



Abstract Book



“Medical Humanities, Practical Wisdom, and Moral Injury”

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The concept of practical wisdom, or "phronesis," has been a cornerstone of ethical thought since the time of Aristotle. Its importance has been rigorously explored by Neo-Aristotelian philosophers like Alasdair MacIntyre, who emphasize the role of virtues and moral character in decision-making. In the realm of medical practice, where ethical dilemmas are not merely theoretical but have immediate, life-altering ramifications, the need for practical wisdom has never been more urgent. Our presentation, titled "Cultivating Practical Wisdom through the Medical Humanities," investigates the synergistic potential between MacIntyrean practical wisdom and medical humanities in enhancing ethical competency and combating Chronic Moral Injury (CH-MI) within healthcare settings (Abadal & Potts, 2022).

Central to this inquiry is the Provider of Services Model (PSM), a consumer-driven approach that tends to marginalize the role of healthcare providers as mere functionaries (Curlin & Tollefsen, 2021). This depersonalized view distorts the telos—or ultimate purpose—of medical practice, often leading to what MacIntyre would consider a lack of "internal goods," such as the exercise of virtue and attainment of professional and moral excellence. The PSM frequently results in morally injurious events and fosters a work environment conducive to CH-MI, an ongoing moral and existential crisis experienced by healthcare providers (Abadal & Potts, 2023, forthcoming).

Drawing on an interdisciplinary methodology, our research integrates insights from philosophy, business, clinical ethics, and organization studies. It demonstrates that medical humanities can enable healthcare providers to navigate the intricate moral landscape of medical practice effectively. They can cultivate a form of practical wisdom that is inherently teleological, situating seemingly technical choices within the broader context of human flourishing and human values. This approach not only elevates decision-making beyond mere instrumental reasoning but also equips medical professionals to reconcile the demands of their role with their ethical convictions and understanding of what it means to be a good doctor or nurse, thereby mitigating the risk of CH-MI.

I propose that integrating medical humanities into both the educational curriculum and ongoing professional development can revolutionize healthcare from the ground up. By facilitating the exercise of practical wisdom, medical professionals can reclaim their role as not just service-providers but moral agents committed to both individual and communal excellence. This calls for an educational and institutional overhaul, emphasizing the humanities as essential components of medical training—among both future medical professionals and healthcare administrators.

This paper ultimately argues that medical humanities offer an invaluable toolset for cultivating practical wisdom, thus providing a robust ethical framework for medical practice and administration. This transformative vision holds the promise not only to improve patient outcomes but to restore the moral and existential integrity of healthcare providers, making it an imperative in the quest for a more humane and ethical healthcare system.

“Dying with Dignity on ECMO: Your Story Continues”

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We just told your family that you are officially no longer a transplant candidate. With tears in their eyes, they look to us for information about the next steps. We tell them.

“As the goals of our care transition, so too does my role. My job now becomes planning for and ensuring comfort at the end of your loved one’s life,” I say.

These are not new words for me, and the sentiment is not novel amongst palliative care clinicians. I contemplated how to stay true to my word and honor my commitment to your comfort and dignity at the end of your life. I attempted to do a literature review and found nothing; I wished there was evidence, research, or something—anything—that was scientifically-based like the intricate machinery keeping you alive. Without that, I turned to my colleagues. Soon enough, I had a plan I felt confident in for you, and I promised your family I would be at bedside with you, your family, and the staff caring for you the whole time.

The day arrived where your family crowded your tiny ICU room, plan for comfort in place. Reassurance and kind words were shared. I stole endless piles of 4x4 gauze (it is softer than the hospital tissues). Medications were given. Then the perfusionist was called. As your ECMO circuit was clamped, you gasped, and the hue of your face changed. Maybe it only happened for moments, resolving shortly thereafter. You seemed to look comfortable later. That image of your eyes, the soft gasp from your mouth, your family’s tears once ECMO was clamped stay with me.

No matter how many times I have been at bedside for this particular end-of-life scenario, these moments remain in my mind. I remember each of you, your families, the day they said goodbye. I hold your memories close and keep your charts accessible. I reflect on when I had no research, no evidence to reference. I reflect on each life lost and what made you comfortable, less anxious, less short of breath. My initial plan for you has evolved over time, and I continue to gather the evidence that I was once desperately looking for to help you, intent on honoring my commitment to you, your family, and every ‘you’ I meet in the future.

“Teaching While Ill: The Medical Humanities and a Pedagogy of Illness”

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39-year-old male with history of ulcerative colitis presents with increasing shortness of breath for the past few weeks. Patient has had a constellation of unusual symptoms and lab findings over the last several months. Patient has reportedly had shortness of breath and dyspnea on exertion since September with daily fevers and tachycardia. Patient was also noted to have mildly elevated liver panel for the past several months as well and significant CT findings of hepatosplenomegaly and significant mediastinal lymphadenopathy, otherwise he has had a broad workup that has been largely negative. Patient will be admitted...

For his medical team, Wilton was a mystery and despite weekly doctor’s visits, appointments with specialists, and countless blood draws, Wilton only got sicker. His wife, Sam, a medical humanities scholar with many medical professional friends, spent hours scouring medical journals and calling friends, searching for any kind of advice. But his medical team and family weren’t the only ones dealing with his rapid physical decline: Wilton’s students were also bewildered at the dramatic change in their usually energetic English professor.

In our presentation, Wilton (now fully recovered) and Sam examine Wilton’s illness experience through the lens of medical humanities pedagogy. As Wilton experienced illness, his pedagogy rapidly changed in unexpected ways. He was no longer the energetic, engaged teacher he once was. But more pointedly, his interactions with and ability to connect to students was hampered. As a medical humanities scholar, Sam recognized the way Wilton’s illness brought up issues of disclosure and the boundary between illness and disability. Together, they worked through the increasingly complex pedagogical challenges facing a teacher with a debilitating illness. Drawing on Wilton’s expertise in writing pedagogy and Sam’s medical humanities background, we argue that the medical humanities is an important lens for navigating issues of when and how much about his illness Wilton could disclose to students. Moreover, we argue that medical humanities—especially its emphasis on medical literacy and medical advocacy—can be an important part of critical pedagogical practice outside the medical classroom.

“Taking the Measure of Public Trust: An Open Call to the Medical Humanities”

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There is a growing recognition that public trust in science is at a low ebb across a range of issues of public concern, from the contribution of human activity to climate change, the proliferation of new autonomous technologies, and to the effectiveness of measures taken by public health during the Covid-19 pandemic. The erosion of trust in public health is deeply troubling. Given that public support has a significant impact on the effectiveness of public health measures, one way of furthering the goal of developing resilient health systems is research in the medical humanities that focuses attention on the salient issues of trust, facilitates the validity of its measurement, and contributes to the identification of steps that are needed to build/re-built trust in public health.

Although there is growing recognition that public support is essential to the effectiveness of measures taken during a public health emergency, there have been no thorough studies of the components of public trust and how public trust differs from other forms of trust (e.g., prosociality, generalized interpersonal trust, and institutional trust). Where the concept of trust is rolled into extant studies, the definition of trust is often left implicit, testifying that an understanding of trust as it relates to public health is under-researched. What is needed is a conceptual framework for public trust that will give public health a means to ensure that public health measures do not undermine the public's confidence in the effective management of public health emergencies.

This talk will present a conceptual model of public trust as a form of social trust that is based on the trust relationship between the public (understood in the appropriate political sense as all the people of a country, state/province, or municipality) and a social entity (understood in the socio-legal sense as an association, cooperative, organization, or agency that carries out social services). It is a relationship where the trustor (the public) collectively depends on a social entity (trustee) to inform public decision-making based on positive and specific performance expectations with respect to the public good or segments of the public that are at risk. A public that trusts a public health agency, for example, is one that collectively depends (i.e., is comfortable in delegating responsibility) on the competence, expertise, and social responsibility of that agency to settle such questions as the safety of vaccines and the most effective strategy to manage a public health emergency that impacts the collective health of the population.

There are no systematic studies that examine changes in levels of public trust, either following a public health intervention or over the course of a public health emergency. The trust relationship between the public and public health agencies is not blanket. The health humanities can play a critical role in creating a roadmap for building trust with respect to specific public health measures, which in turn can be implemented to measure different levels of trust among different segments of the public (one or other social group); and to determine the impact on the public of changes in public health interventions.

“The Difference Between and AI and a Human Ethicist: A Reply to Objections”

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Several recent proposals have put forth conceptual models for artificial intelligence (AI) that could make a recommendation of the kind typically made by clinical ethicists. In an earlier paper we posed two concerns with those proposals, which we have called the transparency concern and the authenticity concern. One global rejoinder to these points is simply to say that the concerns arise with the use of AI to make ethical recommendations in the clinic, have exactly analogues concerns with the recommendations made by human clinical ethicists. In other words, health care providers are at least no worse off taking recommendations from AI, then they are by taking them from human beings. We disagree and argue that AI generated ethical recommendations are deficient in two ways that make the transparency concern and authority concern distinctly problematic for healthcare workers who rely upon AI for ethical recommendations.

In the first part of this paper, we very briefly identify the two concerns. In part two we provide reasons to think that articulations provided by LLMs don't amount to the transparency provided by human ethicists. In the third part, we argue that human ethicist's ability to participate in both initial assessment of a case and engage in reflective on-going dialog about the case—indeed, the ability to reason publicly about the case—mitigates the authority problem in the relationship between the clinical professional and the human ethicist.

