

Callousness, Legalism, and Clinical Moral Perception

Christy A. Rentmeester

In his book, *Moral Reasons* (1993), the philosopher Jonathan Dancy explains what moral perception is. He argues that a person sees morally when she recognizes patterns of salience among features of a situation and construes a reason to act in response. If we apply this view of moral perception to what healthcare professionals do when they see patients and consider how to respond to them, we generate a view of clinical moral perception.

A number of things influence how healthcare professionals practice clinical moral perception. One of the most important influences is how they are trained. What kinds of patterns of perception do trainees see modeled by their mentors? Which beliefs about what patients need and deserve from healthcare professionals guide their perception of patients' situations? Which beliefs are passed along in informal curricula of health professions education, and how do those beliefs change over time?

One troubling trend in medical education, for example, is that students commonly see their faculty mentors treating patients, patients' loved ones, students, and colleagues in a callous manner (Rentmeester, Badura, & Kavan, 2007). Another troubling trend is the tendency of students and young practitioners to practice defensively and think legalistically about how they care for patients. Here, I offer pithy summaries of callousness and legalism and briefly explain how they are two common expressions of poor rather than good clinical moral perception.

One way to understand what constitutes poor clinical moral perception is to first recognize what good clinical moral perception can be. Concisely, a healthcare professional expresses good clinical moral perception when two things

happen: (1) he recognizes features of his patients' situations that configure what they need and deserve from him, and (2) he defines what patients need and deserve from him broadly (instead of narrowly), inclusively (instead of exclusively), and generously (instead of meagerly) (Rentmeester, 2007). For example, in the course of training, some healthcare professionals learn to narrow the scope of what patients deserve from them by applying the belief that patients need and deserve the healthcare professionals' caring responses less generously over time. There are several reasons for why this pattern of perception might be appealing, including exhaustion (Rentmeester, 2007; Rentmeester, in press). One important consequence of this practice of perception, however, is that professionals can acquire reputations for being callous when the scope of what counts as a reason to respond with care to patients becomes too narrow.

Like callousness, legalism also expresses a professional's poor clinical moral perception. A clinician practices legalism when, for example, she orders tests, requests consultations, or does procedures that are unlikely to benefit the patient or generate new clinical information that might help in caring for the patient more effectively (Rentmeester, 2006; Rentmeester & George, 2007). Such orders, consultations, and procedures are done with the idea that doing these actions will make the healthcare professional appear "covered" from an imagined legal point of view. When clinicians are trained to think and see legalistically, they are taught to fear their patients and to see them as threats. This point of view has important effects on clinical care: fear narrows the scope of the professionals' clinical moral perception by drawing their concern away from their patients and toward themselves and expressing

clinician-centered instead of patient-centered orientations to clinical practice.

A couple of educational responses hold promise to reduce callous and legalistic patterns of poor clinical moral perception. First, health professions faculty should pay close attention to how trainees learn to construe the nature and scope of their responsibilities to patients and colleagues. In terms of clinical moral perception, faculty might first ask some important empirical questions about trainees' practices of discerning the vulnerabilities of their patients and the needs of their colleagues. What do trainees see as features of patients' situations that configure compelling reasons for them to act in service to those patients? What do trainees see as features of patients' situations that can narrow their views of what patients and colleagues deserve from them? When do trainees respond negatively to the presence of

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Letter from the President

Divided We Stand, United We Fall

Tod S. Chambers



Customarily, when we speak of the divisions within ASBH, we are concerned with disciplinary boundaries: humanities versus bioethics, philosophy versus social science, policy wonks versus clinical ethics geeks, and medical humanities versus biocultures.

These conflicts are often expressed through battles over time about the annual meeting, the selection of plenary speakers, affinity group meeting times, and the scholars chosen for lifetime achievement awards. Many of the previous incoming president's addresses and "Letters from the President" in *ASBH Exchange* have examined this issue. Art Derse was concerned about losing the "H" in ASBH. Kathryn Montgomery asserted that unity could be found in interdisciplinary. Paul Root Wolpe argued that there are features in our common intellectual interests that unify the society.

As I have watched the society since its conception as the result of a merger of the Society for Health and Human Values, the Society for Bioethics Consultation, and the American Association of Bioethics, I have seen differences maintained, and although they are often benign, these differences can at other times bring forth tensions that I suspect are not easily reconciled. These divisions do not abide primarily in our disciplinary tendencies. When Matthew Wynia opened the annual meeting with his eloquent address 2 years ago by asking, "Whom do we serve?" I realized that his particular answer to this question hinged on a "we" that I did not necessarily share with him.

The questions, I think, that must first be asked are "When you join ASBH, what do you think you are joining? What do you believe you are becoming a part of?"

For some, one is becoming part of a community of scholars focused on medical humanities and bioethics. For some, one is becoming a part of a movement for political change, social justice, and educational reform. And for others, one is becoming a part of a new professional

identity, the bioethicist. The ethics and the telos of each of these spheres of associations are quite different and can at times, when they are not shared by the others, lead to striking indifference or strong, passionate disquietude. The goals of one sphere can be in direct opposition to the goals of another.

