has (in)famously compared the Word to a virus, claiming that language is a parasitic attack on the human mind. This talk will discuss the intriguing ramifications of Burroughs’s claim by exploring his rather odd fifth novel, *Dead Fingers Talk*. Published in 1963 in London, this strange work employs the “cut-up” method to “reorganize” Burroughs’s famous *Naked Lunch* and his more fragmentary work *The Soft Machine* and *The Ticket that Exploded*. The result is a novel meant to not only demonstrate a cautionary tale of a man caught in the grips of a global conspiracy, but to deploy the cut-up method itself as a form of purification, helping to free the reader from the mental constraints that the Word Virus produces. This desire to free the reader from the straitjacket of “control” is a useful means of bringing human attention back to the present, but likewise raises its own set of potential problems that will be addressed in the course of the talk.
The mature minor doctrine is a legal principle that grants adolescents permission to provide consent for medical care. It is generally recognized for allowing autonomous, confidential decision-making over specific “adult” issues such as substance use, sexual health or emergency situations. Recently, it has received attention in light of controversies surrounding vaccination. Many are calling for this doctrine as a mechanism to allow minors to make decisions about their right to vaccination. The benefits of vaccination are not in question; nonetheless, the addition of vaccinations to this group may set a troubling precedent. This use of the mature minor doctrine reignites concerns about how we decide what role it plays for minors in non-emergent cases.

The question of whether a minor is capable of autonomous decisions and when is not novel. Legal and ethical battles have ensued over this issue; there is still no true consensus. There are instances in which parents make healthcare decisions considered harmful to their child. In these cases, physicians can override the parents; however, judicial support to oppose a parental medical decision is cumbersome due to the high burden of proof necessary to demonstrate high risk of preventable harm without treatment. At present, this is not the case for vaccination.

As more states discuss the use of mature minor doctrines for vaccination, one must ask why the courts do not already require parents to vaccinate their children. The reason is that, in part, the decision to vaccinate or not does not result in the same clear cut life-and-death situation as decisions such as providing chemotherapy in a cancer predicted to have a high chance of a cure. We may support mature minors’ choice to get vaccinated because we disagree with parents’ choice not to vaccinate; however, we do not generally allow the child to make a medical decision solely because we, as providers, disagree with the parents. We may sway towards vaccination because its absence may follow a child into adulthood. If this argument is presented, it must be extended to the many other therapies that may fall under this umbrella. The most striking of these may be gender reassignment surgery and hormone blocking therapies in mature minors. If we are to allow this use of the doctrine, we must be willing to allow for its broader application.

Few question physicians who surreptitiously allow minors to receive vaccinations without parental consent. Some openly applaud this behavior. For many, the situation is black and white: Vaccinations are good so we ought to support anything that increases their use. We will not attempt to disentangle the extensive debate on vaccinations; rather, we are considering their role in illuminating certain legal and ethical grey areas surrounding healthcare rights of minors. We plan to examine implications of accepting vaccinations as applicable under the mature minor doctrine. In so doing we may become obligated to accept the use of the mature minor doctrine in more controversial procedures.
Connection, Space, and Distance in the Physician-Patient Encounter:
Lessons from Spiritual Care and Practice-Based Philosophy
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In the context of a modern medicine that is increasingly driven by bureaucracy and technology, medical humanism reaffirms the importance of the patient’s personhood and dignity, as well as the physician’s expression of humaneness in caring for those who are sick. Historically, detachment has been considered the ideal mode of interaction with patients; more recently, it has been considered more negatively as an attempt to avoid or suppress emotions. Despite the increasing value attached to empathy in clinical practice, physicians still offer many justifications for detachment in avoiding engagement with patients, such as: to defend against burn-out, to competently perform their job, and to prevent interference with their objectivity as physicians.

Perhaps for this reason, questions about how to emotionally relate to patients in the clinical encounter are often recast in terms of a metaphor of distance. Should the physician detach from the patient, pulling away to protect themselves and their sense of impartial objectivity, but dehumanizing the patient in the process? Or should they move closer, to connect and engage, with the danger of merging with the patient?

My work demonstrates that from the perspective of patient-centered care, there is a problem with this linear, two-dimensional relationship— it is predicated on the physician moving away or toward in relation to a patient assumed to be static and passive. Additionally, imposing a rigid and dichotomous model of engagement has not done justice the nuances and difficulties of being with a patient in a vulnerable moment. This is clear even within the literature on empathetic/compassionate care, where this struggle to ‘balance’ and ‘negotiate tensions’ is prominent and yet unexamined. There is also substantial confusion about how to be sympathetic, empathetic, or compassionate in a way that is genuinely beneficial to patients and meaningful for providers. This is especially reflected in medical educational interventions, but also has relevance to patient-centered medical practice more generally speaking.

In the clinical context, everything exists in a state of flux – the patient in question, the circumstance, even the provider. Physicians and physicians-in-training need methods to harness this understanding that are useful and meaningful in practice. Therefore, the research questions of this project are: what are approaches to connection in clinical encounters that are not dependent on a linear, two-dimensional concept of distance or closeness? What strategies could aid clinicians in encountering patients with openness?