**“Moral Testimony and Transformative Experiences:
The Case of Peer-Mentors in Spinal Cord Injuries”**

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In this paper, I will discuss the epistemological issue of testimony in the cases of patients with spinal cord injuries (SCI). My focus will be on the case of Tim Bowers, an Indiana hunter who in 2013 was paralyzed after falling from a tree stand. Upon hearing that he would likely be connected to breathing machine for the rest of his life, he opted to be disconnected from the machine and be allowed to die. While many have criticized the doctors for allowing Bowers to make what seems like a reactive and “uninformed” decision, I do not want to argue that he lacked sufficient understanding or decision-making capacity to make this decision. Even if he did have sufficient understanding, however, there might still be some significant epistemic impediments to him having a fully enriched grasp of what it is like to have an SCI. It seems Bowers faced what L.A. Paul has called a “transformative experience,” that living with an SCI is dramatically different from the life he had previously experienced and would almost certainly change many of his beliefs and values from what he held prior to the injury. Paul claims that we are incapable of making rational decisions about transformative experiences prior to having them ourselves, not even the use of testimony of those who have experienced it. I argue that, contrary to Paul’s skepticism, new patients with SCI’s can use the testimony of other peer-mentors—those who have sustained and live with similar injuries—as an epistemic resource on what life with these injuries is like and how their values have changed since their injury.

“Two Justifications for Pharmaceutical Patenting and Why They Fail”

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Philosophical discourse on the justifications of patents typically centers around two arguments. The first is a rights-based argument grounded in the work of John Locke. According to this argument, people have a right to what their labor produces. That is, we own what we produce, which in turn entails a right to protect the fruits of our labor from being utilized without our permission, thus justifying patents. Second, one could make a consequentialist argument in favor of patenting. Proponents argue that patents spur innovation and discovery in the field, leading to greater future societal benefit down the road. Furthermore, they contend that without these sorts of protections, companies would have little to no incentive to attempt to research and develop new products or technologies. While these arguments may work for patenting in other domains, I argue that they fail to justify patents for pharmaceutical products. For the rights-based justification, I examine Locke's *Second Treatise of Government* and argue that any pro-patent arguments that stem from it do not work for pharmaceutical products due to the amount of hands involved during various phases of the creation of most medications. As for the consequentialist justification, I contend that pharmaceutical patents inhibit innovation rather than spur it, preventing companies from doing research on applications for existing medications and encouraging pharmaceutical companies to merely extend existing patents rather than creating new, beneficial products.

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“Re-envisioning Community Health and Healthcare”

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Our panel for the MWU Medical Humanities Conference will focus on the Health Humanities Fellows current work with the East Marshall Street Well Oral History Project. Since 2013 the EMSWP has been working to enact the recommendations of the Family Representative Council, a group representing the descendant community of more than 50, mostly Black Richmonders, whose bodies were stolen by VCU medical campus professors between 1848 and 1860, used for dissection at the school, and then discarded. The remains were found in a well during the 1994 construction of the VCU Health Kontos Building. The Family Representative Council recommendations prioritize ethical research, memorialization, and burial of the ancestors with dignity. They also include an emphasis on contextualizing the broader history between Richmond’s medical establishments and the city’s African American community to address healthcare disparities and to better understand their historical roots within the Richmond community. Through the Health Humanities Lab, student fellows are incorporated into this important project to advance the ongoing oral history project and memorialization centering on community engagement and education.

Our panel will include the director of the Health Humanities Lab, an administrator from the Office of Health Equity, History and Health, and two student fellows who will discuss the project and how such collaborations demonstrate how transdisciplinary projects centering on humanities research can amplify the needs and concerns of community partners to address histories of medical racism, create modes of memorialization, and facilitate institutional transformations.

“Tuning Out: Disabling Responsibility and Active Noise Reduction Technologies”

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This presentation explores how local active noise reduction and control technologies have been positioned as a responsible choice concerning disability and health. Active noise reduction (ANR) technologies create anti-phase sound waves that “cancel out” or attenuate environmental noise; they are “active” in that they produce their own signals. ANR has been increasingly implemented in personal listening devices, while studies explore the introduction of ANR in industrial settings and even neonatal incubation.

At the core of much research and public discussion of ANR is the concern of the “silent pandemic of noise-induced hearing loss,” and about the impacts of noise on health and wellness generally. Other researchers and media are similarly concerned about the hidden health risks associated with prolonged use of ANR, such as whether or how earphone use can produce hearing related disabilities. Meanwhile, autistic and disabled commenters note the importance of ANR to their own abilities to navigate increasingly overstimulating urban spaces. Overall, there appears to be increased attention to how ANR can be used responsibly and safely to resist the health harms of noise pollution.

This presentation focuses on the positioning of personalized ANR use as a health choice, and the production of individual responsibility for making these choices, and the underlying rhetorics of disability. On the one hand, ANR is a tool for access and accommodation for disabled people, and on the other, it is a tool meant to resist the creation of further disability and deafness. What might “responsible” creation and use of personalized ANR technologies look like under the lenses of disability?

However, while the first part of this presentation attends to important counter discourses of Deaf gain, and of the disableist assumptions about disability production, I argue that a more critical response requires attending to the constitutive contexts of ANR use. By reviewing recent academic and media literature on ANR, disability, and health, I urge attention to the upstream conditions that produce personal ANR as a legible disability/health choice in the first place, the presumed inevitability of noise, and the individualization of responsibility for making those choices.

“Health, Harm, and Dispositions”

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A popular approach to defining health in philosophy focuses on the causal link between biological processes and harms to the bearer. This approach seems particularly well suited to provide normative guidance on questions of distributive justice and moral-clinical practice. On Aas and Wasserman's (2017) refined version, health is the absence of disease, and a disease is any biological process in virtue of which its bearer is intrinsically disposed to incur harm. While promising, it is not possible to assess this refined view without further specification. The aims of this presentation are, first, to develop this view by drawing on recent work on dispositions and, second, to subject it to rigorous scrutiny.

This view specifically requires a clear distinction between intrinsic and extrinsic dispositions. Otherwise, biological processes that just happen to lead to harms in a society like ours will come out as diseases. To develop such a distinction, I follow Contessa (2012) and propose that what matters is whether a subject's disposition to harm, possessed by virtue of their biological process, can be removed without altering the biological process in question. If it can, the disposition is extrinsic and that process is not a disease.

This view also requires an alternative analysis of intrinsic disposition to the simple counterfactual-conditional analysis because, on the latter analysis, paradigmatic diseases (like coronary heart disease) will come out as extrinsically disposing to harm and so not as diseases. I invoke Manley and Wasserman's (2008) influential proportional counterfactual analysis of dispositions. On the resulting account of health, a subject is intrinsically disposed by virtue of her biological process to incur harm (=is diseased) if and only if a relevant form of harm would occur in a suitable proportion of relevant stimulus cases and this disposition could not be removed without a change to the biological process itself.

Finally, I assess this elaborated account of health. It handles cases like sickle cell trait better than Aas and Wasserman originally hoped. But it faces two significant objections. The first is that it is far too broad. Without further restriction, those biological processes responsible for disposing us intrinsically to feel pain, to asphyxiate in the presence of large amounts of CO, and to sleep poorly after ingesting too much caffeine are all incorrectly identified as disease-states. I argue, however, that the restriction most commonly invoked in the literature results in the view inheriting a number of problems this view was designed to avoid. The second objection is that the context-sensitivity of disposition-ascription renders the account of health ill-suited to provide the normative guidance we had hoped for.

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**“Stories of Growth and Doubt: Comparing 3rd and 4th Year Medical Students’
Reflections on Difficult Clinical Encounters”**

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Johanna Shapiro, PhD, Department of Family Medicine
Yasaman Lorkalantari, Department of Pediatrics
Alexis Nguyen, School of Medicine
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&

Marvin Paguio
Oakland University William Beaumont School of Medicine

Difficult clinical encounters pose emotional, attitudinal and behavioral challenges for medical students. Unless resolved, they threaten students’ professional competence and negatively impact their well-being. Inability to effectively manage difficult clinical encounters also has negative implications for future physician-patient relationships, physician wellness and patient care. Learning how to effectively and humanistically interact with patients perceived as “difficult” is an important dimension of professional identity formation.

We analyzed reflective essay data from students (n=69) as they moved from third to fourth year of training at a public medical school to examine how their perceptions of patients’, preceptors’, and their own behavior, attitudes and emotions in challenging patient care situations changed; and how such changes advanced or detracted from their professional development.

The student narratives record much positive growth from third to fourth year, including increased empathy and patient-centeredness as well as more examples of connecting with patients, respectful communication, reassuring patients, negotiating with patients, de-escalating behavior, and advocating for patients. Similarly, MS4s reported more instances of empathic feelings toward a range of patients. MS4s were more likely than MS3s to emphasize the importance of nonjudgmentalness, empathy, relationship-building, and critical thinking, as well as reflecting on their professional responsibilities toward patients. These and other developments were all signs of constructive professional identity formation. Yet students simultaneously described more frequent feelings of being caught off guard, frustrated, helpless, scared, worried, confused/uncertain, doubting their own efficacy, and engaging in self-judgment.