Now I am well aware that there are a large number of people for whom the distinctions I have made simply make no sense. If I were to create a diagram of these spheres within ASBH, it would quite definitely resemble a member of the Venn family. I do not wish to argue that these distinctions even need be divided, but those who find themselves in the overlap areas of my Venn diagram need to understand that there are ASBH members—and I am one of them—who sit comfortably in the part of this diagram that does not overlap with any other sphere. There are also those who reside within an overlap of two spheres but not the third. Our society runs into trouble whenever members of a single sphere see the other groups as within them rather than having a potential existence outside of and separate from them. The interests of some of our society's spheres can be of disinterest to other spheres, but when globalized to the entire society they can be seen as dangerous to those who identify solely with one sphere.

I believe that there are creative ways for the goals of all the spheres of our society to be carried out without infringing on the primary goals of the other parts. I wish the society to move past its divisions by accepting those divisions. I wish this to be a society that encourages the professionalization of bioethics, a society that assists in the creation of public policy and the participation in political activism, and a society that promotes scholarship. ■

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An International Perspective on American Bioethics

Cheryl Macpherson

The field of American bioethics has grown significantly in its expertise and funding in recent decades. Political and other developments have led to greater numbers of ethics committees and consultants, institutional review boards (IRBs), and programs for undergraduate and graduate ethics education. Globally, the prominence of bioethics today is due, at least in part, to the influence of American bioethics. This is not surprising given that bioethics is an academic discipline, and disciplines generally prosper with international and interdisciplinary exchange.

What is surprising is that American bioethicists have all but ignored international bioethics. The United Nations Educational, Scientific, and Cultural Organization's Declaration of Bioethics and Human Rights generated international controversy in 2005 but received little attention from American bioethicists. Also, the most recent revision of the influential Declaration of Helsinki passed with relatively little American comment. American bioethics organizations, conferences, publications, and Listservs rightly center on American issues but seem uninterested in international perspectives, even about shared concerns. The majority of posts on the Medical College of Wisconsin Bioethics Listserv address American health care; few posts offer multicultural or international perspectives.

As an American who has lived abroad since 1988 and traveled extensively to teach, attend conferences, and visit relatives in Asia, Africa, and Europe, I feel out of step with American bioethics. I believe that in part this is due to limited American interest in international affairs.

American bioethicists clearly have some interest in international bioethics because I was invited by ASBH to write this paper, and I was also asked to write another paper on Caribbean issues that was published in the *Cambridge Quarterly of Healthcare Ethics* in 2006. American bioethics centers associated with immigrant scholars, physicians, and patients presumably have greater interest than others in international bioethics.

ASBH is a leading voice in American bioethics. The 2007 ASBH Annual Meeting

included more than 100 different sessions ranging from end-of-life care to nanotechnology. Only a handful of sessions addressed international issues: the integration of global health justice issues into medical curricula, traffic in human organs, spending priorities, and military medical ethics (in which American interest grows as more injured Iraq War veterans return home). The 2007 annual meeting seemingly paid more attention to international bioethical perspectives than previous ones.

As ASBH matures, it will perhaps turn more attention to international bioethics. ASBH members and officers that I have met express curiosity about my work on pain relief and research ethics in the Caribbean; however, the abstracts that I have submitted for the annual meeting on these topics have been rejected for several years. This may be due to the volume of abstracts submitted, the planning committee structure, or the foreign source and setting of my work, which is mainly published in journals based outside the United States.

If American bioethicists and ASBH engage more deeply with international bioethics, ASBH membership would likely grow, as would participation in and the vitality of its annual meeting. International exchange permits the strengthening of any discipline. Everyone learns and benefits from insights gained through others' experiences, particularly regarding shared concerns or international capacity building.

Research ethics would benefit too. Much human-subjects research abroad is generated by American researchers and sponsors, but American bioethics neglects foreign issues that have an impact on such research. In accordance with guidelines calling for negotiation with host nations about provision of sustainable benefits, sponsors sometimes establish institutional review boards (IRBs), but the members of such IRBs are handpicked by local colleagues with vested interests in related employment, income, or prestige. Such IRBs often dissolve soon after the sponsoring study is approved or remain in name only.

There is an assumption in American bioethics and among Americans in general that American lifestyles, values,

and dilemmas are global norms. Socio-economic conditions, culture, and other factors influence expectations, standards, realities, and priorities in other nations. Government, education, standards of health care, and the choices one makes in daily life vary immensely between nations.

To generalize, America is self-absorbed. The news media, for example, rarely reports news that does not directly involve American interests. Even events like the Olympics receive American news coverage proportional to the number of American medals received; however, in other nations, remarkable performances are widely celebrated regardless of nationality. Recognizing the academic effect of American parochialism, Harvard University this year approved "societies of the world" as a new required subject area to acquaint students "with the values, customs and institutions that differ from their own" (Szep, 2007).

