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Abstracts of Presentations

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Science Literacy and the Medical Humanities: Connections from the 1918 Influenza Pandemic to Today

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Science is rarely reported on accurately; from snappy headlines about dark chocolate preventing cancer to misreporting data about weight loss to promote a new fad diet, most media outlets sensationalize scientific studies for increased readership at the expense of accuracy. In a time where “fake news” is part of our global conversation, media literacy rates are seemingly poor, especially in terms of scientific literacy. However, regardless of the accuracy of science reporting, these sensationalist headlines influence how the public understands health issues and public health more broadly. COVID-19 provides an especially pertinent example; all it takes is for one gross misinterpretation of data to go viral and scores of people believe false and dangerous information about the virus. In my presentation, I examine the reasons medical communication fails, what impacts those failures have on people’s lived experience of disease, and how the medical humanities can help improve media literacy about epidemiology and public health.

To summarize my work in a short presentation, I will focus specifically on the 1918 influenza pandemic and its connection to today. Although the 1918 influenza pandemic may be the closest contemporary comparison to COVID-19 (if we consider 1918-1919 contemporary, which may be a stretch), healthcare is so much more advanced today than it was in 1918 that it can be hard to make meaningful comparisons between fatality rates and other metrics. However, I argue that tracing media coverage of 1918 pandemic gives us a more useful picture of failures in public health communication. In 1918, governments across the globe spread misinformation about the pandemic, which caused a poor relationship between public health officials and American citizens. I argue that poor information, combined with a lack of trust in the US government led to millions of Americans disregarding commonsense public health measures such as isolating, wearing masks, and basic hygiene. As more and more people compare COVID-19 to the 1918 influenza pandemic, comparing the viruses themselves is not nearly as useful as exploring the media coverage. In this presentation, I posit that American mistrust of public health officials is nothing new; in fact, we can directly trace how poor communication between public health officials in 1918 caused a deep-seeded mistrust which still continues today. I will also touch on how conspiracy theories—such as germ theory denialism—plagued the 1918 influenza pandemic and continues today. Finally, I argue that the medical humanities, in particular, medical narratives written for general audiences, can help increase media literacy and bolster public health.

The Biopolitics of Pseudoscience in the United States, China, and Iran

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Politically promoted medical pseudoscience has been on the rise in the past decades, especially during the COVID-19 pandemic. This presentation argues that the influence of political (including ideological and religious) powers on health care through promoting various branches of so-called alternative medicine is a typical example of biopolitics. The biopolitics-influenced medical pseudoscience has been very costly for the affected societies. For example, the anti-vaccination and anti-quarantine movements have caused serious problems and increased mortality and morbidity during the COVID-19 pandemic. One of the major roles of bioethics is defending the principles of beneficence and scientific validity. It means that bioethics is at the forefront of fighting against biopolitics-promoted medical pseudoscience. Therefore, in collaboration with other health humanities, bioethics needs to develop a theoretical framework and practical strategies to address this problem.

To provide tangible examples, this presentation examines the experiences of the U.S.A., China, and Iran and explores the various aspects of biopolitics-promoted medical pseudoscience in those countries. In the U.S.A., public health strategies against the COVID-19 pandemic have been the subject of fierce political and ideological debates in the past two years. For instance, the anti-vaccination and anti-quarantine movements were fueled by false libertarianism nationalist sentiments. In China, beginning from the era of the cultural revolution, the ideas of self-reliance and the cause of creating a non-Western medicine have fueled the revitalization of Traditional Chinese Medicine (TCM) over the past decades. During the pandemic, many unproven claims have been made about the role of TCM in controlling the outbreak in China. In Iran, the government-led revitalization of Traditional Iranian Medicine (TIM) was fueled by ideas such as self-reliance and returning to self. At the same time, some groups of Islamic scholars started a movement to create a new branch of medicine based on the Islamic scripture that has been named Islamic medicine. All these movements center around adopting obsolete, pseudoscientific, or anti-scientific theories such as humoral medicine, meridians of energy, or conspiracy theories about western medicine. They also promote and prescribe an array of untested and potentially remedies, interventions, and practices. Despite their significant differences, they share a deep animosity toward modern science and evidence-based medicine.

Bioethics needs to address the problem of rising biopolitics-promoted pseudoscience. For this purpose, it needs an ethical framework centered around universal principles such as nonmaleficence and scientific validity, institutions such as international organizations and local ethical committees, and strategies developed and adopted by those institutions.

Profound Familiarity in Rural Life and Its Significance for Health Care Ethics

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Low population density, limited in-migration, and significant barriers between residents and urban opportunities characterize life in most rural areas. These three factors combine to produce social conditions that influence human interactions by shaping values and expectations. Understanding the influence of these social conditions on human interactions, values, and expectations is essential for appreciating some of the ways the delivery and reception of healthcare in rural settings is different from the delivery and reception of healthcare in urban settings. Appreciation for these differences can, in turn, illuminate our understanding of certain ethical concerns that arise in rural healthcare. These concerns include privacy and confidentiality, autonomy and shared decision-making, health disparities and burden-to-benefit ratio.

Losing a Capacity vs Losing a Mind

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When functional and anatomical loss of brain regions results in the loss of cognitive capacities, this has traditionally been understood to involve a single, unified person's loss of those cognitive capacities. However, a new perspective on established medical knowledge suggests that in some cases, there is a loss not only of cognitive capacities, but of independently conscious entities coexisting, even overlapping each other, in the brain. Data from split-brain cases, hemispherectomies, and the Wada test will be used to support this admittedly strange view. The argument works from two premises. First, there are many brain regions which would become the conscious neural survivors of a functional or anatomical loss. Second, in many such cases, the conscious neural survivor notices what it is like (in Nagel's sense) to have lost certain capacities, suggesting that the survivor had prior conscious experience. (The conscious neural survivor of, for instance, a left hemispherectomy would not be the conscious neural survivor of a right hemispherectomy, so there are at least two such things; moreover, such survivors can consciously notice the loss, suggesting prior conscious experience.) I argue that the best interpretation of these two facts is that for any such potential survivor, there is a corresponding conscious entity existing before any functional or anatomical loss takes place. The brain gives rise to a plurality of independently conscious entities.

This view will be compared to alternative interpretations of the medical facts, some appearing at first to be more plausible interpretations, but I will argue that on closer inspection, they are implausible or even logically inconsistent. I will end with a brief discussion of the ethical implications of this view.

The Intersection of AI and Bioethics

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Activision, Inc.

Artificial Intelligence, machine learning, and data analysis are coming to dominate every aspect of the professional world, and healthcare is no exception. Organizations everywhere are scrambling to hire talented people proficient in big data techniques because they believe that they will be the ones to find the ‘silver bullet’ to solving complex challenges in their space. However, in the ‘gold rush’ of AI, relatively little has been done to create an ethical framework for using AI and other data science techniques responsibly. In the wake of Timnit Gebru’s firing from Facebook for the co-written paper on ethical guidelines for future deep learning models akin to GPT-3, the need for such a framework seems urgent. Further, pervasive use of data will only proliferate in the future as more companies see it as a kind of magical solve or guaranteed ROI.

Therefore, I propose the beginnings of a framework for the AI and ethics space. Of course, this will not be an exhaustive framework, but I believe that using some of the pillars of bioethics will guide the groundwork of being ethical with AI. Principlism’s four main pillars are a good starting point (Beneficence, Non-Maleficence, Justice, Respect for Autonomy), but more than that the two disciplines, namely, healthcare and data science, are similar in enough ways to warrant a somewhat direct transposition of the ethics of medicine and healthcare to that of artificial intelligence and data analysis. Specifically, I would like to use Beauchamp and Childress’s framework of Principlism and apply those principles directly to the Timnit Gebru scandal as a kind of case study for developing this framework. This will be an early phase of such a project, and as such I would be excited to receive feedback on where to take the project next.