This project draws from the author’s experience in hospital chaplaincy and ‘alternative’ traditions of practice-based philosophy, both Western and non-Western. These traditions are distinct from the theoretical approach underlying much of Western philosophy, by focusing more on practices leading to change in everyday outlook and action. This practice and outlook-based approach has benefits for providers who desire pursuing such meaning in practice; it also benefits patients to have providers who can truly care for them when they are vulnerable and suffering.
When a patient lacks decision-making capacity (DMC), standard clinical ethics guidelines identify surrogates as authoritative decision makers, even if patients object to surrogates’ decisions. In the absence of valid surrogates, physicians are directed to treat patients in ways that promote patients’ best interests, which, if necessary, includes treating over patients’ objections. What should we think of the fact that physicians are sometimes reluctant to treat patients over their objections, even when patients lack DMC, surrogates assent, and treatments would promote patients’ best interests? While some may offer cynical interpretations of this phenomenon—rooted in pragmatic considerations or the self-interest of physicians—we think such reluctance can instead express well-founded moral intuitions. This is because the preferences of patients who lack DMC still matter morally, even though the standard clinical ethics guidance does not explain how and why this is possible. Furthermore, we argue that such preferences can sometimes provide decisive reasons against treating such patients over their objections. We conclude by identifying some ways in which clinical ethical guidance for treatment over objection should be revised.
The Body Issue: What Global and Historical Perspectives of the Ideal Female Body Can Teach Us About Our Own Present-day Bodies

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Poor body image is currently a worldwide public health crisis disproportionately influencing women and girls, and its effects are reaching children as young as primary school. This issue is compounded with the rise in social media and the Westernization of beauty ideals around the world. However, poor body image is more sinister than just not feeling happy with the way one looks: physical bodies are social bodies, and beauty is linked to our perceptions of health, wealth, power, and overall success, which affect women’s overall views of their capabilities, strengths, and worth. Therefore, we must re-evaluate how we see, treat, and think of our bodies. History can be used as a tool to help expose ideals of women’s beauty as arbitrary, and this suggests fluidity and subjectivity of the very notion of perfection.

The Body Issue: What Global and Historical Perspectives of the Ideal Female Body Can Teach Us About Our Own Present-day Bodies is a graphic novel I wrote and illustrated for my senior project at Yale University, where I graduated in 2018 with a BA in the History of Science, Medicine, and Public Health. The novel received the Yale Martin Klein and George Rosen Prize (awarded to the most outstanding senior essay in history of science/medicine) and has been featured in the 2019 University of Toledo’s Health Science Campus Artist Showcase and on the Yale Medical Historical Library’s Instagram. Certain portions of it will also be published in an upcoming edition of the AMA Journal of Ethics.

The work explores the cultural and social factors influencing female body image and aims to be an entertaining, educational tool for teaching history and medicine. Drawing from historical and contemporary sources, such as advertisements, magazines, and body satisfaction surveys, as well as personal experience, I try to understand the overemphasis on women’s physical appearance. The graphic novel narrates the stories of four different historical societies: Tang Dynasty China, the Efik people, Victorian England, and Sparta, comparing and contrasting them to each other and modern American day society. Education about this history and its influence on women’s and girls’ identities, self-conception, and health can promote open conversation and, perhaps, change for the better how parents talk to their children about their bodies. The graphic novel aims to help readers understand how social and cultural factors can impact body image and recognize that even throughout history, no one perfect female body exists. Finally, the graphic novel also invites readers to consider bodies as a means to individuality instead of assimilation, and decide for themselves the terms on which they’d like to think about their own bodies in diverse social, cultural, and ever-changing environments.
It has long been established by historians including Alexandra Minna Stern, Miroslava Chávez-García, Laura Briggs, and Natalie Lira that the 19th and 20th century eugenics movement in the United States had strong ties to the nativist, xenophobic, and racist ideologies that also drove 20th century anti-immigrant legislation. The majority of this research, however, has focused on the southern border and the links between eugenics and anti-Mexican and, more broadly anti-Latinx sentiments.

What has been largely left out of the study of American eugenics is how this same anti-immigrant ideology played out in cities and states along the northern border. This presentation seeks to address a small part of this gap. Using newly discovered eugenic sterilization records from patients in Michigan’s mental hospitals and homes for the feebleminded, this presentation builds on the work of scholars of eugenics and immigration in Detroit, including most significantly Ashley Johnson Bavery, to bring the Detroit-Windsor border into a larger conversation about eugenics in border cities. I argue that these patient records and other archival material indicate a xenophobic bias that led to the disproportionate targeting of both legal and illegal immigrants, and their children, by Michigan’s eugenic policies.

The primary documents used in this presentation were recently discovered by the author in the State of Michigan Archives. The records consist of the medical files and sterilization request documentation from patients sterilized primarily under Michigan’s eugenic sterilization law “An Act to Authorize the Sterilization of Mentally Defective Persons,” passed originally in 1923 and expanded twice before it was finalized in 1929. Between 1923 and 1974, when the Act was repealed, more than 3,800 Michiganders in state and county hospitals were sterilized under this law. Prior to the discovery of these records in February of 2019, virtually nothing was known about these thousands of victims except for the reason they were sterilized (insanity or feeblemindedness), their sex, and which hospital recommended them for sterilization. While research on these documents is still in the very early stages, preliminary analysis indicates that there was a strong bias against patients who were of Eastern or Southern European ancestry. Unsurprisingly, the same anti-immigrant rhetoric that was common among the middle- and upper-class reformers and authorities, especially in the Detroit area, is also apparent in the language used by hospital and welfare authorities in these patients’ sterilization files.
Responsibility is a multifaceted concept that can be implemented in psychiatric care practices in different ways based on the theoretical framework of the physician. In 1879, a Vermont asylum superintendent, Dr. Joseph Draper, wrote a paper on responsibility in asylum inmates and methods of incorporating responsibility into everyday care practices. This paper was both a justification of his framework and an example of how responsibility should be performed by both caregivers and patients. In particular, Draper argued that theory and rhetoric of his time did not match the existing practices, as theory assumed irresponsibility in the insane while practical applications assumed responsibility in regulations. However, Draper also published reports and annals of his asylum that show his own rhetoric and writings were not applied in practice. My presentation uses rhetorical methods to analyze Draper’s writings, published reactions to his writings, and the disconnects between rhetoric and practices. Draper’s papers include his 1879 paper on responsibility in the insane within asylums, an 1883 paper on responsibility in the insane outside of asylums, an employee manual for his asylum staff, annals of the asylum, and myriad reports published in the *American Journal of Insanity*. This journal also published responses to his reading of his first paper.
A Short History on War Advancements and Sacrifices in Medicine
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Tracey L. Mersfelder, PharmD, Ferris State University College of Pharmacy

War is not a time when we think about advancements; we generally think about suffering, death, and destruction. However, war is often a time of significant medical advancements, considered essential, as there was a need to counteract the transpiring suffering and destruction. In addition, there has been a corresponding sacrifice of many individuals including physicians, pharmacists and nurses, all of whom needed to accommodate changes in their careers.