Is life really different outside the United States? In Europe, employment benefits typically include several weeks of annual paid vacation. There is universal health care of one sort or another at standards rivaling those in the United States. National healthcare systems sometimes cover travel costs for rehabilitative vacations. Maternity leave is generous, and women routinely receive government subsidies toward the cost of supporting each of their children. Each European nation is unique, but most have shorter working days and spend more time during the work week sharing meals than do Americans. European life centers on community and family. American life emphasizes individuality and autonomy.

Life may be gentler in wealthy nations outside the United States, but it is much harsher in poorer ones. Even poor governments provide universal access to health care but at remarkably low standards. Seeing a doctor may mean waiting all day in an unpleasant reception area. It may take hours to locate the single electrocardiogram machine in a hospital and transport it to the patient—or the patient to it. Patient rights rarely exist in such settings, and informed consent

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How do you use the texts and methods of the humanities disciplines in your teaching of medical humanities, bioethics, or any other healthcare courses? We would like to share your ideas in *ASBH Exchange*. Send a concrete description of a particular class or exercise that you have found effective to Johanna Shapiro at jfshapir@hs.uci.edu.

The Hideous Heart and the Moral Imagination: “The Tell-Tale Heart” as a Lesson About Conscience

Krisann Muskievicz

In a world of contrasting (and often competing) values and standards, the development of moral awareness is something that requires both imagination and focused contemplation. Many influences contribute to the process of moral reflection. Robert Coles, in *The Call of Stories: Teaching and the Moral Imagination*, and Martha Nussbaum, in *Love’s Knowledge: Essays on Philosophy and Literature*, propose that literature can serve in this important capacity (Coles, 1989; Nussbaum, 1990). As a specific application of both proposals, I would like to nominate Edgar Allan Poe’s short story “The Tell-Tale Heart” as a piece of literature well suited to engaging the moral imagination (Poe, 1999). As a former public school educator and an interdisciplinary scholar, I have witnessed the power of literature to inspire students’ contemplations of right and wrong. “The Tell-Tale Heart” offers an intriguing space to teach students the skill of moral imagining, and it challenges readers to consider morality in a creative way.

In this well-known story, an unnamed narrator recounts both the sequential events and the psychological processes that lead to his commission of a fatal crime. The narrator in “The Tell-Tale Heart” is not a moral exemplar; however, he does have a moral lesson to share about the difference between being guilty and being accused.

Poe’s narrator, presumably male, is cold, calculating, and shocking. The man’s tale recounts the meticulous premeditation of a murder and includes a gruesome description of the victim’s dismemberment and concealment under the floor boards of the victim’s bedroom. In the quiet after the murder, the police arrive in response to a noise complaint. The narrator leads the officers through the house, and they seem satisfied that all is well. However, just as it seems that the murderer will escape arrest, his conscience forces him to confess. Vexed by the thump of an imagined pulse from beneath the floor, the narrator shrieks, “Dissemble me no more! I admit the deed!—tear up the planks!—here, here!—it is the beating of his hideous heart!” (Poe, 1999, p. 734).

Because of this transformation, the reader contrasts the murderer’s irreverent bravado with the confessor’s crippling guilt. It may be impossible to ignore the narrator’s apparent insanity (or to excuse his crime on those grounds), but the lesson about conscience persists. The moment of the surprising confession highlights the role of the conscience and reminds (or teaches) the reader that one does not have to be caught in order to be guilty.

The conscience knows what the law may not, and Poe’s lesson challenges the notion that one is not guilty until convicted. Poe implies that the narrator could have stayed calm and been free from implication. The drama of Poe’s conclusion is that his storyteller does not—cannot—remain calm with the knowledge of his heinous crime. Through the man’s confession, Poe challenges the reader to relate guilt to conscience rather than to indictment. Though Poe may not have envisioned himself as a moralist—and many would argue he would not have been qualified to do so—his characterization of guilt can be interpreted as a transferable moral lesson.

I do not take Poe’s point to be as narrow as a caution against committing murder. Rather, his tale introduces a more flexible interpretation of conscience and a challenge to translate moral standards in varying situations. In every year that I taught the story, always to eighth graders, I asked the students questions relating to moral imagination. Was the heartbeat an actual sound? Why could the narrator hear it? What does it mean to be guilty? For my students, the abstraction of the term *conscience* became clearer and more concrete through Poe’s narrator, and for some, it was their first experience exploring the inner voice of morality—but not the last. As we read other stories throughout the year, we returned to Poe’s narrator. If someone used shorthand such as, “I bet that character heard a heartbeat,” the rest of the class knew what was meant. The example of the heartbeat translated to other interpretations of guilt and conscience within our literary explorations, and more important, I hope, this skill was a resource for their personal moral growth.