Human-Centered Medicine: Why Medicine Should Go Beyond Science

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University Vita-Salute San Raffaele

In this short presentation, I will discuss a new idea about medicine, which I define as “human-centered”. A human-centered medicine considers doctors and patients alike from their complex human experiences. First, I will address key questions adopting an historical approach: How would we define medicine today? How do we envision medicine to be in the future, especially after the Covid-19 health crisis? Why do we value the doctor-patient relationship, and how does it define medicine? When/how do med students learn relational competences during their medical education and training?

By examining some of the scholarship of Galen of Pergamum, the ancient Greek doctor and philosopher of the second century CE, I will expand the scope of our inquiry from the doctor-patient perspective to the practice of medicine itself, broadly considered in its own definition. If doctors and patients represent medicine, what is the idea of medicine that we can get out of them today? How different is it from the past? Finally, I will propose to frame human-centered medicine into the circular health vision, where human health is co-advanced with the health of animals, plants, and the environment as one complex system.

The Role of Critical Thinking in Clinical Medicine

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Doctors are generally trained, to obtain **objectivity** and **detachment**. Medical education aims to make the doctors look only at patient's biological manifestations and pay no attention to her mind. But the mind and the body are a complex whole, and doctors should have a holistic approach. This holistic approach can be obtained only by reaching a metacognitive level in which we are constantly aware of our thinking biases and inclinations.

The best way to obtain this metacognitive level of analysis, I think, is through critical thinking. In critical thinking someone is critically thinking about her thinking. This kind of reflection about our way of thinking is crucial in better developing our rationality. Yet, an important aspect, critical thinking should not be understood here only as an academic course or as a cognitive skill, but more as a cognitive stance.

Critical thinking at its best comes with a better decision making process after rationally analyzing the pros and cons of a decision, and a kind of intellectual humility. Both are very useful for doctors, for doctors have to take decisions, and also they are tempted by this power of deciding about others to manifest like walking gods.

Doctors have to see themselves as humans and more important is to see their patients and human beings. My presentation is a philosophical analysis of the ways in which the medical staff may benefit by taking a critical thinking course. This course, besides the two already indicated advantages (a better decision making skills + intellectual humility) may help the doctors through a constant metacognitive scrutinizing may prevent medical staff from burn-out symptoms and manifestations.

The main aim of my presentation is to argue conclusively for the introduction of a critical thinking course in the curricula of medical schools. It will be shown that such a course will make doctors better adapted for the interaction with their patients.

Why Medicine Needs Podcasting: Integrating the Humanities into the Practice and Teaching of Medicine with Podcasts

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Storytelling is a valuable tool in both medicine and the humanities. In the clinic, we pass down stories to teach people lessons, give advice, or share something that went wrong to prevent the same mistakes from happening again. Storytelling through podcasting is a more freeform substrate for both formal and informal or abstract topics that cannot traditionally be organized in a journal article. Podcasting allows both the interviewer and the interviewee to dive into a topic with no rules or limits, and can lend the conversation to some great revelations. The listener, in turn, can access information in an entertaining, new format.

My two podcasts, *Another Heartbeat in the Room* and *Just Marcia* are examples of subject-centered storytelling. Both episodes are centered around a non-health professional healer who works in the hospital setting, allowing the listener to learn more about these unique careers that enrich what it means to heal people in our medicalized society.

In *Another Heartbeat in the Room*, Dr. Jeremy Misselbrook is a chaplain and adjunct professor of theology. Along with detailing his career in chaplaincy, he reflects on his personal experiences in grieving a family member; by channeling his own story of loss into helping others, he gains closure about his own grief. Our conversation starts with educational topics, following a traditional interview process. But as the conversation evolves, it takes on a more free and reflective character that sheds light on the more humanities-driven aspects of his career. Through the episode, the listener accompanies Dr. Misselbrook on his journey to discover what healing means to him.

In *Just Marcia*, Marcia Brennan is a resident artist at MD Anderson Cancer Center. She discusses with me what it means to care for inpatient palliative care patients, and reads touching narrative stories from some of her patients. She also details her collaboration and friendship with nurses, chaplains, social workers, music therapists, and other interdisciplinary care providers, elucidating the importance of holistic team-based care in the hospital. The use of sound effects and music with her soothing narrative voice transports the listener into her world as an artist.

In this presentation, I will include excerpts from both of my podcast episodes. I argue that podcasting is an essential tool that should be taken advantage of in medicine because it provides a space for broader conversations about medical topics, allowing for the intersection of other fields to shed light on our understanding of medicine. Podcasting is also a valuable learning tool for students who best learn at their own pace outside of the classroom setting, or enjoy listening to podcasts as a source of entertainment.

Unilateral Withdrawal of Life-Sustaining Treatment Within Crisis Standards of Care

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Under non-triage conditions, there is general consensus among ethicists and health care professionals that, if one has sufficient ethical justification to withhold a life-sustaining treatment, one has equivalent justification to withdraw an already implemented treatment. Standard justifying criteria include autonomous refusal by the patient or an appropriate surrogate decision-maker, disproportionality between the burdens and expected benefits of the treatment, or physiological futility. Within the “state of exception” occasioned by a pandemic outbreak that may require the implementation of “crisis standards of care,” it is generally accepted that one may unilaterally withhold a scarce life-sustaining treatment from one patient who may not sufficiently benefit from it and allocate it to another in greater need, or who is in equivalent need but appears to have a better chance of benefitting from said treatment. The modifier ‘unilaterally’ refers to treatment being withheld without, and perhaps against, the explicit consent of the patient or an appropriate surrogate. The question at hand in this presentation is whether unilateral withdrawal of life-sustaining treatment is equivalently justifiable in triage situations. I argue that unilateral withdrawal may be justified, with certain caveats, for three reasons: 1) it is justified by the widely-accepted principle of double-effect; 2) a ventilated patient has no property-like claim to continued ventilation, excepting patients with a disability requiring chronic ventilator support; and 3) disallowing unilateral withdrawal practically entails a first-come/first-serve policy, which is ethically problematic for various reasons, including further disadvantaging those who already experience significant disparities in health care access.

Engaging Students in Cross-Disciplinary Ethics Dialogue

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Rider Foley, PhD, Department of Engineering and Society, University of Virginia

Kathryn Haas, PhD, Department of Chemistry & Physics, Saint Mary's College

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Healthcare professionals face myriad social, technical, and financial challenges in the course of their work that present moral and ethical dilemmas. As nurses, physicians, and biomedical engineers prepare for careers in healthcare, discipline specificity in ethics training is essential for navigating distinct challenges. However, discipline-specific ethics training might ignore valuable lessons that can help students prepare for the breadth of experiences and contexts that arise in healthcare. This interactive panel will draw perspectives from a team of researchers and educators from different STEM fields—biology, clinical medicine, engineering, chemistry and physics—who are working toward integrating cross-disciplinary ethics education into their programs. The research team also includes three members whose specializations are data science, philosophy of cognitive science/journalism, and chemistry. This panel will discuss the challenges of working across academic disciplines, the way those challenges were addressed over the course of our NSF-sponsored project, and the opportunities that arose from having diverse perspectives on the team. This research will share data from healthcare-related undergraduate students at four different universities who engaged in a shared, cross-disciplinary online discussion board. The panelists will demonstrate how the students' written responses to open-ended prompts addressed cross-cutting issues related to healthcare such as gene editing and drug pricing. The discussion board confronted students with a plurality of ethical stances, divergent views and trade-offs. By engaging in cross-disciplinary dialogue about ethics, the students reflected upon the importance of those diverse perspectives. In contrast to the interpersonal toxicity of some online discussions facilitated by social media platforms, students participating in the online discussion board exhibited professionalism in practicing the interpersonal and communication skills crucial to the team-based nature of medical, scientific, and engineering work in the twenty-first century. Thus, these reflections offer educators and researchers actionable lessons about the value and feasibility of interdisciplinary ethics training. This panel hopes to engage the audience in an interactive deliberation about how to engage students in cross-disciplinary ethics education.