The presentation will discuss the changes that have occurred in medicine during the history of war in relation to the understanding of advancements and sacrifices made from before World War II to the present. Our focus includes infectious disease, expansion of personnel, and development of transport.

The medical profession advanced during the course of many wars. In this discussion, we reflect on an important question. Was war necessary to make these advancements?
With globalization and advancement in technology, our boundaries are no longer defined. Today, we have a multicultural society, that includes people from different cultures and religions; and hospitals need to be ready for Muslim patients as well as physicians in order to maintain cultural and religious diversity, and better serve their patients. In the West, medical professionals are guided by the four prima facie ethical principles of beneficence, non-maleficence, justice and autonomy proposed by Beauchamp and Childress. However, this is not the case in other parts of the world. Medical ethics has emerged from religious roots and can only be understood through religion, since religion develops an understanding of the human person on which an ethic of health care can be based. It has to be remembered that both patients and health care providers are people with religious backgrounds - whose faith affects their approach to health care. With globalization, healthcare providers (HCPs) and patients alike are moving around to different parts of the world, and it is not uncommon for HCPs to provide medical services to patients with ethical values different from their own. Providing an enlightened insight into Islamic medical ethics will help clinicians, Muslims and non-Muslims, be more knowledgeable when communicating with their patients.

In this presentation we look at issues associated with the methods and justifications used to reach ethical conclusions in medicine from the Islamic perspective, and how the Islamic principles and Western principles can be aligned. A better understanding of the Islamic Sharia law can help provide better understanding of how the religion dictates the road map for practicing Muslim physicians and patients. To this end, we look at the three sources of sacred laws: The Qur’an (Koran)—the Holy Text; the Sunnah—the examples of the Prophet Muhammad (peace be upon him); and the Ijtihad—the law of deductive logic. We also examine the five universal rules of the Islamic medical ethics, and compare them to the four established principles proposed by Beauchamp and Childress. This will allow important insights into Islamic medical ethics, enabling the clinician to have a better informed discussion with the Muslim patient.

It is essential to appreciate the wider Islamic worldview to better understand the principles of Islamic medical ethics. Islam is considered to be a complete way of life by its believers and sickness and health are just a part of the believer’s journey through life. Autonomy is not emphasized as an individual in Islam, but is interpreted as a member of the family and society. Compared with Western medical ethics, Islamic ethics is arguably more orientated towards the other three principles. However, certain principles in Islam allow for it to adapt to the needs of the changing ethical landscape, and it is reassuring to know that Islamic ethics does support Western ethics to certain extent.
Regulation of Non-Therapeutic Sex Selection: An Eastern vs. Western Contextual Analysis
Scott J. Schweikart, JD, MBE
American Medical Association

This presentation will discuss non-therapeutic sex selection and how demand for sex-selection differs in the Eastern world versus the Western world. The presentation begins with a discussion of the various methods and technologies used for sex-selection: pre-implantation genetic diagnosis and sperm sorting (pre-implantation), abortion (post-implantation), and infanticide (post-birth). Then, the presentation will examine the cultural context that shapes the demand for sex-selection in the Eastern and Western worlds, as the cultural context is critical in how the ethical issues are to be weighed. In the Eastern context, sex selection is guided by a strong desire for boys dictated by a patriarchal society. In the Western context, desire for sex selection is primarily motivated by achievement of family balancing. Then, this presentation will examine how different forms of sex selection are currently regulated in the East (focusing primarily on China and India) and in the West (focusing primarily on the Europe and the U.S.). In conclusion, the presentation will analyze the relevant ethical issues associated with sex selection and offer an argument for how to approach regulation in both the Eastern and Western contexts, underscoring a need to for a consequentialist based theory of regulation that encompasses the ethical consequences of sex selection as it occurs in the East and West.
Outside the Pre-Med Box: An Integrative Liberal Learning Approach to a 21st Century Pre-Health Professional Identity Formation Education
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Luciana Garbayo, MD, PhD, Department of Philosophy and Medical Education, University of Central Florida College of Medicine

There is a recognized need for strengthening a patient-centered, team-based approach to the patient/care provider/physician relationship in healthcare. Attempts to address this need extend today to pre-med education, as seen in both revised MCAT content and AMCAS volunteer based requirements. These efforts, though a step in the right direction, are not fully capable of meeting this need on their own, if not complemented by curriculum transformation. A lack of a consistent and continuous liberal undergraduate education that is inclusive of all health professions is an enduring problem in constituting the educational experience and for understanding of persons, within their expressions, liberties, contexts and deliberation processes. Our project seeks to contribute to meet this need early, by addressing in particular the educational curricular opportunities in the pre-health professional identity formation. We propose the creation of a pre-health minor based on integrative liberal learning standards and aligned with a 21st Century Liberal Education, with the strong contribution of the arts and medical humanities for its constitution. A curriculum map for this innovative minor is presented, along with a course catalog for the minor, Lib-Pre-Health, as a novel approach to the development of the pre-health professional identity formation education.
Does Yes Mean Yes? The Trouble with Consent

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Erik Nordenhaug, PhD, Department of Philosophy and Religious Studies, Georgia Southern University

According to philosopher Jürgen Habermas, strategic and communicative acts represent two distinct forms of speech. Strategic acts are goal-oriented and are considered successful when discourse brings about a desired goal, whereas communicative acts are aimed at shared understanding and consensus formation. In the late 20th and early 21st centuries, there has been a rise in institutions replacing communicative speech with strategic speech, often for various purposes: legal, economic, psychological. This can be seen in politics, sexual relations, and medicine. For example, while informed consent is understood as a communicative act—dialogue between a provider and a patient regarding the patient’s medical condition, the nature and purpose of the proposed treatment, its risks, consequences, and likelihood of success, as well as that of any alternative treatments, including the option of “doing nothing”—in practice clinicians may lack the ability, confidence, and/or time to engage in consent discussions with patients (and their varying levels of comprehension) and instead may tend toward strategic action, sometimes even just prior to a procedure. Moreover, “informed consent”—as a process related to a technological system—is in a practical way a foregone conclusion: the terms on which one has to “consent” (to a treatment, to the system as a whole, including the “consent” to pay) have been circumscribed.