In *Love’s Knowledge*, Martha Nussbaum argues for the role of literature as a source of philosophical contemplation, and I would submit “The Tell-Tale Heart” as a candidate for the category of moral reflection. Nussbaum claims that we need “texts which display to us the complexity, the indeterminacy, the sheer difficulty of moral choice” (Nussbaum, 1990, p. 142). Such texts are not protocols or sets of sacred rules. In fact, Nussbaum depicts the pursuit of inviolable rules as a childish endeavor, and she stresses the unique demands of new and particular situations. When this “new particular” arises, the student refers to the moral imagination as a resource rather than a protocol. Through literature, students are able to vicariously explore morally challenging situations without the limits of personal experience. This skill is a transferable resource, whether in the eighth grade, the medical school classroom, or the adult world of work and practice.

For the reader exploring the moral imagination, Poe’s narrator serves as a benchmark for grasping the uniqueness of the new particular. Robert Coles asks, “Why don’t all of us—the teachers and the students—try to take these books to heart, not just analyze them and then go on to the next book? We may be smarter, but are we better?” (Coles, 1989, p. 80). He prompts me to hope that readers are moved intellectually, emotionally, and morally in a way that Poe’s tale moved me. Speaking for myself as a young student, I felt I became “better” through a continuing analysis of “The Tell-Tale Heart.” As an adult, I certainly have benefited from my students’ engagement with the story. Their probing questions have reminded me that morality, at its best, is transferable and applicable in varying situations. If we are indeed awakened to the moral imagination through literature, a story such as Poe’s may provide an

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A Bibliographic Tour

Les Rothenberg

Because of space limitations, “A Bibliographic Tour” will be a listing rather than a review but will include e-mail addresses to facilitate reprint requests. Suggestions of your own work or that of others, as well as suggestions for improving the column, are enthusiastically solicited. Please contact Les Rothenberg by e-mail at Les.S.Rothenberg@kp.org. An alphabetized list of all references in this and past columns can be found on the ASBH Web site at www.asbh.org/exchange/biblio.htm.

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Policy News in Washington

Felicia Cohn, Melissa Goldstein

The Food and Drug Administration and drug safety

In September, the Food and Drug Administration (FDA) Amendments Act of 2007 was signed into law. The 422-page bill, the largest overhaul to the FDA Act in the last decade, renews device and drug user fees for 5 years and strengthens product safety programs. Described as one of the most significant reforms to the regulation of prescription drug safety since the 1962 Kefauver-Harris Amendments, the law, among other things, reauthorizes the Pharmaceutical Device User Fee Act (PDUFA) and the Medical Device User Fee and Modernization Act (MDUFA), the Pediatric Research Equity Act (PREA), and the Best Pharmaceuticals for Children Act (BPACA).

The legislation pays for new safety initiatives through increases to the user fees negotiated by the FDA and industry and adds transparency to the user fee negotiation process. It makes almost \$400 million in user fees available for agency reviews of drugs and devices and responds to public concerns about drug safety by requiring the FDA to establish an active drug-risk surveillance system. In addition, the law grants the FDA new powers to require labeling changes and Phase IV clinical trials, impose legally binding risk-management requirements through risk evaluation and mitigation strategies, and mandate specific disclosures in direct-to-consumer drug advertising. It provides for an additional \$225 million in user fee revenue for drug safety activities through fiscal year 2012, starting at \$25 million in fiscal year 2008, and increasing to \$65 million in fiscal year 2012. The law also creates a new requirement that drug companies list all of their clinical trials in a registry maintained by the National Institutes of Health accessible to anyone with an Internet browser. At the conclusion of a study, the results will have to be posted. The act also addresses FDA advisory committee conflicts of interest.

Access by the terminally ill to experimental drugs

In August 2007, the U.S. Court of Appeals for the DC Circuit held that terminally ill patients do not have a constitutionally protected right to access experimental

drugs that have passed early safety trials but have not yet been cleared by the FDA as safe and effective.

The Abigail Alliance for Better Access to Development Drugs (the Alliance) and the Washington Legal Foundation (WLF) filed a lawsuit to prevent the FDA from enforcing a policy barring sales of post-Phase I experimental drugs that have been deemed sufficiently safe for substantial human testing but are not approved for commercial sale. The groups contend that mentally competent, terminally ill adults who are not part of Phase II clinical trials should have access, with the advice of their physicians, to potentially life-saving, investigational new drugs without FDA interference.

In holding against the groups, the court stated that FDA regulation of post-Phase I drugs is consistent with the country's historical tradition of prohibiting the sale of unsafe drugs. In addition, the court rejected the groups' arguments that a right to self-preservation gave the terminally ill a constitutionally protected right of access to experimental drugs based on the doctrines of necessity, the civil action of intentional interference with lifesaving efforts, and traditional self-defense principles.

The court concluded that "the FDA's policy of limiting access to investigational drugs is rationally related to the legitimate state interest of protecting patients, including the terminally ill, from potentially unsafe drugs with unknown therapeutic effects."

The Alliance and the WLF have appealed the court's decision to the U.S. Supreme Court, which will decide whether to accept the case for argument in coming months.