Ultimately, we discovered a narrative of students moving from rote behavioral interactions in their third year to trying to be compassionate, nonjudgmental, patient-centered doctors as fourth years. But it was also a story of students often beset by self-doubts, confusion and regret who did not always receive the support and guidance they needed from preceptors. How this story emerged and what it meant to us is the narrative-informed journey we hope to share.

“Seeing Is Not Understanding: Illuminating Anatomical and Physiological Inferences and Models with the Reenactment of the Discovery of Blood Circulation”

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Emily Bradshaw

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Seeing can be deceitful in Anatomy. Students in a traditional medical track often learn Anatomy using visual memory and rote memorization. This can lead students to develop an acritical, ‘received view’ of Anatomy. In many cases, the content is not well-integrated with related disciplines of Physiology and Embryology, which can negatively impact the reasoning necessary to connect anatomical structure and function. Deep learning and critical thinking skills are needed to explore the relationship of examining anatomical structures in the anatomy lab, connecting this with function, and further what could happen in the case of malformation or pathology. Additionally, this can also include exploring discussions around the language of “purpose.” We argue that students would benefit from learning by understanding the hypotheses, assumptions and errors that over time have led to the contemporary conclusions of the meaning of functions and explanations in the history of Anatomy. Medical Humanities hence can greatly aid critical and deep reasoning in Anatomy and thereby foster early development of key medical competencies.

We propose the exploration of scientific inquiry and historical reasoning together through the reenactment of historical experiments to engage students in deep reflection on the puzzles of meaning construction and conceptual analysis in Anatomy and physiological analysis and introduction to model building pre and post evolutionary explanation. To that end, we present the historical reenactment of the discovery of blood circulation proposed by William Harvey in the seventeenth century, with the contributions of Fabricius, Boyle and Alberti. We present the study of the Anatomy of the cardiovascular system based on the historical reconstruction of medical inferences steps in the discovery of blood circulation in forming the path of understanding the layers of evidence, the context, the types of inference, and how the puzzle of discovery is played. In this process, we highlight the interdisciplinary nature of Anatomy, as well as the relevance of the different sources of evidence across species in Comparative Anatomy between humans and non-human animals for hypothesis formation. In particular, we focus on the study of the rediscovery of the venous valves functions within the reconstruction of Harvey’s bold circulation hypothesis (*De Motu Cordis*, 1628). In the flow of the rediscovery activity, Anatomy and Medical Humanities are integrated, and context and values of humanistic investigations are further facilitated.

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**“Siloed No More:
Building the Medical and Health Humanities in the Liberal Arts Context”**

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Stetson University

This presentation explains the benefits, challenges, and on-going conversations that surround the Medical and Health Humanities as an emergent interdisciplinary field particularly as we seek to engender a culture of interdisciplinary exchange and creative inquiry in a small liberal arts context. While in recent years the Medical and Health Humanities have enjoyed celebration at major institutions that also operate as major medical centers and teaching hospitals for their regions, the Medical and Health Humanities in the small liberal arts context remain relatively rare. At Stetson University, we have begun the process of gathering faculty from the humanities and sciences to begin to create a program that takes seriously the questions of health, illness, and the human, which have recently become celebrated features at larger universities. Yet, even as we model our approach to these exciting topics on leading institutions and our peers, we also negotiate unique sets of questions as a small school in Florida that is largely tuition dependent. From political challenges posed by abortion bans and the limits on gender, sexuality, and race in educational contexts to the financial difficulties of funding new programs without new tenured lines, we work to develop the existent knowledge, skill sets, and interests of our colleagues to create a coherent and exciting curriculum.

In an effort to build programing that will support the popular Health Sciences major at Stetson along with the Environmental Sciences and Public Health departments, we are working to balance disciplinary perspectives with humanistic methods, including, but not limited to, critical disability studies, bioethics, the history of medicine, and epistemological questions not only about how we in the humanities understand knowledge production, but how it is in the era of “One Health”—a term first defined by the World Health Organization that thinks together the human, the animal, and the environmental—all of us from the humanities, sciences, and beyond, think about knowledge production across disciplinary boundaries and in relation to one another. As an institution that emphasizes the Health Sciences and embraces the ecological premise of “One Health,” we also seek to build bridges across these distinct disciplinary methods to bring into focus questions of health and illness, life and death, as socially, politically, and environmentally bound to questions about what constitutes “the human” in the twenty-first century. Ultimately, by creating contexts for students to interact with these questions from philosophical, linguistic, and creative perspectives, we hope to provide solid foundations for those students looking to the health and medical professions as well as those students who continue to ask questions of themselves and others about the nature of human health as it is informed by race, gender, sexuality, and ability.

“Found’ Grief: A Hospice Poetry Workshop Series”

Isha Harshe

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Poetry is a medium of art that evokes emotion and meaning out of both the poet and the reader. Found poetry is created by using words and phrases from existing sources. I sought to apply the methods of found poetry to the community, partnering with a local hospice to craft a three-part poetry workshop series. Grief is a complex emotion and one that is often difficult to navigate. By creating a workshop series where I taught participants about the elements of poetry and how to create found poetry, I aimed to create a space that made poetry an accessible method of processing grief. Participants were first prompted to free write about a loved one who has passed, and use that as a basis for writing their poems. They were encouraged to find inspiration from sources such as songs, newspaper articles, and journal entries to craft their poems at each workshop. At the end of the series, participants shared their poems aloud, and reflected on the positive impact of the experience and using poetry to come to terms with their emotions.

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“The Value of the Electronic Health Record and Value Based Payment”

Raymond J. Higbea, PhD, School of Community Leadership and Development

Guenter Tusch, PhD, Health Informatics and Bioinformatics

Marie VanderKooi, DNP, Kirkhof College of Nursing

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Public health has been practiced at least since Biblical times as described through food laws and the quarantine of lepers (Hanson’s disease). In 1789, President John Adams signed into law an Act for the relief of sick and disabled seamen in response to a yellow fever outbreak and as the first federal public health law. President Thomas Jefferson listed public health actions such as quarantine as activities reserved for the states and not the federal government. During the AMA 1847 organizational meeting a stated purpose of the organization was to “... improve public health.” Despite this stated purpose, the AMA has only sporadically collaborated with public health leaving epidemiology, sanitation, and general health surveillance to state and local health departments. In contrast, just about every other developed country aligns public health with general medicine or primary care. The recent advent of population health is an initial step to bring primary care in the USA in alignment with primary care in the rest of the developed world by aligning population health (the health of large sectors of the population) with primary care. Closely following the advent of population health, the topic of social determinants of health (SDOH) came on the scene which could be argued to be population health on the individual level. Depending upon which data are used, SDOH recognizes that only 10%-20% of an individual’s health is dependent upon medical care whereas, upwards to 60% of an individual’s health is dependent upon factors outside of the realm of medical practice. SDOH is described as the environment in which people are born, live, learn, work, worship, and play or as described by the World Health Organization include education stability, education access and quality, health care access and quality, neighborhoods and built environment, and social and community context.

Until the integration of the electronic health record largely prompted by the HITECH Act (PL 111-5) in 2009 has helped to create greater opportunity for the use of SDOH in medical care. As electronic health records became integrated into medical practices, the software supporting EHRs became more sophisticated, and as primary care practices models have evolved along with the evolution of payment models SDOH became easier to capture. Newly captured SDOH data can now be more easily captured and transformed into actionable data such as patient profiles and easy to order consults to support staff such as social workers, case managers, and nurse educators who have been trained on techniques to address SDOH. Access to SDOH is now aligned with value-based payment models that reward addressing SDOH, have resulted in improved health outcomes and decreased costs. In fact, physician leaders have stated value-based care would not be possible without the data collected and displayed by the EHR or without the EHR. Recent supporting developments by CMS include a new set of Z-codes, i.e., billing codes, that will not allow providers to bill and get paid for addressing SDOH.

**“Seeking Inclusivity:
The Value of Medical Humanities in Justifying Passive Euthanasia in Bangladesh”**

Asmat Ara Islam, PhD

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The diverse interactions of law, religion, and culture in Bangladesh complicate justifying a standard for end-of-life care. Passive euthanasia, within strict limitations, has recently become legal in India. Nevertheless, even with the efforts of lawyers and physicians, the issue is substantially more complex in the context of Bangladesh. Often, the moral justification of passive euthanasia is exclusively grounded on the principle of autonomy. Critics of the idea that passive euthanasia could be justified by the principle of autonomy worry about the equal applicability of individual autonomy in societies that are composed of diverse cultures. I argue, through counterexamples, that the more we understand the bioethical hurdles to applying the principle of autonomy in multicultural societies, the more we can compare the principle’s relevance in realizing and implementing the moral justification of passive euthanasia, especially in the context of global health. To support this argument, I explore how there has been no multidisciplinary effort to develop bioethics in Bangladesh because the current educational practices lack an appropriate understanding of the value of the medical humanities. Drawing on the premises of critical medical humanities, I argue for the value of interdisciplinary collaborative relationships and ethics for healthcare in Bangladesh. First, I identify the moral dynamic between religious fatalism, *dukkha*, poverty, and negative attitudes towards death that shape South Asian understandings of dignity in dying. Next, I examine the relationship between the lack of understanding surrounding the values of the medical humanities and the need to include ethicists in the shared decision-making surrounding end-of-life care, especially through multidisciplinary institutional ethics. Finally, having identified the problem that end-of-life care is understood in a non-inclusive sense in Bangladesh, I conclude that the main worry about the principle of autonomy needs more scrutiny so that the principle captures the shared decision-making in end-of-life care in Bangladesh. My argument is crucial not only for developing and furthering bioethics in Bangladesh and South Asia but also for understanding elderly care planning in multicultural societies so to enhance inclusivity in bioethics.