Medical Humanities and Islamic Humanities: A Cross Cultural Perspective on Narrative Medicine

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Pioneered by Dr. Rita Charon, the field of Narrative Medicine (NM) as situated in the world of the Medical Humanities offers physicians and medical trainees an invaluable perspective on the role of story in the physician-patient interaction. Drawing on literary theory and focusing on four key “narrative situations” in medicine, physician and patient; physician and self; physician and colleague; and physician and society, NM provides a lens through which the physician or trainee can more consciously understand and participate in the unfolding stories of her medical practice.

Coined by Professor James Morris, the term “Islamic Humanities” refers to the body of arts, literature, and poetics inspired, in Muslim civilizations and among Muslim creatives throughout history, by the central Islamic text of the Quran. Strongly exemplified by the robust tradition of artistic and literary adaptations of Quranic stories, the Islamic humanities include a rich, intertextual narrative tradition ranging from the 13th century oral poetics of Rumi to contemporary novels from the Maghreb.

At the shared heart of both NM and the Islamic Humanities is a critical emphasis on narrative as a teaching tool and as a way of knowing epistemologically distinct from other ways of knowing. In the case of NM, narrative knowledge is distinguished from “logicoscientific knowledge” within medicine and medical education; in the case of the Islamic humanities, a long history of ethical training through the tool of the “morality tale” can be traced through the Muslim world’s *madrasas*, mosques, and marketplaces. Read together as complementary methods, NM can be engaged through the philosophical, ethical, and literary lens of the Islamic humanities by engaging specific narrative texts using their respective methodologies. Through a close reading of a medical narrative in Rumi’s *Masnavi*, in its original Persian, using the methodologies of both NM (as laid out by Drs. Charon and Verghese) and the Islamic humanities (as laid out by Drs. Morris and El Shakry), this presentation aims to formulate the beginnings of a dialectical engagement between the Islamic humanities and Narrative Medicine.

Weaving Narrative Ethics in Family Medicine Clerkship Didactics

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In this session participants will engage in exploring how to integrate narrative ethics in clerkship didactics. They will learn how to turn case discussions and board style questions into an active narrative ethics session that engages and supports learners in their understanding of situational medical ethics that may arise when working with patients and medical teams.

Objectives for session are:

1. How to create an interactive narrative ethics didactic using Zoom or face-to-face formats
2. How to elicit what learners observe to be ethical dilemmas faced by physicians
3. Reflect on connections between Narrative Ethics, Person-centered Medicine and Evidence-based Medicine and how to use within clerkship curriculum

Teaching through the framework of narrative provides a unique approach to traditional methods of teaching. Weaving narrative ethics into one 75-minute active learning session allows students to practice turning the clinical experience into a narrative space by calibrating the unspoken with the spoken. Learning to ask questions when situations that have not been taught arise or are unknown is what Larry Churchill refers to as “being narratively aware.” He further suggests narrative awareness aids in “resisting the temptation to adopt a privileged position that assumes I know what is best, or even that I know the right ethical methods or processes for each situation.” If we, as medical educators, are to help students become balanced physicians we have an obligation to help them develop skills for working through situations where there are no clear or correct answers. The practice of narrative ethics may be one step in that process.

Given the practice of Family Medicine is broad; we focus our ethics active learning session on applicable skills students need at this stage of learning: communication and truth-telling. Narrative ethics allows for the exploration of case-based reasoning because it focuses on the story. At this stage our learners are observers, witnesses, as well as participants in the patient’s story. Allowing students, the time to reflect and share on experiences in a safe nonjudgmental space while practicing the art of asking clarifying questions builds their confidence and knowledge. Communications is a core element of understanding physician and patient responsibilities to each other and as an element of building trust. When that trust or inability to communicate occurs ethical issues arise. Helping students understand how their actions add or subtract to that core serves as goal for the narrative ethics session.

This workshop is designed to help expand how narrative ethics can become part of the clerkship experience or other healthcare practicum didactic sessions. We will discuss ideas for case discussion, narrative ethics improv, and practice how to use written cases and stories to extrapolate ethical issues.

Communicating Uncertainty in Medicine: Historical, Visual, and Ethical Perspectives

Tia Forsman, Isabel Josephs, Raphaela Posner, & Joseph Wu
The Warren Alpert Medical School, Brown University, Providence Rhode Island

This panel explores the complexities of communicating uncertainty in clinical practice. While effective communication is widely acknowledged as central to medicine, what constitutes “good communication” is often vague or narrowly understood as the transfer of information. The panel is composed of third year medical students in the Medical Humanities and Ethics Scholarly Concentration at Brown University. Drawing from ongoing research projects, this panel aims to broaden and enrich our understanding of medical communication with insights from the visual arts, philosophy, and psychosocial research.

Tia Forsman’s project uses the visual arts to explore the relationships physicians and patients have with medical images. X-ray, Ultrasound, MRI, CT, PET, and histology images serve as “objective” evidence when diagnosing patients, but there is still a great deal of emotional uncertainty that patients face along their medical journey. How else can we engage with and interpret the information in medical images in a way that acknowledges this uncertainty? As an answer to this question, this project presents multiple artist booklets. Handmade prints, drawings, and text pieces sourced from patient and physician interviews in each booklet embrace uncertainty and abstraction, providing open-ended answers for patients, physicians, artists, and the public.

Isabel Josephs’s presentation explores how improved communication in the field of pediatric oncology can lead to better outcomes among families whose children die of cancer. Caregivers often experience two losses simultaneously: the death of their child and withdrawal of the patient’s medical team and primary support network. This presentation explores the role of the medical team after the child’s death by focusing on the family as survivors. Through qualitative interviews with a diverse bereaved caregiver population, we have gained a better understanding of self-identified psychosocial needs and forms of support. We highlight how adequate grief support can only be achieved with improved and ongoing communication about a family’s needs after the child’s death.

Raphael Posner’s presentation examines the historical and artistic influences that have shaped communication training that medical students receive. The exam room has become a performance space in which both student and patient are actors. Using narrative nonfiction, this presentation explores standardized patient interactions and the intersections of performance and medicine. How can reimagining the exam room as a stage help to shift our approaches to clinical education? What scripts have been given to trainees and how can they create more room for genuine connection? This work proposes new perspectives on improvisation as a teaching tool, promoting empathy, flexibility, and confidence in student doctors.

Joseph Wu’s presentation examines the ethical issues that arise in the communication of health risks. Discussions of risk communication typically assume two aims, which can come into conflict. One is to enable individuals to make informed decisions in line with their values. The other is to encourage behavior change. These separate objectives of risk communication place emphasis on different ethical principles, namely, respect for autonomy and beneficence. How should these ethical values be balanced in practice? This presentation examines the challenges of communicating risks to patients and the ethical issues involved.

State Actors: On Physicians' Public Role

Jake Greenblum, PhD, The University of Texas Rio Grande Valley School of Medicine

Ryan Hubbard, PhD, Gulf Coast State College

If physicians should be regarded as public officials, then this impacts how we should characterize the physician-patient relationship. But should they be regarded in this way? In this presentation, we argue that physicians are indeed relevantly akin to public officials. Although others have argued for a similar position, our explanation corrects for certain deficiencies in alternative accounts, such as R. Alta Charo's and Rosamond Rhodes's. We conclude by mentioning several implications of our view on the physician-patient relationship.

Effort, Capability and Solidarity: A New Direction for Individual Responsibility in Public Healthcare

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Suppose two patients within a public healthcare system need medical care after contracting Covid-19. One patient has acted responsibly, following safety guidelines, but got unlucky. The other has acted irresponsibly, following no guidelines. All else equal it seems intuitive that we ought to give preference to the patient who acted responsibly; be it by treating him/her first or spending limited resources on him/her. The irresponsible actor has failed to regard others covered under the public healthcare system by needlessly creating a demand for resources that others could benefit from.