What earns less attention in medicine is “informed refusal,” or the right to refuse entrance into a system. For even when informed consent appears successful, what we think we are doing at the individual level turns out to be nearly the opposite or at least radically ambiguous at the larger system level. What does “consenting to a medical system” mean? Focusing only on how procedures are consented to or the way a doctor talks to a patient is akin to seeing the interests of the “trees,” not those of the “forest”—even while the forest may be dictating strategic action (e.g., limiting legal liability). Defining and discussing “patients,” “doctors,” and individual techniques like “informed consent” necessarily yield distorted perspectives if the whole in which these parts exist isn’t also defined. In this world where the words “autonomy” and “autonomous” are now publicly being applied to weapons (autonomous weapons), organizations (DAOs, decentralized autonomous organizations), programs (DApps, decentralized autonomous applications), and cars (self-driving autonomous vehicles), we must begin to seriously discuss how the “autonomy” of systems alters the meaning of individual techniques of the system, such as informed consent.

Understanding the consent process solely as one human being talking with another without acknowledging the system implications in the background is a misleading assumption and may be dangerously affirming the “autonomy” of humans in relation to such systems. Through an examination of Habermas’ work, the philosophy of technology, and cases from clinician practice and U.S. law, this panel will discuss the different levels at which the issue of “informed consent” can be analyzed and the state of autonomy in the medical encounter. Are techniques such as informed consent impotent or perhaps illusory at a large-scale level to be helpful to us?
Words matter. They shape our lives. Words create narratives, tell truths, hide false facts. Words spin tales, open up different worlds while shattering others. Words allow society to come together in understanding or they can tear us apart. What we say and when we say it is why cultural competence and bioethics are important.

August 17th, 2018 will hold a spot in my memory for the rest of my life. That day I received the news I have cancer. I scheduled appointments with doctors at a prominent university-based medical research center and with a doctor in my town who was recommended by another doctor. I researched the treatments for my type of cancer and options to mitigate the side effects of the chemotherapy cycles. Once my research was completed I felt I could discuss my treatment and my thoughts on treatment plans with the doctors. I felt confident in my research and my ability to discuss available treatments before each consult.

I met with the university-based surgical oncologist first. We discussed treatment options, she spoke with me about the importance of me being comfortable and taking part in the decision-making process. Two days later I met with the medical oncologist in my town. She walked in the room, called me sweetie, brusquely asked “What happened there” as she pointed to my hands. I was born with several congenital anomalies the most notable being my hands. Her words set the tone for the appointment. The doctor-patient relationship is one reliant on respect—without it the relationship will fail.
In this presentation I discuss the emotional and practical highlights of *Stitches*, my graphic memoir about a childhood diagnostic radiation regimen, administered by my father, that ultimately caused me to develop throat cancer and led to the temporary loss of my voice. The presentation explores the significance of graphical autopathography from the perspective of a patient, and touches on the practicalities of developing and producing a work of graphic medicine.
Health narratives, or autopathographies, should be considered a vital part of medical education in order to encourage holistic practices which focus on the patient as a person. These narratives, from the perspective of the patient, allow the patient’s voice to be heard in a field that so often silences it. These narratives can help close the gap between the patient and the practitioner who is often so focused on the disease, they forget the patient is not a subject, but a human. They forget that the disease is not only in a lab or an examination room, but a lived reality for a person.

This presentation takes a look at two autopathographies, Olivia: my life in exile in Kalaupapa by Olivia Robello Breitha (1988) and Miracle at Carville by Betty Martin (1950) written by patients who had the biological illness called Hansen’s disease. In this presentation a stark difference is drawn between Hansen’s disease and what, through Susan Sontag’s theory of “illness as metaphor,” I will term Hansen’s monstrous metaphor, “leprosy” (1978). Through analysis of both Betty and Olivia’s narratives it becomes clear that what they suffer from most is the monstrous metaphor “leprosy” which they have been forced to embody. In analyzing their narrations, the voices of Betty and Olivia expose diagnosis as a moment of a psychic rupture. Suddenly, they see their body through the dehumanizing and pathologizing discourse around “leprosy”. Their internal reactions describe what can only be understood as alienation from one’s own body. I argue that diagnosis can be a moment of mental violence, not only as a result of the biological ailment, but the social condition which the diagnosis ascribes to the patient’s body. As a result, the social condition should also be considered part of that which the patient must contend. Annemarie Mol’s The Body Multiple (2002) is a vital text which I incorporate into my own discussion of why health narratives, as they illuminate the multiplicity of illness in that they affect the patient in complex ways, should be part of medical education because the practitioner needs to account for these multiplicities of illness in caring for the patient. Additionally, by analyzing this historical extreme case of an illness that has sustained a social imaginary and evokes images of zombies and “lion faces” the potentiality and therefore the power of diagnosis over the individual is uncovered as one that has the ability to alienate the ‘self’ from its own body. Therefore, I argue the body is a space from which the ‘self’ can become “unhomed”. By incorporating Homi Bhabha’s notion of cultural “unhoming” the body becomes an unsafe space for the ‘self’ to exist (1994). Ultimately, what this analysis reveals is that the moment of diagnosis is a crucial point where the gap between the patient and practitioner must be closed by a holistic approach, including accounting for the multiplicity of illness, as it is in this fragile moment that one can cause mental violence to the patient.
Effective communication and empathy between providers and patients has long been a challenge and remains an ongoing need in optimizing clinical care. As one of several modalities, Narrative Medicine has been suggested to increase the level of empathy in providers, particularly with respect to end-of-life decision making. Developed by Columbia University physician Rita Charon, Narrative Medicine is an effective branch of medical education that shifts the emphasis to the patient perspective to ascertain the first-person account of illness and health. The approach is rooted in the principle that language can act as a mediator and device for healing. Vehicles such as literature, writing, and the arts can further be leveraged as fictional narratives that may offer educators a humanistic approach to enhancing patient-centered care. Our presentation examines *Wit*, a play by Margaret Edson that allows narrative medicine to flourish as an education tool in end-of-life settings. The narrative, told from a first-person perspective, follows the trajectory of a patient with terminal cancer and demonstrate the psychological and personal dynamics affected by paternalistic environments. We describe the benefit of using plays to teach students using the foundational basis of Narrative Medicine. More specifically, we support the use of literature to expose the effect treatment has on the mental health of patients. Our aim is to provide medical educators with a framework that may enhance the level of empathy for medical students and residents. We argue that Narrative Medicine as a tool provides a healing mechanism for the patient as well as the clinician.
Becoming Epistemic Peers with Queers in Medical Contexts: Preventing Microaggressions to Improve Communication and Care for LGBTQ+ People