The court's decision can be found at *Abigail Alliance for Better Access to Development Drugs v. von Eschenbach*, No. 04-5350 (D.C. Cir. Aug. 7, 2007).

United Nations lowers AIDS estimates

The United Nations lowered years of estimates of the number of people throughout the world infected with HIV in a report issued on November 20, 2007. The report indicates that 33 million people worldwide are infected with HIV, down 16% from the 2006 estimate of 40 million. About 2.5 million will be infected this year, a 40% decline from last

year, and 2.1 million will die from AIDS. The revised figures suggest that the AIDS pandemic is on the decline with the peak in infections in 1998 and in deaths in 2005. The number of individuals living with HIV is gradually increasing, but at a slower rate. The new estimates reflect improved data collection methods as well as improved treatment rates and changes in sexual behavior in some regions of the world according to UNAIDS executive director Peter Piot. The new prevalence numbers were based on data obtained from surveys, including questionnaires and blood samples, conducted house-to-house in 30 high-prevalence countries. Previous reports were based primarily on studies of women receiving prenatal care projected on the whole population.

The full 2007 AIDS epidemic update report is available at http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf.

Stem cell breakthrough

Japanese and American researchers reported a significant advance in stem cell research on November 20, 2007. The researchers reprogrammed mature human cells taken from the subsurface layer of facial skin in a 36-year-old woman to behave almost exactly like pluripotent embryonic stem cells. The Japanese team is led by Shinya Yamanaka at Kyoto University, who also led the reprogramming efforts in mice announced in June 2007. James Thomson at the University of Wisconsin-Madison leads the American team. Yamanaka dubbed the new cells "induced pluripotent stem cells" or "iPS." The rejuvenated cells were able to grow into all of the main tissue types in the human body and offer a technique for producing perfectly matched replacement cells that could be used to treat a number of diseases.

The discovery offers an alternative method to cloning and avoids the contentious debate over the use and destruction of human embryos. The technique involves using a retrovirus to turn on genes that are active during embryonic development to determine if they would reset mature adult cells. Each research team identified different sets of four proteins known as transcription factors that initiate an unknown biological process that in laboratory conditions

returns the cells to embryonic state. The technique requires further work before it is ready for clinical use. The studies in mice show that the viruses used to reprogram the cells have caused mutations that lead to cancer, and one of the genes may also cause tumors. The Japanese research is published in the journal *Cell*, and the American work is published in the journal *Science*.

MRSA infection

The deaths of two previously healthy school children in Washington, DC, in October 2007 have increased attention on invasive infections from the strain of bacteria known as methicillin-resistant *Staphylococcus aureus* (MRSA). According to 2005 data, an estimated 94,360 cases of invasive diseases caused by MRSA occurred in the United States, and 18,650 of those cases (approximately 20%) were fatal.

The Active Bacterial Core surveillance (ABCs) MRSA investigators, led by R. Monina Klevins of the Centers for Disease Control and Prevention, identifies MRSA as a major public health threat. ABCs published a report in the October 17, 2007, *Journal of the American Medical Association (JAMA)* on the scope and magnitude of MRSA infections in the U.S. population. The report indicates that the infection, which does not respond to many common antibiotics, is much more prevalent and much more dangerous than previously recognized. MRSA infection is spreading beyond the hospital and healthcare setting where it was previously confined. Almost 14 percent of the estimated invasive disease cases occurred in the community, with reports coming from schools, day care centers, and prisons. The MRSA strains that originate in the community are genetically distinct from those in healthcare environments.

Basic infection control and prevention measures in healthcare settings include hand hygiene, contact precautions, environmental decontamination, judicious use of antimicrobial agents, active surveillance for high-risk patients, and staff education. Yet such strategies are not always used. Mandatory reporting and more aggressive and broader approaches to surveillance are controversial. At least 19 states now require hospitals to collect and report data on healthcare-associated infections. Illinois and New Jersey now require all patients to be tested for MRSA

when they are admitted to the hospital, but several professional associations oppose such legislative mandates, arguing that individual facilities should determine the best assessment and containment mechanisms for their settings. Strategies for community control are much less developed.

International survey: U.S. adults most likely to report medical errors and skip needed care because of costs

A seven-nation survey published by the Commonwealth Fund in November 2007 has found that U.S. patients are more likely than any others to report experiencing medical errors, to go without care because of costs, and to say that the healthcare system needs to be rebuilt completely. The project surveyed 12,000 adults in Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom, and the United States.

According to the survey, U.S. and Canadian patients are the least likely to be able to get a same-day appointment with their physicians when sick. In contrast, half or more of patients in Germany, the Netherlands, and New Zealand reported rapid access to physicians. In the United States, Canada, and Australia, two-thirds or more of those surveyed reported difficulty getting care on nights, weekends, or holidays—the highest rates in the survey.