“Damaged Bodies, Grieving Selves: The Privilege of Bearing Witness”

Aniisah Bibi Aboo Bakar Kara

In Mauritius, an Indian Ocean Island country located off the Southeastern coast of Africa, the Ministry of Health and Quality of Life has been vigorously deploying strategies to track the evolution of different types of cancer and encourage cancer screening, and early diagnosis. This process is documented in a National Cancer Control Programme report released every four years. I would like to draw your attention to the following extract from this recently released report.

“Breast Cancer is the most common cancer in the female population and accounts for 20% of the total number of cancer cases registered in Mauritius. It was the main cause of death amongst women in 2020 (n=184,24.4%)” (National Cancer Control Programme, 2022).

The statistics recorded along with the scarcity of local phenomenological works related to illness studies leave researchers and policy makers with a limited insight into the lived experiences of the women afflicted by such disease. Fortunately, local NGOs such as Breast Cancer Care and Link to Life encourage those women to reclaim their voices and embrace their embodied alterity. Discussions around women’s bodies tend, to remain relatively taboo in the public sphere. I was given the privilege of bearing witness to the stories of 15 Mauritian women coming from different sociocultural, economic, and religious backgrounds. This presentation will explore how the illness experiences of those participants are shaped by:

1. The socio-cultural and religious discourses influencing the experience of womanhood and illness.
2. The process of mourning the loss of self and the crisscrossing of identities exacerbated by spatiotemporal dynamics.
3. The clinical encounter that either facilitates or complicates the process of acceptance.

Altogether, this presentation will address the importance of bearing witness to such experiences in the hope of animating a conversation between local health policy makers, local academics, patients, and survivors.

“Art after Pandemics”
Craig Klugman, PhD
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Historically, the end of a pandemic often sees a time of cultural and artistic flourishing. Consider the Renaissance after the Black Death killed 20 million (one-quarter of the population of Europe), to the Roaring 20s and Bauhaus after the 1918 flu killed 50 million people. The arts express the joy of survival, mark the sorrow of loss, and give form to our collective trauma. In the first 3 years of the COVID-19 pandemic, 770 million cases were reported, and 7 million people died worldwide. This presentation will explore explosions in creativity following pandemics, focusing on the Black Plague, 1918 Flu pandemic, HIV, and COVID-19. Each of these tragedies brought about new voices and perspectives in art, architecture, painting, and sculpture. Some art movements occur immediately after the plague and some occur in the decades after, once a society has processed its grief and adapted to a changed world. Each pandemic also led to the creation of memorials for those who died. After seeing what changes COVID-19 has already created, the author asks what might we see artistically the coming decades and what kind of memorial will artists create for our most recent global infection.

**“Reading and Enacting the Practice of Care in Molly McCully Brown’s
The Virginia State Colony for Epileptics and Feebleminded”**

Brooke A. Kowalke, PhD

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Rita Charon’s claim that “Rigorous training in close reading—at least narrative medicine’s version of close reading—improves reader’s capacity for attention but also revolutionizes the reader’s position in life from being an onlooker checking the log of past events to become *a daring participant in the emergence of reality*” is one way that the medical humanities matter. She argues, and I agree, that we can read to change the world. I would further contend that we can develop a more comprehensive and active understanding of care by applying a care ethics framework to our practice of close reading. In this paper, I use a care ethics framework to close read Molly McCully Brown’s *The Virginia State Colony for Epileptics and Feebleminded*, in which she writes poems set during the height of the eugenics movement that give voice to the staff and residents of the Colony. By imagining the voices of individuals whose stories appear only in fragments of the historical record, she invites readers to connect with both the institution that marginalized the residents on the basis of their “degeneracy” and with the residents themselves. Readers enter into a caring relationship with the speakers of these poems—from the unlikeable voices of the staff to the sympathetic voices of the residents.

Maurice Hamington and Michael Flower, in their introduction to *Care Ethics in the Age of Precarity*, suggest that “care can be characterized as responsive inquiry, empathy, and action. Care is always a response to the particularity of someone’s circumstance that requires concrete knowledge of their situation, entailing imaginative connection and actions on behalf of their flourishing and growth” (Hamington & Flower, 2021, p. 6). The idea of imaginative connection is particularly salient here. As they engage with Brown’s poems, readers develop a concrete knowledge of the speakers’ situations through the details shared in the poems, they make an imaginative connection with the speakers as they decipher metaphors and fill in the gaps on the page within and between the lines of poetry. And then, they are challenged to take action—not on behalf of these speakers from the past, but on behalf of their metaphoric descendants who find themselves still vulnerable to the ableist perceptions and practices of the 21st century.

**“Medical Ethics:
Are Love Relationships Between Doctor-Patient and Doctor-Guardian Permissible?”**

Marion Ledwig, PhD
Center for Psychiatry, Reichenau
Konstanz University

It is a professional law in medicine not to have a sexual relationship with any of your patients going back to the Hippocratic Oath which states: “In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and seduction, and especially from the pleasures of love with women or with men be they free or with slaves.” While the Hippocratic Oath is history, doctors instead adhere to the Declaration of Geneva as of today which doesn’t mention seduction and pleasure of love any longer. Thus one could ask oneself can the rest of the Hippocratic Oath go, too? In particular, in my presentation I will consider not only the permissibility of doctor-patient love relationships, but also the permissibility of doctor-guardian love relationships which has not been treated in the literature so far. In my presentation I will conclude the following: First, there are circumstances where it is outright cruel to forbid doctor-patient love relationships such as when the doctor works in a remote area. Second, the argument from power doesn’t take into account that nowadays there seems to be a shift in the power relationship between doctor and patient. Third, the ideal mindset of a doctor seems to be feeling sympathy and therefore showing concern and care for the patient by means of good communication skills, conveying useful information, having good diagnostic skills and therefore applying sensible treatment to the patient and being impartial with regard to one’s patients. There might be emotional and medical knowledge dependency between the doctor and the patient. The diverse dependencies between doctor and patient in case of a love relationship depend on (1) the specialty of the respective doctor, (2) the duration of the treatment by the respective doctor, (3) how long ago the last treatment by the doctor took place, (4) the personalities of the doctor and the patient, (5) whether there are alternative doctors and people available, (6) the age difference between the doctor and the patient, and (7) how sick the respective patient is. With regard to the doctor-guardian love relationship there can at least in principle be a qualitative difference to the ordinary case of the doctor-patient love relationship. For only in the former case total negligence of the patient can happen.

“Medical-Aid-in-Dying and Mental Illness: Contextualizing Patient Choice”

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Michigan State University

Arguments in favor of Medical-Aid-in-Dying (MAiD) for psychiatric illness are frequently rooted in arguments for greater patient self-determination regarding care. However, concern has been raised that expansion of MAiD to psychiatric illness may further entrench legacies of marginalization for those identified as mentally ill.

In particular, perspectives from critical disability studies and Mad Studies raise concerns regarding how a limited framing of autonomy may, paradoxically, reinforce legacies of marginalization and discrimination by neglecting to interrogate factors that may motivate individuals to seek MAiD as a result of stigma or lack of ability to access needed care, rather than as an option pursued after all other avenues for care have been exhausted.

This presentation will critically interrogate framings of patient choice in considerations of MAiD in cases of psychiatric illness. In particular, it will advance the argument that it is essential to critically assess factors motivating requests for MAiD in order to avoid further perpetuating systemic discrimination and marginalization through an overly narrow lens of patient choice.

PANEL

**“Examination of Student Understanding of Interprofessional Education
Using Case Study Simulation”**

Denise Ludwig, PhD, Interprofessional Education Office
Raymond Higbea, PhD, School of Community Leadership and Development
Breanna Chycinski OTD, OTRL, Occupational Science & Therapy
Lisa Kenyon, PT, DPT, PhD, PCS, Doctorate of Physical Therapy
Grand Valley State University

The purpose of this study was to use interprofessional education (IPE) to examine changes in the understanding of interprofessional practices (IPC), as defined by the World Health Organization (WHO), of healthcare program students with limited exposure to IPC. The range of pedagogy needs to increase for use of IPE to ensure alignment with all student learning needs. Competencies of teamwork, communication, knowledge of roles and values systems are identified as critical IPC competencies. Survey research, using a validated clinical instrument, was used to identify IPC competencies introduced using an education model of case study simulation. The instrument provides information about perceptions of the appropriateness and benefits of IPE and IPC without a focus on any one profession. Simulation participants, n=388, represented eleven disciplines in healthcare and education. A medically complex case study using standardized patients was used to teach IPC competencies. Findings revealed a statistically significant difference or increased learning for 90% of survey items. These data suggest that the use of the education model is valid for incurring learning outcomes that improve understanding of IPC.

“Bribery, Conflict of Interest, and a Physician’s Fiduciary Duty to Patients”

Michele Martinho, MD

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

“The Art of Equity: Critical Health Humanities in Practice”

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University of Virginia School of Medicine

Over the last decade, evidence for the value of the health humanities has accumulated, and the American Association of Medical Colleges recently called for the inclusion of health humanities in medical education. Recently, practitioners of the health humanities have begun to call for recognition of the larger role this field might play in educational work that “moves beyond empathy and wellness to prioritize the intersection between humanities scholarship and social justice” (Adams and Reisman, 2019). In this presentation, we will discuss two theoretical frameworks that can inform a “critical health humanities” pedagogy, as well as several concrete examples of innovative approaches to operationalizing this emerging role of the humanities in medical education.