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‘Microaggressions’ are brief and commonplace verbal, gestural, or environmental indignities that, whether intentionally or not, convey hostility or derogation toward members of marginalized groups (Sue 2010). Given the power differentials inherent in the doctor/patient relationship, clinical encounters are often rife with microaggressions, which can be a detriment to effectively communicating patients’ symptoms and needs, and can thus stand in the way of patients receiving quality care (see Freeman and Stewart 2018). This is the case regardless of physicians likely good intentions. The difficult reality of microaggressions is that they often occur – and cause harm – without the perpetrator even realizing what they have done or said.

In this presentation, I discuss the harmful implications of microaggressions in clinical contexts, particularly those leveled against members of the LGBTQ+ community. I argue that routine experiences of microaggressions committed by health care providers can, over time, degrade queer peoples’ trust in health care professionals, produce anxiety about ‘coming out’ to providers, cause queer people to withhold information that is pertinent to their health, or, in the worst-case scenario, avoid health care contexts altogether. When queer people are unable to effectively and openly communicate with their health care providers – or, avoid them altogether – the many health disparities that LGBTQ+ communities already face can worsen. As such, I argue that as a matter of health justice, health care providers need to become more aware of microaggressions, and work to stop committing them. Furthermore, I offer positive proposals for how health care providers can better collaborate with queer patients and become more effective listeners of queer testimony. Drawing on the work of Lauren Freeman (2015), I argue for an “epistemic peers” model of communication with queer patients in the clinic, to help reduce the frequency of microaggressive comments and to ultimately improve the quality of communication and knowledge exchange between queer patients and those tasked with providing quality health care to them.
Recent research focused on examining the healing power of nature connection reinforces anecdotal and folk wisdom that such connections are powerful and efficacious. Correspondingly, physicians increasingly prescribe nature contact—from shinrin-yoku, or forest bathing, in Japan to an annual calendar of nature events in the Shetlands to US state parks providing free passes for park entry.

As the possibility of making nature part of a health plan becomes more relevant, other questions have arisen regarding how to recognize different needs and levels of comfort in nature—and how to handle historical inequities possibly leading to discomfort in natural areas. There are also concerns about financial limits to accessing nature. So, a challenge for nature prescriptions is to ensure a plan that offers access to all. A necessary part of the discussion has to include finding options for a diverse range of patients with varying interests and financial standings. Fortunately, many different activities, including fishing, gardening, biking, rock climbing, surfing, and urban birding, provide therapeutic means of immersing in a natural setting.

This presentation will discuss how to use the humanities to generate a sense of healing connection and how to prescribe it—through an introduction to nature and healing or discussions of arts and writing activities in natural areas. I consider broadly the different activities available for patients, consider how to work with individuals to determine what form of nature contact may be more or less positive—and accessible—and show how to develop a year-round calendar of nature events for a specific location.
"He’s Been Mostly Dead All Day": Is Irreversible Brain Death a Fiction?
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In the April 17, 2019 issue of the journal Nature, researchers at Yale University published the results of experiments on the disembodied brains of pigs, retrieved from a slaughterhouse. After having been separated from their bodies for four hours (and so, it would seem, quite dead), researchers catheterized the brains and injected a proprietary solution that mimicked the fluids normally found in the brain. While not restoring consciousness, the procedure did restore cell function and kept the internal structures of the brain in something like a maintenance mode for hours (as opposed to the rapid degeneration that typically happens after death).

In a sea of medical uncertainty, brain death has, for the past 50 years or so, felt like a sure thing. Dead brains can’t recover, so once the brain has died, the person has died, even if a ventilator and other life support systems indicate otherwise. Brain dead patients could thus be removed from those systems with no need for moral hand-wringing. In recent years, however, this “medical certainty” has begun to seem far less certain. Thirteen-year-old Jahi McMath lived for five years after having been declared brain dead, during which time her body not only maintained but continued to develop in ways previously believed impossible under the brain death criteria. The Yale pigs are just another such example of increasing evidence that the irreversibility of brain death might be something of a convenient fiction.