There are, however, compelling reasons to reject individual responsibility as a measure of public healthcare rationing. A healthcare system should not make those who are unwell even worse off through penalization, given that the objective of a healthcare system is to promote health and wellbeing. Further, uncontrollable antecedent factors such as a negligent upbringing may not allow for individuals who act recklessly to be held responsible in such a way that they can be justifiably penalized. Solving this tension is important: both practically as a potential rationing-criteria; and ethically as an insight into our mutual obligations under social systems we all participate in.

My aim is to provide a novel alternative to this longstanding clash in medical ethics. First, I reject a solution offered by Benjamin Davies and Julian Savulescu, who argue that irresponsible behavior can be enforced in public healthcare when patients reject a “Golden Opportunity” to commit to improving their health. Golden Opportunities are offered by the healthcare system and designed to minimize influences which undermine the autonomy of the patient, while providing them with as much information as possible. I reject Golden Opportunities as a measurement of responsibility because they cannot be used to deem someone irresponsible in a way that warrants penalization: the patient either takes responsibility and receives treatment or is deemed unfit to make an autonomous and informed decision, and so unfit to be held responsible, thus still receiving treatment.

Second is my positive proposal. I draw on the framework of The Capability Approach, a theory of wellbeing due largely to Amartya Sen and Martha Nussbaum, which holds that everyone has a range of capabilities they may act on, even those who are not well-off. I argue for a capability-relative measure of responsibility, where individuals can be penalized if they do not act responsibly, relative to their capabilities, with respect to their health. The more capability one has, the more they are on the hook for. The Capability Approach also has desirable motivational import. Encouraging all to improve their health, even those with modest means, can promote healthy lifestyles through a mutual culture of health-promotion and self-empowerment. This in turn will minimize the number of patients who require treatment due to irresponsible behavior and minimize those who may be penalized accordingly.

Moral Distress as a Lens for Understanding Media Portrayals of Covid-19 Frontline Workers

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During the coronavirus pandemic, various media outlets showcased harrowing tales from frontline workers. For instance, [Newsweek](#) featured the writing of Dr. Sadath Sayeed who discusses troubling rationing decisions: “Nevertheless, I also cannot help feel that a crucial part of our humanity will be chipped away each and every time such decisions are actually made.” [New York Magazine](#) featured Dr. Adam Brenner from Brooklyn, New York: “I don’t know how long I can keep doing this for. In my mind, I’m going to do it, I’m going to be there until this is done, but it’s going to be very hard to come back to work after this is over.” These stories convey the high levels of stress experienced by those healthcare workers treating Covid-19 patients and dealing with overwhelming patient volumes, hard decisions about resource allocation, and the difficulties of treating isolated patients while masked, among other challenges. These stories also bring to light the reality that many health care workers were not only navigating hard situations, but doing so in a way that prompted intense soul-searching. Yet, media outlets tended to focus only the psychological aspect of this stress.

In this presentation, I will argue that many of the narratives of frontline healthcare workers during the coronavirus pandemic are stories involving moral distress—an ethical-mental-physical-and-emotional reality—yet, this category was rarely used. Examining the stories through the lens of moral distress serves two purposes: to identify the unnamed phenomenon of moral distress that is in the narratives and to use the stories to help us understand how moral distress has taken form during the coronavirus pandemic.

Moral distress was first introduced by Andrew Jameton in *Nursing Practice: The Ethical Issues* in 1984 to describe a special stress experienced by nurses who know the right action, but are prevented from enacting it usually due to institutional restraints. Moral distress is comprised of three parts: context, mechanism, and effects. The context is being constrained from performing the right action. The mechanism is the “initial distress” followed by accumulating stress known as “reactive distress” or “moral residue.” The effects are multifaceted and can be experienced on the physical, mental, and/or spiritual level and often lead to burnout. Moral distress is distinct from moral fatigue, compassion fatigue, PTSD, and moral injury. It is not only a psychological phenomenon, but also a spiritual and ethical one.

Using medial portrayals from the frontlines, I will show how moral distress has taken form during the coronavirus pandemic. I will show how constraints are largely global, rather than institutional. I will show that the problem of moral residue seems particularly stark and worrying considering the length of the pandemic, and I will show that the effects are likely long-lasting and on a large scale. Recognizing moral distress in the stories of frontline healthcare workers such as Sayeed and Brenner is a necessary step to healing, for healing can only begin once the problem is properly named.

Palliative Performance as Political Protest in Western Medicine

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Roman Baca MFA, Parsons, York St. John University

Col Tamara Averett-Brauer (Ret.), MN, BSN, RN, Air Force Research Lab

Lt Col Sarah L. Huffman, PhD, United States Air Force

Central to common place understandings of the word “care” in modern Western medicine is some form of curative or comfort medical intervention. Basing the concept of care on medical intervention also implicitly shapes normative expectations about what counts for appropriate interventions as well as who should provide and receive the intervention. While “care as intervention” holds true in both Western military and civilian medicine, there are differences when considering end-of-life care. Over the past two decades, battlefield medicine has narrowly focused end-of-life care on curative interventions giving rise to an oft cited static of 98% survivability from battlefield injuries. Lauded as a victory in military medicine, 98% is never qualified; leaving this statistic open for endless interpretation. As such, this statistic constructs a military, medical, and ethical fiction that depicts war without death and forwards the goal of achieving this reality. Medics (physicians, nurses, medics, et al) should intervene with life-saving care such that all catastrophically wounded survive. In contrast, over the past two decades Western civilian medicine has broadened end-of-life care to embrace comfort interventions. Recognizing death as an appropriate and acceptable outcome in medicine, palliative care seeks to minimize suffering without curing the underlying injury or disease. Accordingly, medics should intervene with comfort medicine for those who are dying. Performance—whether military (curative) or civilian (comfort)—places the medic in center stage as heroic “care” provider who singularly focuses on the suffering injured or ill person as recipient of “care.” Considering that the word palliation is etymologically derived from the term pallim, meaning to cloak or cover over, the political performance of care literally “palliates” the suffering of the medic. However, political performance of palliation does not end in comfort but in ignorance of the suffering and pain end-of-life care places on the medic. This is particularly true when considering military medics who provide life-saving interventions far forward on the battlefield with few resources. Turning to the theological works of Jean Luc Marion, Emanuel Katongole, Brian Robinette, and Walter Brueggeman—four theologians invested in grief and healing as a form of political justice—this presentation will explore the lived experience of combat casualty care providers who have encounter mass casualties in austere settings. We will broadly suggest that the performance palliation needs to be expanded in two ways to include comfort measures for medics. Specifically, we will explore how artistic performance akin to classical Greek dramaturgy could provide avenues for communal lamentation and political healing in the aftermath of providing medical care at the end-of-life. As a case in point, we refer to the works of Mr. Bryan Dorriers and Mr. Roman Baca. While our presentation will focus specifically on military medics, we believe that palliative performance could be serve as a healing modality for any medic and be an avenue to mounting appropriate political protest to change institutional systems that have a tendency to remain deaf to the palpable and visceral reality of human vulnerability and anguish.

The OB-GYN and Me: An Experience Challenging Paternalistic Patient Counseling

Jordan Longabaugh, MSV
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Allow me to paint a picture of a common scenario: a young-twenties female, armed with handouts and a carefully crafted spiel to convince a patient to do something, anything – a vaccine, colonoscopy, you name it. My efforts were often met with polite head shakes, short refusals, or the “You’re Not the First Medical Student That’s Tried” laugh. You could imagine my total awe in the presence of physicians that I can best describe as influential. These attendings could walk into an exam room and get a patient on board with seemingly any-and-all of his or her recommendations. I saw a variety of methods, from gentle scoldings to tender insistence to mild guilt trips. The patient never reacted particularly poorly, and as such tactics typically worked to carry out necessary health maintenance tasks, I wondered at what point in my career I would become so powerful.