U.S. adults were most likely to have gone without care because of cost and to have high out-of-pocket expenses. In the United States, 37% of all adults and 42% of those with chronic conditions had skipped medications, not seen a doctor when sick, or forgone recommended care in the past year because of costs. These rates are well above those in all other countries. Patients in Canada, the Netherlands, and the United Kingdom rarely reported having to forgo needed medical care because of costs.

In addition to cost concerns, U.S. patients reported more fragmented and inefficient care, including medical record and test delays, perceptions of waste, and more time spent on paperwork when compared to patients in other countries.

Finally, adults in all seven countries placed high value on having a relationship with a regular source of primary health care that is accessible and coordinates their care. The study identified such patients as having a “medical

home” if they had a regular source of care who knows their medical history, is easy to contact, and helps coordinate care with other providers. About half (45%–61%) of the adults surveyed described having such a care center. In all countries, patients with a medical home reported significantly more positive healthcare experiences.

In the United States, uninsured adults were at high risk of having no such connection to the healthcare system. Twenty-six percent of the uninsured surveyed, compared to 53% of insured adults under age 65, had access to such primary care services.

More information on the survey can be found at <http://content.healthaffairs.org/cgi/content/abstract/26/6/w717>.

Medical school tuition and young physician indebtedness

The American Association of Medical Colleges reports significant increases in medical school tuition in an analysis released in October 2007, based on data from their Tuition and Fees Survey and Graduation Questionnaire. Tuition and fees at public and private medical schools have increased annually by 11.1% and 4.7% respectively (compounded annually) during the period of 2001–2006. Students reporting debt at graduation include 86% of public school graduates and 85% of private school graduates. Total debt for public school graduates has increased by 6.9% from \$86,000 to \$120,000 and by 5.9% for private school graduates from \$120,000 to \$160,000. The report notes that there is no consistent source of information on physician salaries, but the data available suggest that they are not keeping up with debt with annual increases of about 3% and an average salary in 2006 of \$216,600. Further, the terms of debt repayment have been tightened with interest rates increasing. Projections suggest that by 2033, debt will average \$750,000 per student at graduation.

The full report, “Medical School Indebtedness and Young Physician Indebtedness: An Update to the 2004 Report,” is available at <https://services.aamc.org/Publications>. ■

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Melissa Goldstein is an associate research professor of health policy and health sciences at the George Washington University Medical Center.

Call for 2008 ASBH Awards Nominations

ASBH invites you to recognize leaders in the fields of bioethics and medical humanities by nominating them for an award. ASBH offers awards to acknowledge accomplishments for lifetime work and distinguished service. Nominations can be submitted by any ASBH member and self-nominations are permitted. The awards will be presented during the ASBH 10th Annual Meeting October 23–26, 2008, in Cleveland, OH.

Lifetime Achievement Award: Recognizes outstanding contributions and significant publications that have helped shape the direction of the fields of bioethics and the medical humanities. The recipient agrees to make a major presentation at the ASBH 10th Annual Meeting.

Distinguished Service Award: Recognizes outstanding and dedicated service to ASBH. The award is presented to an individual or a group who has advanced the mission of ASBH in a significant and lasting way.

The ASBH Awards Committee will consider all complete nominations. Nominations must include the nominee's name and current professional affiliation as well as the reasons for making the nomination. Nominations must be postmarked no later than **Friday, February 29, 2008**, and sent by e-mail to the ASBH national office at aclaver@connect2amc.com.

11th Annual National Undergraduate Bioethics Conference (NUBC)

The Human Use of Human Beings in Medicine and Science

April 4–5, 2008, Union College, Schenectady, NY

Featured speakers include Tod S. Chambers, PhD, ASBH President; Susan E. Lederer, PhD, University of Wisconsin–Madison; and Harriet Washington, DePaul University.

The call for submissions deadline is **March 1, 2008**. Submissions may include panels, skits, plays, poems, art historical studies and works of art, and papers on clinical ethics, research ethics, health policy, case studies, historical studies, and entries into a bioethics bowl competition. See the Union College Web site at <http://ethics.union.edu> for more information on submissions and the bioethics bowl competition.

ASBH Discounts on Scholarly Journals

ASBH members receive discounts on new or renewal subscriptions to our partner journals. ASBH has developed collaborative agreements with a number of scholarly journals that support the mission of the society. These outstanding publications offer a diversity of views on a variety of topics in bioethics and medical humanities. For more information about our partner journals and the subscriptions discounts they offer, visit the partner journal page on the ASBH Web site at www.asbh.org/journal.

The American Journal of Bioethics

The American Society of Law and Medicine and Ethics (ASLME)

The Cambridge Quarterly of Healthcare Ethics

The Hastings Center Report

International Journal of Feminist Approaches to Bioethics (IJFAB)

Journal of Clinical Ethics

Journal of Medicine and Philosophy

The Kennedy Institute of Ethics Journal

Literature and Medicine

Medical Humanities Review

Perspectives in Biology and Medicine

Theoretical Medicine and Bioethics

Note: ASBH partner journals as of January 2008.