This presentation will consider how we ought, morally, respond to this information as philosophical and clinical bioethicists.
In the midst of the current outbreak of measles, it is easy to villainize anti-vaccination parents—especially those parents that are most ardent and vocal. While such a besmirching may feel cathartic or even warranted, it does little to ameliorate our current predicament. Given this, the question becomes: how should healthcare professionals and the public-at-large view fervent anti-vaccination parents? As shady grifters using social media to con vulnerable parents and ultimately the healthcare system? As victims tragically harming themselves and their loved-ones as a result of their ignorance of science? As suckers placing their trust in questionable scientific positions and even more questionable “experts”?

In this presentation, I will argue that, though still unsavory, the most appropriate way to view ardent anti-vaccination parents is not as villains, or victims, or grifters, but as suckers. I will demonstrate that the key characteristic of the sucker, i.e. fidelity absent a genuine internal struggle, is also a key driving force for this level of the anti-vaccination mindset. I will also provide a robust philosophical definition for “sucker,” a most needed, and too often ignored exploration given our present post-truth world. Building off of my past seven years of writing about and working with vaccine hesitant parents, I will end this presentation by advancing a tentative method for addressing ardent anti-vaccination in the clinic and beyond. We often bemoan anti-vaccination parents’ gullibility, but each of us can look gullible to the people outside of our worldview. All humans seem to share some predilection toward being a sucker. In this way, a strong look into the classification of what makes a sucker a sucker is not just a means for better understanding the outcasts on the fringes, but is a mirror for all of us to better understand ourselves and our allegiances.
Mary Shelley’s *Frankenstein* is commonly interpreted as a precautionary tale against scientific experimentation into forbidden knowledge. I maintain that *Frankenstein* can be read as providing a more lenient version of the Precautionary Principle in that Shelley’s story is not a blanket precaution against scientific innovation altogether, but a warning against the impulse to develop technology, especially related to issues of human consciousness and identity, beyond our conceptual and moral understanding. Moreover, the narrative of Doctor Frankenstein developing an artificial human raises the question about the relationship between mind and body and how awareness and the rich subjective nature of experience can emerge from a fixed, mechanical, and inert body. So rather than seeing her novel as providing a definitive perspective on consciousness, her story can be construed as a thought experiment into the nature of consciousness. That is, the story of *Frankenstein* raises all the right questions for the reader to understand the mystery regarding the status and origins of consciousness and the ethical ramifications of artificially creating a sentient being.

Today, the question about the nature of consciousness and how it emerges is no longer a hypothetical question. A new version of Frankenstein’s monster is potentially occurring in an Austrian laboratory, of all places, where a team of scientists have grown small “cerebral organoids” in petri dishes in order to understand the first stages of brain development in the hopes of detecting developmental disorders in humans (*Nature*, August 28, 2013). Other research institutions, such as Harvard, MIT, and Ohio State University are engaging in similar projects. Scientists at Ohio State University have developed a nearly complete human brain in a dish that equals the brain maturity of a 5-week-old fetus (*Nature*, May 19, 2016). While all of these researchers maintain that there is no risk of these developing organoids becoming conscious, many journalists and ethicists have raised the concern that these scientists may be making assumptions about what makes a being conscious, a mystery that has not actually been settled in the philosophical or scientific community.

In this talk, I will point out that each of the above-mentioned researchers have a different sense as to when a developing brain may become aware and assume a different theory of how consciousness ultimately emerges from brain structures. While it may be true that these brains that are being grown in dishes are not sentient, the diverse views among these researchers on how consciousness is created in the brain suggest the need for clarification on the nature of consciousness and how it is generated. I will use Mary Shelley’s *Frankenstein* as a lens to help sort-out some of these metaphysical, ontological, and ethical issues of consciousness.
This presentation examines the perceptions of healthcare professionals regarding the triggers and root causes of clinician moral distress that threaten professional integrity in three main domains: patient and family centered issues, team and unit factors, and organizational barriers.

To conduct this study, a 21-item Moral Distress Scale-Revised (MDS-R) survey was administered to 697 interprofessional healthcare providers working in four ICUs. All participants were provided paper MDS-R surveys based on professional role and clinical setting. Participants were allowed to write in comments specific to any of the clinical situations included on the MDS-R survey. In addition to the 21 items on the survey, participants were invited to share their voice and unique perspective regarding other situations contributing to their moral distress by providing text comments in a designated section of the MDS-R survey. Participant text comments were reviewed and typed into an excel spreadsheet for theme analysis and interpretation. Themes were generated by the content included in the specific survey item in which participants commented and by the theme of the text comment.

All participants reported experiencing moral distress. Feelings of moral distress were associated with patient, team, and system level factors. Patient and family level contributors to moral distress reflected clinician concerns of continuing life support and prolonging the outcome of death when they perceived that continuing aggressive care was not in the patient’s best interest, a lack of disclosure of HIV status of patients or children to at risk family members, and abuse of staff by aggressive family members demanding patient care the clinical team deemed inappropriate or non-beneficial. Team and unit level factors contributing to moral distress were related to participants feeling pressure from superiors to order unnecessary tests, failing to initiate an ethics consultation by team members due to fearfulness of an attending physicians response to the requested consultation, a lack of collegial respect and collaboration among clinicians, variations in staff preparedness during patient rounds, poor team communication, and intimidation/bullying by colleagues. System level factors perceived to cause feelings of moral distress included clinicians feeling unsupported by senior level administration and their superiors in leadership roles. When clinician concerns and opinions were either ignored or dismissed by system administrators or high-level leadership, participants experienced feelings of moral distress.