My first true clerkship was in obstetrics and gynecology, and in my early study of this branch of medicine, I originally concluded a central idea: there are rules. I appreciated how “hard and fast” everything seemed, handed to me out of a textbook in definitive language like “patients with gestational hypertension are delivered at thirty-seven weeks.” Without the influence of brilliant providers, I likely would have attempted to relay these recommendations to our patients using the approaches described above. On the antepartum floor, I witnessed patient counseling that eliminated any of the notes of paternalism I had regarded as acceptable – and even admiring.

The antepartum wing is typically an extended stay locale, the temporary home to those with pregnancy conditions that need close observation. Nearly all our patients were agreeable to a daily injection of heparin due to their physiologic hypercoagulability with a side of immobility, but one of our expectant mothers stood out for her hesitancy. I acknowledged her right to ponder our recommendation yet my internal budding Dr. Know-It-All was throwing her hands up. At the moment that I had defaulted to irritation, I watched my obstetrician attendings choose understanding. They engaged in a lengthy conversation about her personal history, specific concerns, and how a middle ground could be achieved for the safety of her and her baby. She was initially agreeable to frequent ambulation and compression devices for clot prevention. In touching base with her regularly, though, in exchanges where the values of both sides were voiced and honored, I found that she was agreeable to injected heparin within two days. Our hope as providers was satisfied but in a far more meaningful way than I had typically seen.

Ashamedly, it only took me a few years of book work in medical school to subconsciously adopt a “I Know More So I Must Know Best” mentality. However, through moments like above, I’ve learned that thoughtful patient encounters – ones that rank humanity and common understanding as high as they do the expression of medical expertise – are the best antidote to a physician-patient power structure.

Mad Vulnerability: Rethinking Autonomy from the Perspective of Mad Studies

Kathleen Lowenstein
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Michigan State University

Work within critical disability studies and feminist bioethics has argued for a reevaluation of the ways in which autonomy is conceptualized and understood within bioethics. In particular, both traditions have argued for an explicit interrogation of the way in which structural considerations shape our understanding of and response to questions of distress and vulnerability. However, relatively little work has explicitly interrogated considerations of autonomy from the perspective of Mad Studies, an emerging discipline that seeks to center the historically marginalized perspectives of those identified as mentally ill.

This presentation will build on existing critical work on conceptualizations of autonomy, particularly considerations of autonomy from within clinical frameworks, by placing them into conversation with Mad Studies, asking how these considerations change when the historically marginalized perspectives of those identified as mentally ill are centered.

Bodies & Books: An Undergraduate Literary Seminar on Health (In)Equity

Irène Mathieu, MD, Department of Pediatrics, University of Virginia
Benjamin Martin, MD, Department of Internal Medicine, University of Virginia

Health disparities and health equity are increasingly being discussed in the media, particularly in light of the ongoing COVID-19 pandemic. We designed a seminar course aimed at providing undergraduate students with an interdisciplinary introduction to health disparities, a major social problem, by exploring social determinants of health (SDoH) through the critical analysis of literature, predominantly poetry, fiction, and non-fiction, as well as podcasts, film, and more. The SDoH discussed included race, gender, sexuality, transness, colonialism, immigration, incarceration, poverty, ruralism, and disability. Students learned about concepts of health equity, including the biopsychosocial model, intersectionality, intergenerational trauma, power dynamics in the patient-provider relationship, cross-cultural care, and the role of creative expression and personal narratives in experiences of illness and health. We also examined forms of resilience as resistance to oppression, including humor and gratitude.

For undergraduate students interested in health care, public health, creative writing, literature, anthropology, and/or sociology, the course provided an opportunity to deepen their understanding of social determinants of health through a medium that has been shown to have beneficial effects in multiple domains. Reading literature improves performance on the theory of mind task, which is a measure of empathy (Kidd & Castano, 2013). When medical students are exposed to the humanities they show improvement in a number of positive personal qualities, including empathy, tolerance for ambiguity, wisdom, emotional appraisal, spatial skills, and self-efficacy (Mangione et al, 2018).

Each session was structured around group discussions. Guided writing exercises were embedded in class with the goal of deepening close-reading skills and the ability to relate art to current events and social issues. In addition, students were prompted to create “self-reflections,” written as poems, essays, fiction, or songs, and which served as an opportunity to apply creative techniques learned in class to their own personal exploration of health disparities. The course culminated with a final assignment in which students selected one social issue in health care and explored it through a creative project, such as a series of poems, short story, song, short documentary film, or creative essay. Students who participated in the course are currently completing evaluations.

We will present the details of our innovative seminar, along with sample works by our students (shared anonymously and with permission) and results of a course evaluation we designed to capture students’ impressions of the course. We will discuss how diverse forms of literature can contribute to health equity education, particularly for undergraduate learners and those in (pre-)health educational programs.

Sexuality and Cancer: The Role of Pleasure in the Fight for One's Life

Chloe Matovina
Feinberg School of Medicine
Northwestern University

This presentation will investigate the role of sexuality and intimacy in cancer treatment and survivorship through the lens of war metaphors. Rhetoric used to describe cancer is often strongly militarized, focusing on a fight for survival. Many are familiar with the benefits of war metaphors: they convey messages of strength and may help patients conceptualize a complicated disease process. Also well-understood is how they contribute to shame and blame for patients who do not survive their cancer diagnoses. Less examined is the way these metaphors deprioritize anything outside the realm of life and death—including sexuality.

That is an error this presentation will correct. Given that cancer diagnosis and treatment significantly affect sexuality, intimacy and sexual function, health professionals should be equipped to discuss these topics with patients; however, sexuality and pleasure are often left unaddressed in cancer care settings. Further, as cancer care and survivorship continue to improve, it becomes increasingly realistic for patients to think beyond the realm of survival and consider quality of life as a relevant decision-making factor. While the “fight for survival” remains important, patients must also consider what kind of life they are fighting for.

To maximize quality of life for patients with cancer, pleasure and sexuality must be prioritized as part of standard oncologic care. This can be accomplished by a shift away from war metaphors in the language used to describe cancer along with improved longitudinal training of medical professionals. Throughout this presentation, the audience will be challenged to think of sexual pleasure as a critical component of quality of life in the medical setting.

Student Pharmacists' Impression of Three Plagues

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Ferris State University College of Pharmacy

Introduction:

The COVID pandemic was one of the top news stories of 2020, and it affected people worldwide in different ways. Several procedures were implemented to help “flatten the curve” by slowing the infection rate and lessening the strain on the healthcare system and this was not the first time in history.

Objective:

To obtain one institution's Doctor of Pharmacy students' perspectives on the similarities and differences of two notable historical plagues compared to the current COVID plague.

Methods:

Student pharmacists who, as part of a history of pharmacy elective course, were asked to watch a documentary on the history of the Black Death and the 1918 flu pandemic. After watching these video clips, the students were asked to identify four similarities and four differences for each plague as compared to the ongoing COVID plague. The study was classified by the Institutional Review Board as exempt.

Results:

A total of 15 (75%) students provided consent. Three main themes were identified based on the frequency of the student's responses. These themes were medical, social, and overall advancements leading up to the COVID-19 pandemic.

Top medical themes included vector differences, viral vs. bacterial, mortality, age differences, treatment options and clinical signs and symptoms.

The second theme involved social aspects. The two top social aspects were the enforcement of quarantines and the use of personal protection equipment.

The third theme was that many advancements have been made since the period of the two pandemics. Comments such as human ingenuity, increased medical knowledge, developments in tools to battle pandemics, and healthcare innovations were mentioned.