We have found structural competency and critical consciousness to be particularly useful for conceptualizing the practice of critical health humanities. Structural competency is a medical education paradigm that calls for training around how socially constructed variables—such as race, class, immigration status, socio-economic status, and more—impact the ways in which they experience health, illness, and health care. The term “critical consciousness,” or *conscientização*, first coined by Paulo Freire, refers to awareness of one’s own social position and ability to transform society, and has been invoked as a key objective of medical education.

How should critical health humanities be taught? Our work at the University of Virginia offers a window into the diverse ways learners at different levels can benefit from this field. For undergraduates, critical health humanities can be used to introduce and solidify foundational tenets of public health. We designed a seminar for first-year and second-year undergraduates at our institution, which explored social determinants of health (SDoH) through the critical analysis of art and literature. For medical students in their active clinical years, critical health humanities affords an opportunity to complicate their understanding of the system in which they play active roles. At the University of Virginia, the Center for Health Humanities and Ethics (CHHE) serves as the hub for educational offerings related to the health humanities. Through close reading, group discussions, and reflective writing, in these courses medical students grapple with questions of power, equity, and ethics in medicine.

We have also led meaningful critical health humanities work outside the classroom, including story slams, journal clubs that center literary works, and the invitation of “professional” storytellers to such educational events. We will discuss several examples of these additional educational activities.

Finally, we posit that this field offers an important opportunity to create cross-campus, extramural, and/or transdisciplinary pedagogical approaches. Community partnerships can also be sources of educational collaboration, and might simultaneously serve as examples of the deep listening, power sharing, and collaboration that the critical health humanities aims to foster.

“An Ethical Call for Early Implementation of Palliative Care for Underserved Heart Failure Patients”

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In this presentation, I argue in support of the urban bioethical obligation to provide early palliative care services to heart failure patients from disadvantaged communities who have historically had difficulty accessing and navigating the healthcare system. While I explore the utility of broadly implementing palliative care services for heart failure patients, I am particularly focused on offering underserved patient populations access to increase equitable care. Heart failure is a disease that affects millions of Americans, but has a disproportionate impact on underserved, minority communities. Over the coming decade, heart failure will become a chronic disease for more Americans as treatments improve, but the disease cannot be cured. Minority populations are, and will continue to be, disproportionately impacted by heart failure due in large part to their increased risk factors, which stem from social and structural determinants of health. Heart failure is a tumultuous disease to manage for even the most well-versed patient. Individuals from underserved communities are more likely to face barriers to properly manage their disease, such as decreased health literacy, insufficient insurance, inability to purchase healthy foods, or safe spaces to exercise, all of which contribute to poor outcomes with heart failure management.

The field of urban bioethics specifically focuses on the principles of agency, social justice, and solidarity in communities that are dense, disparate, and diverse. Healthcare providers in underserved communities can use the principles of urban bioethics to help patients achieve better health outcomes, particularly within the realm of heart failure. One underutilized way to do so is by connecting heart failure patients from this demographic with palliative care services. Palliative care offers incredible benefits for patients and caregivers covering a variety of areas, such as goals of care discussions, shared decision-making, and psychosocial support. The palliative team can support agency by enhancing the understanding of a patient’s personal context to help the patient and primary team develop a treatment plan via shared decision making. Social justice requires equitable access to opportunity. Palliative care is a vital and underutilized resource that can undoubtedly boost the patient’s chances of adequately managing his or her disease because the specialty can skillfully assess the patient’s medical, social, and spiritual needs, while also overcoming structural barriers with the help of social workers. Solidarity is a principle that is followed across all medical specialties. A patient entrusts his or her well-being to the physician and the physician pledges to guide the individual towards a healthy outcome to the best of his or her ability. Engaging the palliative team early in the course of heart failure is a clear signal that the provider is pursuing every available avenue to ensure the patient is receiving holistic care to maximize the chances of a healthier life, and thereby strengthening solidarity between patient and provider. Offering early palliative care services to underserved heart failure patients offers extra resources to effectively manage their disease and lifestyle in a personalized fashion, and aligns with the urban bioethical principles of agency, social justice, and solidarity.

“Natural Disorder: Psychiatric Waste and Ecological Matters of Care”

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Intertwined discussions between environments and mental health have grown exponentially in the past few decades. Such conversations, however, remain rather anthropocentric: researchers assess the implications of ecological exposure to the mental flourishing of humans or, more recently, the increasing detrimental waste produced by humans in psychiatric, psychological, and other clinical institutions. The threads of causation and validity here are particularly strong, but they obscure the subjectivity of environments in these same networks of relations. With respect to the first, experts continue to examine the efficacy of activities in the “natural world” where individuals can destress, invest in a fulfilling endeavor, build connections in a community, and expose themselves to healthy organic compounds. Environments hence constitute an indifferent space where persons can “find and express themselves.” Issues of waste and pollution are more explicit: the explosive production of antipsychotic and antidepressive medications in response to diagnostic inflation has exhibited a series of drastic harms to local ecosystems, including a contamination of water bodies, plant life, and microorganisms. Each of these presently represent a “resource” to be managed, preserved, or avoided. Essentially, mental health care is moderately oblivious to any “illnesses” and “disorders” that may be found in environments themselves.

This paper revisits interactions between care/treatment practices in mental health and ecological networks through the lens of “matters of care.” Puig de la Bellacasa (2017) suggests that scientific deliberations portray issues as simply “matters of fact” that can be articulated in clear, universal, and empirical terms. Absent from debates of fact are potent naturecultures: symbiotic associations between material interactions and socially-constructed discourses. The medical gaze presented in biomedicalization, including its applied use in psychiatry and psychology, is indeed representative of a cultural boundary within which certain subjects and expressions are signified. I thus respond by accentuating alternative naturecultures that highlight varied environments as active and distinct entities within a network of interdependent care. Evaluations of disorder stress disconnections in the healthy and sustainable entanglement between caring subjects. My analysis identifies relational detachments and harm (like psychiatric waste), interrogates presumptions in biomedical discourse, and recreates them into matters where there is not only and simply concern, but also *commitment, attachment, and collaboration*.

Central to this project are methodological tools from care ethics that also communicate a normative direction for future policy and practice. Care theory shifts attention towards skills of attentiveness, responsibility, trust, respect, and competence response in place of mutual disinterested negotiation. Persons and environments are understood as autonomous agents *because of* their interdependency, not when dependency is lacking/missing. While this remains true in a practical sense, I argue that such tools should be overt foundations for practitioners in those reinvented naturecultures. Care is ultimately an inevitable condition, but it is also an orientation designed to promote flourishing in both human and non-human subjects.

**“Bad Sewing Always Makes Me Fidgety’ *Dobbs*, Defects, and
Susan Glaspell’s *Trifles* in the Twenty-First Century”**

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The Supreme Court’s 2022 decision in *Dobbs* abandoned a half-century of precedent recognizing a constitutional right to abortion. Arguing that any right not explicitly outlined in the Constitution must be “deeply rooted in this Nation’s history and tradition” and “implicit in the concept of ordered liberty,” the Court’s majority cherry-picked the past, silenced the voices of women, and re-enshrined a patriarchal lens of the law. Like the wives in Susan Glaspell’s play *Trifles*, what “counts” in a complex narrative of the everyday lives and health of women is discounted as legal evidence, perpetuating inequality and harm “on the basis of sex.” Though first performed in 1916, four years prior to the Nineteenth Amendment and well before women could regularly serve on juries, Glaspell’s *Trifles* remains relevant for addressing the sexism embedded in the Court’s decision and emerging state laws. In *Trifles*, Mrs. Hale and Mrs. Peters—relegated to the periphery by the men—take center stage and come to understand the murder of Minnie Wright’s husband (and society’s and their own parts in it) through “kitchen things” and the erratic piecing of a quilt. While Mrs. Peters initially hesitates, saying “I don’t think we ought to touch things,” the two women navigate the chasm between being “married to the law” and “loyal to [one’s] sex.” Today, such “bad sewing” persists in the Constitution’s fabric and the threads linking nineteenth-century abortion laws and more recent Court precedents—creating a flimsy legal cover for “a raw wind that gets to the bone.”

PANEL

“Professionalism in Undergraduate Medical Education: A Preliminary Report”

Eli Schantz, Jonathan Harris, Afsheen Mansoori, and Clayton Hick
Indiana University School of Medicine

The notion of professionalism informs policy-making at all levels of medical practice, from national specialty organizations and licensing boards to hospital disciplinary committees. The creation of policies to promote professionalism, however, is made all the more complex in the context of undergraduate medical education, where the notion of professionalism not only acts to govern student’s behavior, but also to shape the professional identity of physicians-in-training. This challenge is evident in the ambiguity and conceptual circularity which can be found in the professionalism policies governing undergraduate medical education. We offer, here, a preliminary report on our current effort to descriptively characterize the breadth of this phenomenon.