This study found that members from all professional roles experienced unique situations contributing to moral distress. Previously unreported triggers of moral distress were identified and span the domains of patient and family factors, team and unit dynamics, and system level constraints. The opportunity to hear the voice of the provider through their written-in comments sheds light on the limitations of the MDS-R to capture nuanced ethical situations that clinicians are confronted with in the course of delivering care to critically ill patients. These shared situations bring to the forefront the challenging professional issues many clinicians face and provided participants a platform to share their perspective and voice.
Before photography, when cadavers were in short supply, artists and medical students relied on drawings or models to learn about the human body. Ecorché figures – drawn and then as 3-D models in 16th century Italy – depicted layers of muscles for anatomical study. These male figures were posed in action. Female anatomical figures, when they were created, were however prone. Susini’s *Anatomical Venus*, 1780, is an example of such a female figure. Termed “peepshow science” by some, these sculptures primarily of wax and extremely lifelike nonetheless prove that some were aware of the inner workings of the body. A striking difference in the stance of these forms is that the “anatomical Venuses” seem oddly lascivious – even with their entrails pouring out of their abdomens, they seem to be moaning in slight pleasure. This presentation will provide an introduction to the ways male and female bodies were presented as objects of study for students of art and medicine in Europe in the sixteenth to eighteenth centuries.
“We Can Do a Few Things Now, or Everything Never”: The Benefits of Preliminary Narrative Medicine Interventions in Clinical Practices and Institutional Curriculum

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For over twenty years, narrative medicine has proven to be an effective model for achieving meaningful and productive patient-physician relationships. Its principles and practices have been integrated into educational and health care settings across the globe. However, for many clinicians and institutions new to its tenets, narrative medicine can feel like an abstraction rather than a practical and essential way to deliver care. They can remain uncertain as to how to translate narrative medicine theories about “recognizing, absorbing, interpreting, and being moved to action by the stories of others” into specific clinical practices or curricular programming.

A common concern among both skeptics and potential adopters of narrative medicine practices is the perception that they are prohibitively time-consuming and labor-intensive. Clinicians envision narrative medicine as yet another checklist to complete in patient interactions that are already demanding and compressed. Directors of medical education and teaching faculty already struggle to integrate and assess ACGME competencies and to provide programming for clinicians who have completed training. Time and resource constraints discourage them from even imagining developing narrative training programs. Some also doubt that the collaborative, creative, reflective work that is at the heart of narrative medicine instruction would find acceptance within institutional contexts that prioritize efficiency, productivity, and reproducibility.

These concerns are not completely unfounded; there is, indeed, an up-front investment of time and effort for clinicians and institutions to cultivate “narrative competence”—as there is in the development of all clinical competencies. However, in this presentation we propose that many of these concerns may be based on an inaccurate “additive” model of narrative medicine in which its pedagogies and practices are viewed strictly as new content areas and tasks. In contrast, narrative medicine is more accurately viewed “not so much a new specialty as a new frame for clinical work.” In as such, its principles and practices can be integrated into existing institutional curriculums and clinical practices as well as enacted through new clinical and curricular vehicles. Moreover, the development of this new framework can be incremental and, even at its most preliminary stages, can produce asymmetrical returns.

To illustrate this claim, in this presentation we draw on our experience as a “novice” institution as a case-study. We describe the two-stage strategy and sequence of narrative interventions we have employed at Henry Ford Hospital in Detroit to develop a narrative mode of attention on both the practitioner and institutional levels. We describe the significant benefits that have accrued from our preliminary efforts and identify their alignment with common institutional priorities such as improving patient care, increasing practitioner resilience, and developing ACGME competencies. We illustrate with real world examples the significant benefits available to patients, practitioners, and institutions even at the start of their participation in “narratively fortified clinical relationships.”
When the Onus Becomes the Omen: Mapping Burnout with Narrative Medicine
Indigo Weller
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Columbia University

This presentation proposes a new set of terms to describe the complex temporalities of burnout within clinical settings. Whereas concepts such as burnout are most often made legible as a point of no return for the impacts of workplace stress, the metaphor doesn’t capture the gradual loss of vitality inherent in the demands of clinical practice and rotation. Drawing from in-depth interviews with clinicians who are Narrative Medicine graduates, the presentation first reframes burnout as a result of ‘clinical enervation’ to describe a nuanced gradation of fatigue— both visible and invisible, collective and individual—embodied over time. The philosopher Byung Chul Han’s discussion of the relationship between burnout culture and the fracturing of attention, alongside Robert Nixon’s concept of “slow violence,” theoretically situate these gradations for the clinician to parse the costs of the competing timescales of care between what a clinician desires and what the structure affords. Lastly, the presentation introduces the term ‘relational reinnervation’ to theorize how the tools of Narrative Medicine, such as reflective writing, close reading, and listening serve as a collective inter-professional redress to the enervations of the clinical environment via restoring ‘the blood supply’ to the relational and the personal. Both terms describe processes which, the author ultimately suggests, form one starting place to resensitize the field of medicine to the gradual rather than the terminal repercussions of fatigue and stress.
CRISPR-Cas9 is a targeted gene-editing tool that is poised to make an unprecedented impact in the world. Among its potential benefits, this technology may eliminate disease, personalize medication, fortify the global food supply, create clean energy, and reduce the organ shortage. This technology also carries attendant moral concerns; including the effect on global ecosystems, the likelihood of fostering stigma and discrimination, and the possibility of modifying every species on the planet in perpetuity, including our own.

CRISPR has revolutionized the process of gene editing due to the fact that is far cheaper, faster, and more efficient than previous methods. This has led to its democratization in that anyone can purchase a CRISPR kit online. At home experimenters may take their craft beer skills to the next level by creating yeast that glows, practicing gene therapy on live frogs, or making antibiotic resistant E. coli.

In the professional research environment, Harvard professor George Church and his team are currently exploring techniques to reintroduce extinct megafauna such as the wooly mammoth in order to increase biodiversity and slow climate change. Church has also used CRISPR to knock out all 62 retroviruses in pigs, which has been a fundamental obstacle to successful xenotransplantation.

Juan Carlos Izpisua Belmonte’s work focuses on the role of CRISPR to mitigate organ rejection by the creation of pig-human chimeras. This process involves modifying pigs with human stem cells so that the pigs become veritable Trojan Horses, growing human organs in place of their own, thereby eliminating the risk of immune reaction. The most fraught and immediate concern follows the work of He Jiankui who claims to have engaged in germline editing by using CRISPR in embryos.