Conclusion:

Through completion of this assignment in a history of pharmacy elective course, student pharmacists learned about two past pandemics while living during one themselves. They were able to identify similarities and differences among the pandemics. They have experienced history.

Cathartic Poetry – The Therapeutics of a Narrative-Based Self-Case Study

Ioan-Alexandru Mirea MD
Carol Davila University of Medicine and Pharmacy

The medical practice, especially for young physicians, consists of a conundrum of science, craft and human understanding. Considering that the science could be found written anywhere, the craft could be “stolen” from the senior and more experienced doctors, but the human understanding would remain the most apparently unattainable and intimate of any aspects of the professional and also private life. Furthermore, not addressing the human experience and ignoring or not adequately comprehending the doctor-patient relationship, peer-to-peer or physician-institution relation, dysfunctions and mental health issues will emerge, starting from minor inconveniences to serious disorders, such as: anxiety, burnout syndrome, depression and more. So, as a young resident doctor in Psychiatry, I asked myself: How could I reach inside myself and grasp the dimensions of human experience, interaction and relation, that are totally subjective and pertain solely to me? And how to better heal myself and understand closely what I am experiencing?

Through poetry and a narrative-based approach to one’s experience, a type of an outer self-view emerges and thus the cathartic writings become material for a hermeneutic analysis. Poetry, as opposed to music, visual arts or performing arts, has the advantage of using already a known tool: the word. Whereas in dance or music, for example, the performer is forced to have a set of procedural, technical knowledge, poetry leaves the ultimate liberty through word expression. Transforming this cathartic experience into a surrealist exposure of emotions, impressions and thoughts, in a narrative manner free of technical and talent-related limitations, would ultimately provide the young doctor or medical student with a case study. The artwork should be perceived as a different entity in order to be analyzed properly in a philosophical and also therapeutic manner. After setting a potential procedure of the poem’s analysis and understanding as a therapeutic intervention, drawing conclusions and accessing new metacognitive dimensions, should be the end goal of the whole pursuit.

The goal of this inquiry is to identify different types of cathartic poetic pursuits and the means to manage and extract the most from those artistic experiences, either from philosophical perspectives or therapeutic ones. From the lyrical subject’s perspective, there are three main variants that could be isolated or combined in the poetic experience: the lyrical self as the doctor/student and thus representing the author’s self most of the time, the patient or patients as playing an immersive role, actually writing about the physician’s impression of the patient’s impression about the doctor and lastly, the passive observer of hospital or medical narratives. Each of these three instances could play an amazing therapeutic role in the cathartic poetic pursuit of one’s self case study.

The Ethics of Narrative-Based Medicine for Improving Therapeutic Relationships for Persons with Schizophrenia

Andrew Molas
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York University

I defend the benefits of narrative-based medicine (NBM) as a means for improving therapeutic relationships between caregivers and persons with schizophrenia. I begin by discussing evidence-based medicine (EBM) has become the standard and the most widely adopted model of medicine that has been embraced within the medical community, including psychiatry. Since the aim of EBM is to provide an objective and value-free approach to medicine, EBM claims to provide one of the most accurate and effective treatment methods available for addressing health concerns. However, because the focus of EBM is on symptom reduction and restoring a person's state of health, one reason why EBM is limited is because it neglects the additional social and existential features of a person's life that must be factored into successful treatment options. As an alternative to EBM to address these additional factors and fill in the missing gaps, NBM probes into the broader context of meaning that the experience of illness has for the person seeking medical care. Instead of focusing on treating symptoms as mere medical anomalies, a narrative approach aims to provide a clearer sense of the meaning of illness on the person's life. This exploration of an additional experiential component of the person's experiences, combined with traditional approaches to medicine, offers a holistic picture of the person and of the impact of illness on their daily life. Moreover, NBM has potential benefits for helping minimize the stigma surrounding mental illness and to support persons with schizophrenia on their path to recovery.

The Power of Narrative-Based Medicine in Developing Empathy

Caitlyn Mulcahey

Ethics, Equity, and Justice Concentration
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With the decline of the Golden Age of Doctoring and the diminishing paternalism within patient-provider interactions, physicians and students alike must redefine what holds importance in successful patient relationships. Such reformers might include the pillars of medical ethics such as beneficence, non-maleficence, autonomy, and justice as guiding principles. However, such ethical foundations suffer when empathy is not adequately developed in the applier. One cannot employ beneficence or non-maleficence without first understanding what is good or harmful within the context of the patient's rich personal history. One cannot honor choice or fair practice without first taking into consideration the patient's foundational value system.

Medical School Curriculum treats empathy as an antecedent. It is an assumption made by admission councils that an applicant has entered the medical field with refined empathy and an innate drive to help others. While this may be true of applicants and admittees in some contexts, empathy is not always innately gifted or experientially earned prior to medical school. Moreover, in the practice of treating diverse human beings, there will always exist a space for honing empathetic skills.

It is apparent from my experience that medical school curriculums do fringe the empathetic perimeter when purposing clinical vignettes. The cases often rely heavily on the patient's account of events and encourage students to discern the patient's goals in seeking care. Students are taught that thorough history taking is a necessary tool for arriving at a proper diagnosis. However, I argue that isolated evidence acquisition fails to capture the most important lesson from a patient's story. Teaching students to honor a narrative as an extension of self presents an opportunity to understand and develop empathetic connections which are necessary for foundations of trust and relationship building. A student should not treat patient encounters as a data pull—obtaining information and evidence directly scripted from a biomedical approach. A narrative-based approach would encourage students to look broadly at the patient as a person. With repeat encounters initiated from intentional story-gathering, students will train their cognitive patterns to recognize whole people and to feel with the patient rather than for. This may in turn prevent the “parts not whole” tunnel vision or desensitization that are commonplace in medical student professionalization. Furthermore, a narrative-based approach will encourage students to also “self-offer”. That is to say they will learn to take off their prestige and social capital white coat, walk beside the patient on level ground, and admit they are human too.

In honoring the value of narrative, I engage my topic in the form of a poem that tells the story of my interaction and understanding of empathy as a medical student, [which may be found here](#):



Examining the Ethical Considerations of Limited Resource Allocation During an Emerging Infectious Disease Outbreak Response

Ariadne Nichol
Center for Biomedical Ethics
Stanford University School of Medicine

Emerging infectious disease (EID) outbreaks pose significant epidemic threats. Responses to EID outbreaks frequently occur in resource-constrained regions and under high pressure, often causing challenges with regard to resource allocation. As seen in the recent 2013-2016 Ebola Virus Disease (EVD) outbreak in West Africa and the current COVID-19 pandemic, there is a continued need to evaluate and address the ethical challenges that arise. The study objectives were to explore the ethical issues surrounding the 2013-2016 EVD outbreak in West Africa, and in particular, to examine the ethics of allocating limited experimental therapeutics. In-depth semi-structured interviews were conducted with senior healthcare personnel (n=16) from international organizations intimately engaged in the 2013-2016 EVD outbreak response in West Africa. Interviews were recorded in private, transcribed, and iteratively coded using grounded theory methodology. A majority of respondents indicated a clear propensity to adopt an ethical framework for international responses to EID outbreaks. Respondents agreed that prioritization of frontline workers' access to experimental therapeutics was warranted based on a principle of reciprocity. There was widespread acceptance of adaptive trial designs and desire for greater trial transparency. Many respondents also emphasized the importance of community engagement in allocation scheme design and culturally appropriate informed consent procedures. The study results inform a potential ethical framework of guiding principles to be adopted by international response organizations in the face of allocating limited resources such as experimental therapeutics in future EID outbreaks to ease the moral burden of individual healthcare providers.