Here, we present a review of professionalism policies at our home institution, Indiana University School of Medicine, and eight randomly-selected allopathic medical schools. We define “professionalism policies” as those policies which (i) satisfy LCME Standard 3.5 or otherwise define professional characteristics or behaviors or (ii) are referenced by the policies described by (i). We designate such policies as ambiguous when they (i) define professionalism circularly or (ii) rely on undefined ideas of appropriateness, reasonableness, or suitability.

Of the nine sets of policy assessed here, eight (89%) had multiple policies which were designated as ambiguous. Six sets of policy (67%) used patently circular language, such as policies from Wake Forest University School of Medicine and Indiana University School of Medicine. Seven sets of policy (78%) referred to undefined ideas of appropriateness, such as Loma Linda University School of Medicine and Stritch School of Medicine. References to reasonableness or suitability were less common, with only two sets of policy (22%) including the former and one policy set (11%) including the latter.

Professionalism has been explicitly identified by the LCME as a key competency for graduating medical students. Here, however, we have collected evidence that a primary modality for communicating professional expectations—namely, professionalism policies—are currently inadequate, and offer circular or otherwise ambiguous definitions of professionalism which cannot guide the professional development of students. While we cannot yet claim that this problem is universal among allopathic medical schools in the United States, there is cause for concern—and an important opportunity for medical educators and students to turn their attention to correcting it.

**“Learning and Teaching the Value of Medical Humanities:
Situated Views from an Anthropologist in an Interdisciplinary Honors College”**

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When considering the question of the value of medical humanities, it first occurred to me: for whom do the medical humanities hold value? Based on my role as an instructor teaching medical humanities courses in an undergraduate honors college, I set out each academic year to convince first-year students, many of whom intend to pursue health professions, that the medical humanities should matter to them. Over the semester in our interdisciplinary introductory course, we engage with philosophical approaches to the good life and perspectives on “wicked problems” facing the world across many disciplines. In my section, we take up theoretical topics and case studies meant to demonstrate the diverse approaches that comprise medical humanities and the insights that scholarship in medical humanities has to offer for people intending to spend their lives working in medicine, nursing, public health, and related fields. Many of these students find the material compelling enough that they go on to take other courses in the medical humanities over their undergraduate careers, to write about what they learned in class or in related independent thesis projects or in health-related study abroad opportunities in medical school and other applications. Studying the medical humanities prepares them to observe keenly and to ask good questions in those further studies, and sometimes it changes their paths entirely. I count these as successful demonstrations of the value of medical humanities.

As a faculty member, I have learned to value the medical humanities by teaching them as part of an interdisciplinary team outside of a usual department structure. Working with scholars from different fields to co-create meaningful curricular and co-curricular experiences for our undergraduate students and for students at our university’s medical school has taught me about how medical humanities provide a meeting place for expanding boundaries of scholarly learning and impact. Working alongside my colleagues and students has helped me situate my own work more broadly: outside of this context, when could I, a cultural and medical anthropologist, include among my book manuscript readers a pre-med student turned social worker and a future nurse-midwife? Their insights made my book, *Infertility in a Crowded Country: Hiding Reproduction in India* (Indiana University Press, 2022), a better one, as did talking through issues of gender, power, meaning, and health structures in South Asia and comparatively around the globe with so many students in our majority-minority College, many of them people with family connections to South Asia, and with colleagues across fields. Medical humanities continue to inspire me toward new ideas for scholarship, teaching, and collaboration with community partners. I am excited to continue to discover how they will matter for our students and community partners, as well as for me and my colleagues, as we all continue on our own paths toward understanding, making meaning, and addressing the challenges facing human beings in our times.

“Are the Medical Humanities Inherently Political?”

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Like humanism itself, medical humanities literature tends to avoid the rough and tumble of overt politics. With Hippocratic obligations as its lodestar, the medical humanities often appeal to a higher order than politics. Aristotle, of course, saw politics as the master science, with all else—including ethics—subsumed within. This suggests that there may be something inherently political about the application of a humanistic lens to medicine, or even the idea of the medical humanities itself. Is the humanistic deficit that the medical humanities purport to address itself part of an unarticulated political critique? If so, what *kind* of political critique?

Taking a wide-angle lens approach, this essay explores the political-theoretical underpinnings of the broad interdisciplinary field of medical humanities to ask what inherent political content the field might contain. To understand these underpinnings, we must return to an analysis of why the medical humanities arose at the time they did, in response to material conditions in medicine itself. Certainly, as we see humanities courses, faculty positions, and even departments vanish across the United States, these disappearances appear to be a response to a political moment. Similarly, as many medical educators acknowledge that clinical medicine needs the medical humanities more than ever, there appears to be an unarticulated political project at work. Through a close reading of widely cited medical humanities texts, as well as available definitions of the medical humanities, I show how the question of politics is either elided or engaged, hidden or acknowledged. Ultimately, I seek to excavate latent political content contained within medical humanities scholarship to ask what that content suggests about the vibrant and growing field that is the medical humanities itself.

“Patient Narrative: Mapping the Complicated Landscape of Female Chronic Pain”

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Today the genre of patient narratives contains numerous stories of women who have struggled with chronic pain for years, seeking care from western biomedicine to no avail. A cursory exploration into this genre shows part of this issue stems from the history of hysteria and subsequent exclusion of female patients from biomedical studies. The legacy of this history has clouded the biomedical gaze so that it cannot see female patients clearly. The question must be asked, how can this biomedical gaze be cleared so that it can better see female patient’s pain? To explore this question, I conduct discursive analysis guided by the theoretical framework of the geographic self to analyze two patient narratives, *Ask Me About my Uterus* by Abby Norman and *The Tiger and The Cage* by Emma Bolden who both tell their stories of life with endometriosis. This research illuminates the valuable role patient narratives can play in this process of broadening the biomedical gaze by examining how female chronic pain is expressed in these works.

As a guide for my discursive analysis, I utilize the geographic self as lens through which I analyze the ways these two women describe their pain experiences. This geographic perspective allows for discussion of an internal bodily space where the *self* or the mind resides and experiences the body. The body itself becomes a kind of spatial home where, as the being inhabiting that body, we experience a relationship between our *self* and our body. As embodied beings, we have a relationship with this body, as we exist within it, and as it shapes how we interact with the world around us. This geographic framing discursively captures the internal *bodyspace*, and focuses on embodiment as a mind/body relationship. This allows for a reading of these two patient narratives that reveals the dynamics of the chronic pain struggle.

Reading these selected patient narratives through this conceptualization, the complexity of chronic pain can be seen as not merely an unpleasant sensation, but a disruption in this mind/body relationship. Norman and Bolden describe their bodies causing them pain and failing to behave how they once did. Their bodies cause pain to their *self*. This symbiotic mind/body relationship is altered. Thus, the complicated experience of pain is revealed as a disruption of that crucial mind/body relationship. This analysis also illuminates themes of betrayal and validity as part of embodied pain experiences. My work unpacks the complicated nature of both of these elements as well providing further discussion and knowledge on chronic pain experiences.

The goal of this medical humanities-based research is to demonstrate the value of harnessing humanistic mediums as teaching mechanisms to combat the more traditionally objective way that biomedicine trains its doctors, by showing how patient narratives can provide insights into new ways of thinking about pain and approaching the clinical conversation. Ultimately, I argue this kind of analysis can serve to clear that medical gaze so that it can better see the female patient.

“Medical Gaslighting’ on the Examination Table: Dissecting a Viral Phenomenon”

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I critically address the history, analysis, methodological issues, and uses of the idea of medical gaslighting. ‘Gaslighting’ is hot. Voted “Word most useful/likely to succeed” by the American Dialect Society in 2017, it was Merriam-Webster’s word of the year in 2022. The term derives from a 1938 play by Patrick Hamilton, and two films based on it, in which a husband attempts to convince his wife that she is insane by means of subtle, persistent manipulation. The term has recurred in popular culture and academic writing on psychotherapy and abuse since and underwent an uptick in use from 2014 onward. A variant, ‘medical gaslighting,’ has been increasingly deployed in online patient forums, journalism, and academic writing, with usage from 2020 onward in relation to the experience of Long Covid patients.

Salient features of the notion of gaslighting include that it attracts significant interest in both academic and broader culture; that its deployment seems to have epistemic and political significance for those who use it (for e.g. victims of abuse or those who have had problematic healthcare experiences); and that the term has a distinctly negative moral valence: whatever gaslighting is, it is very harmful or very wrong. These features make precise analysis of the gaslighting phenomenon desirable but raise methodological questions about what a correct analysis (and therefore use) might be.

Gaslighting has both perpetrator and victim, and the main initial philosophical analyses divide along these lines. On Abramson’s 2014 account, a distinctive feature of gaslighting is the abusive motivation (conscious or not) of the perpetrator. McKinnon, by contrast, focuses more on the role of biases and structural injustice in bringing about self-doubt in the victim (2017). Discussions of medical gaslighting mix these accounts in problematic ways. A key difference is the degree of wrongness or culpability ascribable to the perpetrator. On McKinnon’s account, the perpetrator of gaslighting can lack an abusive motivational structure (or intent) and still count as gaslighting, arguably mitigating (not eliminating) culpability. I argue Abramson’s account or something similar to be the better analysis: it fits the cultural history of the word/concept; meaningfully locates the notion of gaslighting in the constellation of concepts falling under the umbrella of “epistemic injustice” (testimonial injustice, hermeneutical injustice, epistemic exploitation, etc.); and does justice to the ideas that gaslighting is particularly wrong(because of the motivation for it) and particularly difficult to detect (because determining whether it is occurring has to do with trying to understand motivational states of perpetrators). Thus, the (real) problems in healthcare being referred to as “medical gaslighting” by patients and some scholars are typically better understood as other forms of epistemic injustice. Calling them ‘gaslighting’ is problematic because it risks misidentifying or overstating the health-care provider wrongs involved. I conclude by considering the possibility of a distinctive form of medical gaslighting in which a physician might illicitly deploy the language of clinical psychology regarding a patient as a means of securing the patient’s compliance with the physician’s judgment or treatment plan.