This interdisciplinary panel will consider the scientific, ethical, and policy questions regarding CRISPR and provide recommendations for the responsible applications of gene editing.
This presentation about the challenge of relearning new brain pathways to circumvent musician’s focal dystonia shows what it feels like to almost lose something that is so much a part of one’s identity. I use PowerPoint slides, play snippets of flute music and read from my own poetry about musician’s focal dystonia, published in journals such as Hospital Drive and JAMA. A musician and music professor, I developed focal dystonia in 2012. Just before diagnosis, I had begun the study of poetry, not realizing at first that a new art and voice would be essential while dealing with the threatened loss of another. While I have written a research article on dystonia and given talks about it, this presentation is an artistic examination of the experience.
Who Should be an Advance Care Planning Facilitator?
Andy Wible, PhD
Department of Philosophy
Muskegon Community College

Advance care planning is essential for patients to retain autonomy when they are no longer rational. Yet, even with strong community efforts, less than forty percent of adults have one. Due to the difficulty of the topic and the importance of the decisions, most people (patients and even medical professionals) would rather put it off. Done well, developing advance directive materials involves a conversation for full informed consent. That conversation is best done with a qualified facilitator. But who should be that facilitator? Should it be a doctor, lawyer, nurse, social worker, ethicist, or community member? Positives and negatives of these options will be examined to determine the best medical and moral choice. The tentative conclusion is that due to conflicts of interest, persons outside of the medical and legal fields should be the initial facilitators of these conversations.
There's been some controversy in the literature about whether to conceptualize addiction (understood as craving and compulsive use, not physical dependence) as a brain disease or disorder, as akin to a bad habit, or as rational, even if disvalued, behavior. I argue here that at least some instances of addiction indeed ought to be categorized as disorder (though for reasons different than those typically given by proponents of the “brain disease” model). However, some other instances of addiction are probably also best construed as falling under the “bad habit” model.

At least one of the arguments that addiction is a brain disease rests on the claim that addiction is rooted in neurological changes, especially those involving the dopaminergic reward system. As Marc Lewis and others have argued, merely that a brain system changes does not establish that it is disordered, or diseased. All learning involves change in the brain and, indeed, the sorts of changes seen in addiction are of the same kind as the sorts of changes seen in habit formation.

To show that addiction involves a brain disease or disorder, we must show, not just that there are brain changes, but that the changes are of a particular kind. I briefly recap some arguments against a “dysfunction” view of the relevant changes and in favor of a “capacities” view. The upshot of this argument is disorder involves not dysfunction, but rather the impairment of a species-typical capacity.

The question to be asked about addiction, therefore, is whether at least some instances of addiction do involve impairment of species typical capacities (specifically, the capacities for self-regulation) and whether the brain changes involved in addiction are such as to constitute an impairment in these capacities. “Species-typical” is an important descriptor, since human beings are not perfect self-regulators. We do form bad habits, fail to appropriately prioritize future interests, etc. “Impairment” must therefore be understood as relativized to capacities that human beings actually have, not some ideal set of capacities. Furthermore, there is also a fair amount of individual variation in our capacities for self-regulation, so we that we cannot simply appeal to what is typical for human beings.

I argue that a way of operationalizing the requisite notion of impairment is whether someone falls so below the norm that they require “special help,” where “special help” is help that extends beyond what is routinely offered to everyone. An analogy here might be learning disabilities. Some children find learning to read relatively easy; some find it more difficult. But we expect that most children will be able to learn to read by ordinary pedagogic practices. The kids for whom ordinary practices do not suffice are those we classify as being disordered, or disabled. Similarly, then, we can distinguish between those persons whose addiction is a form of disorder from those whose addiction is (merely) bad habit in terms of the resources they need to change their behavior. The DSM criteria are broad enough to capture both sorts of addiction.
The 1918 Influenza Pandemic is not well recorded in history. Alfred W. Crosby posits in his book, *America’s Forgotten Pandemic*, that during the pandemic in the US “the latest streetcar accident, with its few score deaths, made sensational headlines, while the [influenza] pandemic received meager coverage and only made the front pages of the New York newspapers while it was killing five or six hundred a day in New York City” (314). Crosby argues that the 1918 Influenza Pandemic is largely forgotten and overshadowed by the lasting memory of World War I. Few examples of personal illness narratives from the time period exist, despite how many people caught the disease. Although personal narratives about illness, such as autopathographies, are rare before the mid-twentieth century, the pandemic’s forgotten history makes these accounts even more uncommon. Rarer still are women’s accounts—many of the influenza accounts that survive today are from military hospitals and soldiers. Katherine Anne Porter’s 1939 novella “Pale Horse, Pale Rider” is a notable exception; although her work is semi-autobiographical fiction, “Pale Horse” details the protagonist Miranda’s struggles with her role as a woman during wartime and provides a first-hand and graphic account of influenza and the trauma of illness during a time period where such topics were rarely written about or discussed.

Many historians contend that Porter’s “Pale Horse” is one of the most-read and comprehensive personal accounts of the 1918 pandemic. However, despite the historic importance of Porter’s work, few scholars have examined “Pale Horse” as an illness narrative because the story is fictional. Yet, Porter’s tale of a woman’s perspective of war, illness, and death provides an early example of autopathography, as well as a much-needed historical account of the 1918 Influenza Pandemic in the context of World War I. In my presentation, I examine the history of illness narratives in America, and I argue that examining historical illness narratives is vital to the medical humanities today. By expanding the bounds of the illness narrative genre throughout history to include a wider variety of works—such as Porter’s semi-autobiographical novella—medical humanities scholars and medical practitioners can gain a more insight into illness, treatments, and medical practice.