The Ethics of Utilizing Emerging Technologies in Medicine

Ariadne Nichol, Center for Biomedical Ethics, Stanford University School of Medicine
Cara Hunt, MA, Pediatric Gene Therapy and Medical Ethics (PGTME) Working Group, Grossman
School of Medicine & Division of Medical Ethics, NYU Langone Health
Nell Mermin-Bunnell, Emory University School of Medicine

The growing number of emerging technologies in the healthcare space is cause for careful scrutiny and attention to ethical considerations. While issues like privacy, informed consent, and equity are always present in medicine, they take on new forms with the introduction of technologies such as AI, machine learning, and gene therapy. This panel will include bioethicists who will discuss the ethical implications of emerging technologies in healthcare; i.e. How do emerging technologies impact data and privacy? How do they change the doctor/patient relationship? How do we ensure technologies are distributed equitably? Are there better ways to inform patients about how emerging technologies work and what risks they pose? How do developers of these technologies view the ethical considerations of their work? Panelists will draw from recent empirical and normative analyses of their respective work on gene therapy and AI and machine learning for mental health and healthcare. Many would argue that the experience of healthcare could never be replaced by technology. Moreover, system injustice and inequality permeate the field, giving us all the more reason to approach technological solutions to complex health problems with appropriate caution and thoughtful regulation and oversight.

Mapping Health Disparities in Late 19th and Early 20th Century San Antonio Through Digital Humanities

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University of Texas at San Antonio

Health disparities continue to be one of the fundamental concerns for the largely Hispanic residents of South Texas. For example, South Texas has higher rates of tuberculosis, childhood and adolescent leukemia, childhood lead poisoning, and certain types of cancers (cervical, liver, stomach, and gallbladder) than the rest of Texas. The most acute health concerns are adult obesity and diabetes, which occur at higher rates than both Texas and the nation. For the Hispanic community in this area, a lack of resources and deficiencies in the public health infrastructure perpetuate these issues.

My goal in this presentation is to provide a historical context through which these health disparities can be better understood by focusing on an ongoing historical GIS (Geographic Information Systems) project in San Antonio and Bexar County, Texas, "[The Seed of Texas](#)." This project tracks the history of the area through topical modules that integrate historic maps, documents, archival records, and resources. One of the stories being highlighted in this work is the long history of health disparities in the community. The current phase of the project looks at the history of San Antonio from the arrival of the railroad in 1877 until the end of WWII in 1945, a critical period for providing historical context for the disparate health outcomes on the city's west and south side, whose residents historically and today are majority Hispanic. This presentation also shows that large digital humanities projects and historic GIS can contribute to building a rich and informed medical history for a community by looking at one example from the beginning of the 20th century.

At the turn of the 19th and 20th centuries many local activists such as Father Carmelo Tranchese and physicians suspected that the lack of clean housing, sanitation, and running water on the west and south sides were the cause of illnesses such as cholera and tuberculosis. By bringing together historic death records from 1880-1936, locating instances of disease based on city ward, alongside maps of the earliest city infrastructure, city directories, and census data, we are able to build a history of how these diseases spread through unclean sources of water and crowded living situations and how the failure to expand resources in these areas perpetuated these illnesses. Additionally, historic GIS data makes it possible to visualize the ways in which many of the infrastructure projects of the New Deal and the middle of the 20th century failed to address these issues, focusing instead on the largely white communities of San Antonio's north side and the commercial downtown.

Building this story of health disparities in the early history of San Antonio provides contextual information on where modern health disparities originated and, by building this work through historic GIS data, we can also more easily compare maps of historic and modern health outcomes. This kind of data can help health policy makers identify the deep roots of historic health inequality and plan projects and initiatives to more directly address these continuing issues within the community.

Grass-Rooting Medical Humanities

Jennifer Orth

The Biomedical Humanities Club (HuMed)
Seton Hall University

Bioethics teaches us the obligation of medical professionals to look beyond any patient's social identity to instead see and understand the person as a human being first. This field should receive a dedicated comprehensive focus in Medical School, but most programs only allocate two weeks of training toward this discipline, resulting in inadequate training for future physicians. The Biomedical Humanities Club (HuMed) is an undergraduate organization that educates its members on ethical practices and conduct in medicine. It is governed by three pillars: education, outreach, and advocacy. HuMed hosts speakers to speak on integral bioethical topics such as race in medicine and equity in COVID-19 vaccine distribution. Each month, HuMed offers volunteer activities aligned with its monthly topic. HuMed believes in advocacy to make actionable change, and we offer a petition letter writing course to teach members how to write to their congressional representatives and local council members. HuMed empowers students to participate in discourse outside of class time because not all can take a Bioethics course at their school. Bioethics is an essential skill that doctors must use in every encounter with their patient. Starting early to instill these values in future medical professionals allows the world to stop seeing a patient as their social identity, and instead, treat them with the best standard of care.

Escaping the Paradigm: Resentment Towards the Biomedical Gaze

Shaun Respass
ASPECT Program; Department of Philosophy
Virginia Tech

The Open Paradigm Project is an initiative devoted to enhancing the voices of persons who have been harmed or otherwise disserved by psychiatric treatment. They, along with several other advocacy groups, promote alternate treatments for distress and campaign for improved patient rights and conditions. The project is renowned for its compilation of first-person stories, during which individuals describe their experiences and frustrations with their histories of ‘illness’ and care. The result is a collection of accounts detailing apprehension, anger, grief, and caution around existing treatment options, mainly the over-extensive use of chemical antidepressants and similar substances. In these rich stories, it is apparent that the way persons in distress are diagnosed is significantly detached from the way in which they see themselves.

I argue that the biomedical structure of mental health is limited in its capacity to accurately recognize and respond to the everyday distress of despondent patients. Furthermore, I demonstrate a series of harms instituted and/or stimulated by the medical gaze utilized in depressive care. By leaning on these public stories, I highlight trends in fractured identity formation, self-regulation, and physical/cognitive harm that I contend warrants ‘resentment’ which, according to Stauffer (2015) exists “in the space between persons – it is a response to harm that seeks acknowledgment and amends.” It demands recognition not only of the harm done but of the dignity of the harmed person, as well as assurances that such harm will not happen again (114-115). Resentment operates as an ethico-political claim for repair and legitimate reform, but the neglect of this claim constitutes an ‘ethical loneliness’ in which these persons are “abandoned by humanity, or by those who have power over one’s life possibilities”. The biomedical paradigm of mental health care therefore structurally perpetuates and in many cases instigates the neglect and/or direct harm of those they seek to treat, cure, or heal.

Visual Thinking for Teaching and Research in Medical Humanities

Atsuko Sakai, M. Arch., Assoc. AIA, LEED AP BD+C

Ulluminair Salim, PhD, MPH

Holly Donahue Singh, PhD

Nana Tuntiya, PhD

Judy Genshaft Honors College

University of South Florida

Our panel will examine intersections of global health, visual thinking, and representational politics in the context of teaching and research in medical humanities. Each panelist will offer ‘notes from the field’ to illuminate the ways in which visual creation and consumption—from Japanese popular culture and manga to graphic novels, photography, and filmic representations of the (global) south—opens new pathways of thinking and being in the world. A cornerstone of honors education at the Judy Genshaft Honors College is our commitment to global citizenship; thus, our panel foregrounds the use of visuals/graphics to engage students in symbolic travels beyond the linearity of text with the goal of creating intellectual, interpersonal, and embodied linkages. How might reading a graphic ethnography about medical complexity and international politics open new worlds for health professions students as they learn to care for diverse patients? How might watching an animated film or documentary about gender inequality and the health effects of poverty render the complexity of representing other(s) and telling silent/silenced stories? Likewise, how might popular forms of artistry such as manga make visible alternative ways of approaching and communicating complex social and medical phenomena? We seek to explore these questions by situating them in the classroom context, drawing upon examples of the tripartite translational work of reading, watching, and doing/creating to communicate experience. Each panelist will offer specific examples of this multi-tiered engagement as a pathway to understand self, others, and the complexity of interpersonal and systemic relationships.