Call for Nominations: Board and Nominating Committee

Nominations for Board and Nominating Committee positions will be accepted until **May 1, 2008**. Please see the ASBH Web site at www.asbh.org/about/callformom.html for more information, including a nomination form, position descriptions, and information on how the ASBH election is conducted.

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ASBH-Endorsed Meetings

Popular Culture Association/ American Culture Association (PCA/ACA) Medical Humanities Area

March 19–22, 2008
Bay Area Marriott
San Francisco
585/475-4422

Dilemmas and Struggles in Trans- plantation: Ethics, Psychosocial Considerations, and Policy

The Chicago Transplant Ethics Consor-
tium, the Academy of Psychosomatic

Medicine, and the American Society of
Transplant Surgeons
April 4–6, 2008
Chicago
[www.surgery.northwestern.edu/ctec/
index_files/Page1101.htm](http://www.surgery.northwestern.edu/ctec/index_files/Page1101.htm)

SEEING MAKING HEALING: Art, the Arts, and Creativity in Medicine and the Medical Humanities

The 6th Annual Meeting of the Pennsylv-
ania Medical Humanities Consortium
May 13–14, 2008

Carnegie Museum of Art
Pittsburgh
412/647-5700

The 4th Annual Pediatric Bioethics Conference

Predicting Our Future: Genetic Test- ing in Children and Their Families

July 25–26, 2008
Bell Harbor International Conference
Center
Seattle
206/987-7825

New Books, Videos, Etc.

David Orentlicher

We have five new books and one video series to announce. We look forward in future issues to highlighting your books, videos, and other publications (other than articles, which are the subject of “A Bibliographic Tour”). Please let us know about them when they become available to the public.

To notify us of the publication either of your own work or that of someone else, contact David Orentlicher at dorentli@iupui.edu or Indiana University School of Law–Indianapolis, 530 W. New York Street, Indianapolis, IN 46202-3225.

Bosek, Marcia S., and Savage, Teresa A. (2007). *The ethical component of nursing education: Integrating ethics into clinical experiences*. Philadelphia: Lippincott Wilkins and Williams (www.lww.co.uk/index.cfm?1&fuseaction=MA.productInfo&isbn=9780781748773).

Doukas, David J., and Reichel, William. (2007). *Planning for uncertainty: Living wills and other advance directives for you and your family*. Baltimore: Johns Hopkins University Press (www.press.jhu.edu/books/title_pages/9306.html).

Gutkind, Lee (Ed.). (2007). *Silence kills: Speaking out and saving lives*. Dallas: Southern Methodist University Press (www.tamu.edu/upress/BOOKS/2007/gutkind.htm).

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Mahowald, Mary. (2006). *Bioethics and women: Across the life span*. New York: Oxford University Press (www.oup.com/us/catalog/general/subject/Medicine/Ethics/?view=usa&ci=9780195176179). ■

David Orentlicher is Samuel R. Rosen Professor of Law and codirector of the Center for Law and Health at Indiana University School of Law–Indianapolis. He is on the faculties of the School of Medicine and the Center for Bioethics at Indiana University and serves in the Indiana House of Representatives.

Job Notices on the ASBH Web site

Job notices are posted each week on the ASBH Web site at www.asbh.org/jobs. There is no charge for ASBH members to post a notice on the Web site. If you would like to post an open position related to bioethics or humanities, send your job notice in a Microsoft Word or plain-text format to Mark Waymack at mwaymac@luc.edu.

MASTER of ARTS in BIOETHICS

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Designed for clinicians, lawyers, and students of the humanities and social sciences, this interdisciplinary program emphasizes the philosophical foundation of bioethics and offers opportunities for clinical experience and in-depth research. This program of the Center for Bioethics and Health Law and the School of Arts and Sciences allows students to combine study in ethical theory, philosophy and history of medicine, cultural and gender studies, health law, public health, and social sciences. Students may complete coursework, including clinical practica, in one calendar year. A thesis is required. Joint JD/MA and MD/MA programs are available. Applications are considered on a rolling basis, beginning **February 1** until **August 1** or until the class is filled. Financial assistance may be available to highly qualified applicants who apply early. For information and application materials, contact: Director of Admissions, Center for Bioethics and Health Law, Suite 300, Medical Arts Building, 3708 Fifth Avenue, Pittsburgh, PA 15213; bioethic@pitt.edu; 412-647-5700; see also www.pitt.edu/~bioethic.

Callousness, Legalism, and Clinical Moral Perception continued from page 1

these features? Are trainees formally supported in their training programs to cultivate strategies by which they can generate and maintain capacious clinical moral perception?

Asking these questions offers faculty members better understanding of whether their programs implicitly endorse callousness or promote legalism. If faculty members find that callousness and legalism are implicitly promoted in their formal and informal curricula, then they have opportunities to appropriately acknowledge, *problematize*, and eliminate practices of poor clinical moral perception in clinical education settings. In addition, faculty mentors can be better trained to model

self-awareness and capacious, generous (instead of limited, legalistic) practices of discerning what patients need and deserve. ■■

Christy A. Rentmeester, PhD, is an assistant professor of medicine at the Center for Health Policy & Ethics, Creighton University Medical Center, Omaha, NE.