“Reflections on Gender Disparities and Epistemic Injustice in the History of Safety Standards in American Orthopedic Surgery”

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It was 1937 when a female doctor, Dr. Ruth Jackson from Iowa, joined for the first time the ranks of the American Academy of Orthopedic Surgeons, after years of struggle to be admitted as the only woman in the profession, and the first board-certified female doctor in the US (Ruth Jackson Orthopedic Society). During World War II, radiation in orthopedics emerged and gained prominence in the aftermath in the US. Yet this historical landmark in orthopedic surgery has not been followed by appropriate safety radiation protections and protocols considering the specificity of the risk profile of female orthopedic surgeons entering the profession. In the next seventy years, female surgeons were unduly exposed to radiation with little knowledge of the risks. In 2007, radiation exposure during surgery was found to inflict a high cancer risk to female orthopedic surgeons due to the lack of adequate radiation protection compared to their male orthopedic surgeon counterparts. More recent studies have shown the lack of radiation protection as the highest risk in the breast region, specifically in the UOQ (upper outer quadrant) of the breast. The prevalence of breast cancer in female orthopedic surgeons is almost 4x higher, compared to the general female U.S. population (Chou et al. 2022).

The lack of data on the subject and its reflection on safety training are of great importance for understanding the long-standing problem, despite its grave harm. National Institutes of Health Radiation epidemiologist Cari Kitahara points out the lack of large studies on female medical workers' radiation risk. A spokesperson for the American Academy of Orthopedic Surgeons said there is currently no specific training for radiation risks for female orthopedic surgeons (apud Julia Lurie, Mother Jones, 2022).

This presentation will address the value of medical humanities in revealing historical disparities such as in orthopedic surgery distribution of risks regarding gender and addressing the invisibility of data. We will give expression to the testimonies of female orthopedic surgeons and address also the lack of enough scientific information. Furthermore, we will discuss and analyze the problem of fairness in the context of orthopedic surgery safety standards and training standards, and the overall lack of knowledge regarding such risks in education and training, when it comes to the dangers of radiation in the operating room (Joeris et al. 2018; Khan et al. 2023). We shall address epistemic injustice issues in knowledge construction on orthopedic surgery safety and the distributions of risks and knowledge based on gender.

“Finding the Voices of Illness: Exploring Polio Stories”

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When poliomyelitis—also known as infantile paralysis, became epidemic in the early 20th century, it captured public attention and, changed American society—an experience that resonates with the recent experience of COVID-19. Polio did not affect a large number of individuals, but it primarily infected children, who if they survived could experience permanent paralysis that shaped their lives. Because of the way the virus and its impacts were publicized, polio also became the first modern disease- the subject of fundraising efforts, with posters of children wearing leg braces, and images of children iron lungs generating sympathy for sufferers. But even though these images caught the imagination and raised funds, the powerful impact of polio on American society is generally forgotten. It is not, however, forgotten by the individuals who caught polio, and their stories of that experience- with the illness, rehabilitation, returning to school or work, developing a different identity that could center on their polio experience, speaking about the disease, living with a disability, and developing a voice. Also, in America, some experiences haven't been recognized and recorded and stereotypes about African American susceptibility could affect access to care and ability to voice their stories. This presentation describes a project identifying and interviewing polio survivors from diverse backgrounds and experiences, exploring how that experience shaped their lives and how they chose to live in the world, with interviews transcribed and included in a digital collection curated by the University libraries. It also discusses the process of working with the range of survivors and their stories, their voices, and their identities, and the way in which experiences with polio reflect more general experiences with infectious disease outbreaks. Thus, these voices help to navigate a post-COVID world.

“Newborn Screening Research Consent and Bioethical Challenges”

Brittany Sullivan and Shibani Kanungo, MD, MPH

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Newborn Screening (NBS) as a public health program detects debilitating conditions in asymptomatic newborns to improve long-term morbidity and mortality. The Department of Health and Human Services (DHHS) Health Resources and Services Administration (HRSA) Recommended Uniform Screening Panel’s (RUSP) evidence-based process guides state policies on which conditions to include in their newborn screening panel. As of 2023, the RUSP recommends screening for 35 core conditions and an additional 26 secondary conditions. Most of these conditions are detected by the collection of dried bloodspots (DBS) from every newborn via heel stick onto a NBS card. Apart from the bloodspot, additional medical information about both mother and newborn are also collected on these cards. These cards serve as a potential gold mine repository for research purposes. Informed consent has been a topic of debate within the public health sector and general populace. Despite being an inarguably successful public health initiative, the NBS program has faced several legal challenges. Our project aimed to determine the current landscape of research consent in NBS in the USA.

NBS research consent processes were explored through publicly available websites including state-specific health departments, third-party non-profit organizations (i.e. NewSteps, Baby’s First Test), and state-specific regulations. Further clarifications were obtained by contacting individual state program coordinators. Legal challenges were explored using LexisUni database with search terms: “newborn screen” OR “newborn screening” AND “consent” OR “refuse”.

NBS samples were retained by all 50 states, however length of retention varied between 1 month to indefinitely. Costs for blood spot testing varied from no cost to up 220 USD for initial testing. 27 states permitted use of residual DBS for research purposes. Of these 27, 24 states required written informed consent for research use, while 3 did not. Opt-out options for research purposes were allowed in 12 states. Of these 12, 10 states provided information about this on their own state websites. 15 states did not provide opt-out options for research use but instead allowed research use only for families that opted in. Legal challenges have been made in 9 states between 2002 and 2022. Key issues for these included informed consent, constitutional rights, genetic privacy, potential for misuse of samples, and religious freedoms.

Significant variability in NBS research consent process exists. It was difficult to identify who is responsible for each element of the research consent process and the best circumstances to obtain the research consent. Increase in public knowledge and transparency about NBS processes and policies can alleviate NBS research consent concerns.

“Humanizing One Another: The Value of the History and Philosophy of Medicine”

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One salient value of the Medical Humanities involves providing students, especially future medical practitioners, with a wide understanding of the broad scope encompassed by the term ‘human.’ Especially as legislatures pass laws that dictate or impede medical procedures or access for members of certain groups, a robust discussion of what is meant and included in the term ‘humanity’ is helpful. Historically, members of various population groups have been deemed to be less human than others. Aristotle’s views about the generation of women involving some de-formation—literally a deviation from the expected human form—were expanded from his original discussion of the puzzle of dyadic human reproduction to include the assertion that women were somehow naturally inferior. The inferiority of women was further reinforced by ancient and early medieval philosopher/theologians like Augustine. But both Aristotle and Augustine also struggle with other types of so-called deformity, such as disability; disability itself seems to dissolve into an accusation of monstrosity depending on the extent of the disability. Medieval thinkers puzzled about intersex individuals and their humanity, with intersex individuals being called anything ranging from being unique individuals who demonstrate a spiritual connection to masculinity and femininity to being monstrous creatures. Geography played a role in presumptions about the people who lived there, with certain behavioral attributes being associated with different geographic areas. Behavior then played a role in ranking the desirability of members of groups from different areas. Eventually, racial determination was made based on factors like parentage or skull shape, and these determinations included bald statements about the lack of humanity of some human ‘races.’ The history and philosophy of medicine contributes to the medical humanities by exposing the limitations previously placed upon ‘humanity.’ In order to be able to incorporate a broad definition of humanity, examining the reasoning given for limiting who counts as a human provides a basis for expanding the definition. In each of these cases, the reasoning is tragically awful: women must be human because they are necessary for the production of more humans; humans who give birth to a child with unexpected characteristics are producing a human child; intersex individuals have genital configurations within the ordinary range of human genital configurations; changing geography doesn’t change one’s character or humanity; skull shape varies, but the ranking systems regarding skull shapes that prioritize Eurocentric features were conveniently written by Europeans, etc.. In learning about the failure of these attempts to diminish the great variety of ‘humanity,’ we can not only counteract further bad reasoning in attempts to limit it, but we can also consequently embrace the breadth of humanity instead of limiting it further. Medical humanities helps provide a basis for the humane treatment and assessment of patients, grounding such treatment in an acceptance and affirmation of the humanity of that patient.