The Racialized Imagination and the Practice of Medicine

Patrick T. Smith, PhD

Theological Ethics and Bioethics, Duke University Divinity School
Trent Center for Bioethics, Humanities, and the History of Medicine
Population Health Sciences, Duke University School of Medicine
Kenan Institute for Ethics, Duke University

Health care in the United States, being a microcosm of the broader society in which it developed, possesses a mixed legacy. Along with advances that have helped many people, unfortunately, there remains a sordid legacy concerning racial prejudices, biases, and the perpetuation of health and health care disparities. And this, in many instances despite the best of intentions. How are health care professionals to understand the conceptual issues surrounding medical racism and racial justice? This talk describes the idea of a racialized imagination and how it continues to work itself out in the practice of medicine. It identifies categories and philosophical resources to help frame these issues to help ethically reimagine the work of health care.

illuminating the Subjective Patient Through Art

Heather Snay, MA
Department of Geography
University of Kansas

This presentation responds to the common question within the field of medical humanities that is, how can art be utilized in biomedicine to improve patient experience? The intersection of art and medicine is frequently discussed in medical humanities, but the *tangible* incorporation of art into medicine has largely been unsuccessful. To answer this call, I suggest an incorporation of art that focuses on the body, illness and healing into premedical education.

This argument comes out of my own experience teaching undergraduate premedical students and a current exhibition entitled *Healing, Knowing, Seeing the Body* at the Spencer Museum of Arts at the University of Kansas. Through analysis of this exhibition I highlight what art illuminates about the human condition of living within our bodies. How art can uniquely reveal the complexity of an individual's internal corporeal reality, both illness and healing experiences. Through an analysis of a few selected pieces from artists Holland Houdek, Dario Robleto, and Andrew Carnie in this exhibition, I suggest that the separation of science and art, of the objective patient and the subjective person, is really not that separate at all. I draw on Kirsten Ostherr's argument that "the very appearance of medical imaging outside of the clinic makes it difficult to define clear boundaries between objective and subjective, science and art" (2013, 117). I interrogate the idea that images such as X-rays, pulse beats and anatomical renderings of organs such as the human heart, are truly objective data. When these images are in the place of biomedicine, do they still not contain the subjectivities that these artists have rendered visible through these same images outside the place of the clinic? Do these images still hold these subjective experiences, but biomedicine fails to see it? What harm might this do to the patient? Does it matter to understand the entirety of the patient in the efficacy of their care? How does an exhibition like *Healing, Knowing, Seeing the Body* make us (re)consider if the boundaries between art and science are truly impermeable? When the topic is the human body can the objective be separated from the subjective?

These questions derived from analysis of this exhibition demonstrate the ways art can push the boundaries of what we can come to know about the body. As a result, I argue that a key aim of the field of medical humanities should be to incorporate such art in the education of premedical students in order to help them understand this inherent subjectivity to the patients they will one day treat. As they are taught to subtract the individual to see the disease more clearly, I want to use art to teach them to remain cognizant of that which the "medical gaze" (Foucault, [1963] 1994) sees as a distraction. I believe this is how art can be used to help remedy the disconnect between practitioner and patient, thereby improving the efficacy of biomedicine by allowing it to see its patients more clearly.

Case Report: Determinations of Medical Futility in COVID-19

Nathan Stout, PhD
Program in Medical Ethics and Human Values
Tulane University School of Medicine

This presentation outlines and analyzes a case that I worked on as a clinical ethics consultant in which further therapy for a COVID-19 patient was deemed futile by the healthcare team. The patient lacked decision-making capacity, and the family was insistent that he continue to receive aggressive treatment including full code orders and tracheostomy. The ethics team was consulted to weigh in on the question of whether or not further treatment could be denied on the basis of futility and the risk to hospital staff due to the patient's COVID-positive status. Ultimately, the ethics team recommended that the team follow-through with the family's request. In addition to raising difficult ethical dilemmas, this case is instructive insofar as it highlights more general concerns related to medical futility, the duty to care, and medical uncertainty. I argue that the resolution of this case provides good reason to believe that we should prefer a narrow, conservative conception of medical futility and that this is especially so in situations of high stress and uncertainty.

Nature, Arts, and Equity During a Pandemic

Nina Stoyan-Rosenzweig, PhD
Medical Humanities
University of Florida College of Medicine

During the COVID-19 lockdown, interest in connecting with nature increased astronomically as homebound families searched for ways to connect with events occurring outside the home and not in digital space. And because it became clear that viral infection was less easily transmitted outside, outdoor activities were seen as safer and additionally promoting wellness. As often happened, however, the pandemic also exposed systemic racial and social inequities—in this case showing how safe access to outdoor spaces wasn't freely available to all. One major development during the pandemic, however, and powered by social media, was a ground roots uprising to address inequities and particularly to destroy the stereotype that people of color chose not to be involved in birding and other outdoor activities. Briefly, in response to the Central Park birder incident involving birder Christian Cooper, and dog walker Amy Cooper, Black scientists organized Black Birders Week—a seven-day event highlighting Black birders and encouraging engagement of other BIPOC in all outdoor activities. It did not end with Black Birders Week— since then the number of events has continued to increase with role models highlighting career opportunities for high school students, families showing how Black-owned land can be used to promote ecotourism, and, especially, efforts highlighted how the arts are an essential component in connecting BIPOC to outdoor opportunities and to the range of wellness practices that the arts and nature provides. This presentation highlights how the pandemic facilitated engagement with nature and, through exploring social media, how this movement acquired momentum and has become so powerful.

Pay for Play: Ethical Considerations of Payments in Public Health

Andy Wible
Department of Philosophy
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Should governments pay people to achieve public health goals? Should people be paid to get the Covid-19 vaccine to lessen deaths and achieve herd immunity? This presentation will look at some of the ethical issues around positively incentivizing people to be healthier. Does the loss of autonomy override the public good? Should vulnerable groups receive more compensation? Is it fair to compensate the otherwise non-compliant? Are some types of incentives morally preferable? How much should long term monetary savings matter compared to length and quality of life? What values matter most? The tentative conclusion is that payments do not wrongly influence people to do the right thing.

Storying Students' Experiences of COVID-19

Catherine Wilkins, PhD, Judy Genshaft Honors College, University of South Florida
Lindy Grief Davidson, MDiv, PhD, Judy Genshaft Honors College, University of South Florida
Benjamin Young, PhD, Judy Genshaft Honors College, University of South Florida
Brianna Cusanno, M.A., Department of Communication, University of South Florida

While COVID-19 has disrupted higher education and presented numerous challenges to students' mental health, it's also made more evident the essential role that the humanities can play in healing. The forced move to distance learning has increased anxiety and stress among undergraduates, while concurrent social isolation poses a risk of developing a myopic view of the pandemic based solely on one's personal experience. The discipline of Narrative Medicine provides a framework for processing personal experiences of COVID-19, while contextualizing them in light of others' stories within a broader context of global public health, therefore promoting narrative humility and empathy.

This panel brings together several instructors from disciplines including Communication, Philosophy, and Art History to discuss how they have applied Narrative Medicine principles with an aim of boosting students' narrative competence and humility while improving their mental health and creating a sense of community. The focus of the conversation will be a Narrative Medicine course taught by Dr. Lindy Davidson, and a two-part workshop series called, *Story of Myself*, an NEH-funded extracurricular component of the Medical Humanities in a Global Context Honors pathway at a R1 public university, facilitated by Dr. Benjamin Young, Dr. Catherine Wilkins, Dr. Sayan Basu, and Brianna Cusanno. In Spring 2021, the content of these workshops and course were modified to include literary, visual art, and reflection activities specifically related to COVID-19. This presentation will provide the outline for the course and workshops, demonstrate one of the interactive narrative activities that was part of the workshop's curriculum, and share preliminary findings from student evaluation data. The panel's intention is to help other educators consider how to embed principles of this experience in their own teaching, for the sake of students' mental health and narrative competence.