**“Health Policy, Medical Communication, and the
Modern Threats of Mis/Disinformation to Health and Medicine”**

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The creation and distribution of health misinformation, disinformation, and conspiracies in the wake of the COVID-19 pandemic is at an all-time high, supercharged by mainstream and social media entities that prioritize captivating an audience or going viral over content integrity. Health communication and accessibility of health information are one of the leading items that individuals utilize the internet for, and this leads to many being manipulated into scams, dangerous “alternative medicines”, and stifling confusion. The scientific truths well established in medicine and public health are now up for debate, imperiling national health everywhere. This session will educate attendees on how health mis/disinformation is created, spread, and what effects it has on population and public health in the immediate as well as the implications for the future. This presentation will;

- Breakdown the differences between misinformation, disinformation, and popular health conspiracies
- Provide key causes of health mis/disinformation consumption like low health literacy-Outline what groups and communities are targeted by mis/disinformation and in what ways these affect them
- Show the direct effects of mis/disinformation and conspiracies on public and population health
- Provide examples of how mis/disinformation and conspiracies change health best practices and policies in governance, altering population health, safety, and life expectancy in the long term
- Give solutions that medical and public health professionals can execute to improve health science communication as well as modern tools such as social media platforms to better connect and collaborate with populations on health information

This presentation is designed to be integrative of attendees’ engagement and multimedia components for accessibility and maintaining attention. Attendees will have a multitude of opportunities to engage in answering questions, analyze examples of health mis/disinformation, and be given resources at the end that they can explore and use to improve health literacy as well as combat health mis/disinformation and conspiracies. Intentional time for Q&A is also built in at the end of the presentation so attendees can further engage the presenter about what they have learned.

“The Ethics of Responsibility over Personal Health in the Age of Scientific Wellness”

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There is a growing consensus in our society that it's not enough to be disease-free and able to function in the framework of our daily obligations. There is a more important goal to focus on: how to improve our sense of wellbeing beyond just feeling okay. What does a concept of wellness entail in our day and age? Do human beings have an agreement on what it means for them? Finally, what prevents us from living the best, healthiest lives and who is responsible for removing those barriers – the individuals themselves or the healthcare systems?

While wellness orientation is inherently positive, its implementation does not always take forms that are productive or beneficial to all members of society. The entanglement of wellness promotion with the increasing expectation for citizens to persistently work toward achieving their optimal functioning places a new burden on their limited time and disregards potential variations in their initial health status. The examples already exist of such expectations sometimes translating into treatment prioritization, a departure from established healthcare practices that is bound to have influence on wider cultural acceptance of this approach.

The notion of responsibility over one's state of health is not new to medical sociology. Past research showed that the sympathy margin is narrower for people whose behavior contributed to the current medical condition even after extensive data demonstrated that this is often far from individuals' choice. Some insurance plans had excluded treatment for injuries caused by lifestyle choices, such as participation in extreme sports. However, only after the transition of the healthcare system from treating already existing conditions to identifying and managing risks to one's health, the change in the medical paradigm has occurred. The emphasis on health promotion reoriented medical research and influenced public opinion, and we now see it manifesting in the actual policies that regulate medical practice, while the new self-monitoring technologies facilitate collection of data for subsequent analysis. This paper will discuss the ethical considerations of policies that center on health promotion and individual responsibility over personal health and their impact on access to care, disability, and adding new health-based hierarchies to already existing social and economic inequalities today.

“Narrative Frameworks for the Development of Physician Identity”

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While narrative medicine is both an interdisciplinary, academic field and a framework and methodology for clinical practice, narrative medicine principles and the skills of narrative competence are thought of almost exclusively in relation to the role of physician-as-healer. In this paper, however, I argue that narrative frameworks and the “knowledge of what to do with story” can also contribute to the formation of the physician roles of bioscientist, advocate, and educator. To illustrate this claim, I draw from my experience teaching narrative medicine-based courses for residents in an urban teaching hospital. The courses are part of a broader curriculum designed to help residents identify the different components of physician identity and the factors that influence its development over their medical careers, and to understand the interrelatedness of physician identity and relationships with patients, colleagues, communities, and themselves. Narrative awareness and a facility with the giving and receiving of stories of self and other are revealed as the bridges between physicians’ roles as healers, bioscientists, advocates, and teacher/mentors.

“Processing Disorder for Future Practice”

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How do you begin to treat an issue that is socially celebrated? What do you do when the person knows what they are doing is unhealthy, but craves the empowerment, the freedom, and even the punishment?

Eating disorders are complex manifestations of an unbalanced mental, physical, social, and emotional system. Most people with eating disorders try to hide themselves. In my case I was involved in swim team and had nowhere to hide. The difficult thing to understand is this: I was proud of my eating disorder. I loved that I was able to go a couple of days without eating and push myself to do those workouts. I wanted to see how long I could last without food. It was a challenge and—like everything else in my life—I needed to excel at it. I was small, skinny, and finally achieving what I wanted. In this essay, I explore some of the paradoxes of my own experience with an eating disorder. As a medical student preparing myself for my future practice, self-reflection is integral to aligning myself with the needs of my future patients. There is a complexity in healing that can be better understood through personal reflection and narratives, even as we devise clinical and other responses. This essay will explore the nuances of my eating disorder while reflecting on the importance and value of the medical humanities more generally.

“Evaluating How Language Games Limit the Use of Ethical Frameworks in Public Health Ethics”

Mallory Wietrzykowski

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Public health ethics theories and frameworks have been constructed mainly in response to public health emergencies, such as the HIV/AIDS epidemic or, more recently, the COVID-19 pandemic. These instrumental theories and frameworks are generally formulated to aid public health employees tasked with working through ethical dilemmas. Much of the content of public health ethics has been applied to the field from an already well-established field of bioethics, and especially clinical ethics. Seemingly, while moral frameworks and theories such as Tom L. Beauchamp and James F. Childress' *four principles theory* have become embedded into the daily practices of clinical health care, there is not a comparably significant theory that has been adopted into the daily practices of public health. A possible reason for this asymmetry is that the functions of public health differ from the available moral frameworks. I investigate this phenomenon further by first assessing how the language and culture of clinical health care is distinct from public health. Following, I consider how the distinctness of each discourages public health institutions from adopting ethical frameworks and theories whose meaning is grounded in clinical health care.

I consider discrepancies between clinical health care and public health through the lens of Ludwig Wittgenstein's *language games*. Wittgenstein argues in *Philosophical Investigations* that meaning is learned through experience and the use of language as one learns to participate in a language game. I argue clinical health care and public health each practice a distinct language game because the training and activities of employees in each field teach and shape them for participation in a particular tradition. Specifically, employees in each field learn to assign meaning to functions from their participation in their field. My argument is motivated by Matthew Vest's critique in *Ethics Lost in Modernity* that being situated in distinct language games gives one specific rules that can lead them to ignore the pluralism of moral thought. Even if some ethical theories or frameworks transfer well from one field to another, the significance of their meaning cannot be made sense of when inconsistent with one's language game.

Each field's approach to working through moral dilemmas is contingent to their distinct language game. Since clinical health care and public health each occupy a distinct language game, neither can fully incorporate a moral theory that is solely from the tradition of one or the other. While public health employees may see that aspects of moral theories in clinical ethics are beneficial to the daily practices of public health, it is unlikely that employees would think the application of these aspects are equally meaningful in public health. If it is the case that the distinctness of clinical health care from public health creates a barrier to the incorporation of public health ethics into daily practices, as I attempt to argue, then further attempts to establish a theory of public health ethics must be distinct from clinical ethics and grounded within the language game of public health.

“The Increasing Universal Need for Empathy”

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Moral injury is the phenomenon that occurs when someone acts against their personal moral code, resulting in a negative self-image and feelings of guilt. Through interviews and surveys from doctors in Egypt, Lebanon, and other Arab countries during COVID-19, it is evident that the lack of instruction from national health ministries and a shortage of resources, led medical professionals to feel helpless in their ability to treat patients, oftentimes being forced to choose which patients deserved hospital beds and which did not. Similar trends between the concerns of doctors regarding ethical dilemmas and declining mental health indicated a need to implement Medical Humanities as a source of relief and a call to the importance of mental wellness.

The stress on doctors also impacted patients, as they felt their illnesses were not properly addressed, thus straining the doctor-patient relationship. The project brings to light many issues plaguing healthcare systems in the Arab World, which have been exacerbated by the COVID-19 pandemic, but which are by no means new problems. The desensitization of doctors to patient illness experiences due to overwhelming medical systems, including declining mental health when dealing with an uncertain infectious disease, leads to an increased awareness of a universal issue facing medical care: the lack of adequate support for physicians as they struggle to balance the stress of the workplace with morally and humanely treating their patients with empathy. The possibility of developing an empathetic approach to medicine can flourish through a higher level of awareness for listening to and documenting patient and physician experiences via the Medical Humanities genre of narrative medicine.

Without socio-political support, there is increased tension between physicians and patients. There must be coping strategies available for doctors when dealing with bioethical issues, and they should not be placed in situations where they feel that they are crossing a moral boundary because this negatively impacts their mental health and ability to provide for patients. In an effort to promote a public health and Medical Humanities approach to treating illness in the Arab World where attention is severely needed in the wake of the 2023 Turkey-Syria earthquake, this project aims to draw on graphic novels as a way to compile imagery, multiple perspectives on the Syrian healthcare system through first-hand accounts, and medical anthropological commentary. Inspired by the 2017 graphic novel *Lissa*, mostly situated in Egypt, a similar approach will be taken to paint a realistic portrait of the medical, social, and political realities of Syrian citizens, taking Medical Humanities as the holistic manner with which to consider the intersectionality of human experience and medicine.

Community partnerships may include Doctors Without Borders, Save the Children, and collaboration with UNICEF in a humanitarian effort to involve local student volunteers in creating “care kits” and sending resources to areas most impacted by the 2023 earthquake. In an effort to motivate students of diverse backgrounds to get involved, there will likely be committees formed where students can choose which service initiatives interest them most.