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Literature and Medicine

continued from page 4

important source for principled contemplation. ■■

Krisann Muskiewicz earned a master's degree in humanities from the University of Houston—Clear Lake, TX, and is currently a doctoral candidate in the Institute for the Medical Humanities at the University of Texas Medical Branch in Galveston. Her dissertation project focuses on literary and narrative studies in medical education.

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Summer Internships

Visit the ASBH Web site at www.asbh.org/meetings/resources/bioethics.html for undergraduate internship programs in bioethics offered by universities, colleges, and organizations in the United States and abroad.

Another Perspective

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is not a norm. Technologies including intensive care, dialysis, and even mammography are absent in many nations.

Government hospitals and clinics in many developing countries lack computers. Patient records are often inconsistent and unreliable. Community structure hinders efforts to maintain privacy and confidentiality. Caring, committed doctors and nurses become demoralized by the working conditions and their inability to meet the overwhelming needs of patients. Paternalism and hierarchy are pervasive, but patients are grateful to receive care.

Many nations lack policies to ensure access to adequate pain management. Reports from patients, families, and palliative specialists indicate that pain continues to be undertreated, even in wealthy nations. In developing nations, cancer patients and others with severe and persistent pain are routinely sent home with nothing more than ibuprofen. The World Health Organization recommends global use of oral morphine for moderate and severe pain. Although it is inexpensive and available, regulatory restrictions, deeply entrenched taboos, inefficiencies, and related factors limit clinical importation and use of opioids in poor nations, even more so than in wealthy ones.

In poor countries, access to care is limited by resources and injustices. Available standards of care are in many places lower than even the poorest American could imagine. There are no protections

against conflicts of interest and malpractice and no resources with which to employ medical specialists or expensive techniques. These profound limitations, however, are giving rise to a stronger bioethics abroad, as is apparent in the journal *Developing World Bioethics*.

In the Caribbean, the Bioethics Society of the English-speaking Caribbean (BSEC) was established in 2005. Still in its infancy, BSEC is working on regional capacity building for research ethics. BSEC is also concerned with medical education, professionalism, conflicts of interest, clinical ethics, and human rights. Like ASBH's focus on American issues, BSEC's focus is the Caribbean. Our contexts differ, but we share topics and dilemmas with international and American bioethics. As BSEC grows in expertise and resources, its potential for mutually beneficial exchange with the United States and other nations will grow. American bioethicists should welcome, and even initiate, dialogue with their foreign counterparts. ■■

Cheryl Macpherson, PhD, is a professor and chair in the bioethics department of the School of Medicine, St. George's University, Grenada.

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Member-Get-A-Member Campaign



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"Encourage both your friends and those who challenge your beliefs to join. Talk about a place where important debates happen with respect, where minds are open. Fellow ASBHers, we are engaged in a wonderful enterprise of contradictions. Let's celebrate that, and grow it, together." —Immediate Past President Paul Root Wolpe, October 2007

The American Society for Bioethics and Humanities (ASBH) encourages debate, scholarship, and service among its diverse membership. It is the go-to professional society for all bioethics- and humanities-related issues, and it belongs to all of us. Paul Root Wolpe made membership growth a top priority when he was president to ensure the future of ASBH and to enrich the value of ASBH to its members. In order to grow and to serve the needs of the society, we are offering incentives to you as the recruiting member and the new member to act now:

Each ASBH member who recruits a new individual member in 2008 will receive

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Every time you recruit a new member, you contribute to our growth and strengthen our position as the leading society for everyone in the fields of clinical and academic bioethics and the health-related humanities. Just have the new individual member write your name on the membership application when he or she joins. The recruiting incentives apply only to the four income-level individual membership categories. Please call the ASBH national office at 847/375-4745 to have membership brochures sent directly to you so that you can distribute them to your colleagues.

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ASBH 10th Annual Meeting

The ASBH 10th Annual Meeting will take place October 23–26, 2008, at the Cleveland Renaissance Hotel in Cleveland, OH. Proposals will be accepted on the ASBH Web site at www.asbh.org through March 1, 2008.

Don't Miss This Preconference Symposium and Workshop!

The program planning committee is pleased to announce that Hiram College's Center for Literature, Medicine, and Biomedical Humanities will present along with its cosponsor, the Division of Medicine of the Cleveland Clinic, a special symposium titled "Return to the House of God: Medical Resident Education 1978–2008" on Wednesday, October 22, the day before the ASBH 10th Annual Meeting begins.

The symposium will continue as a preconference workshop on Thursday, October 23. The first day will take place in the Stokes Wing of the Cleveland Public Library, a short walk from the Renaissance Hotel. This symposium recognizes the 30th anniversary of the publication of the novel *The House of God* by Sam Shem (Stephen Bergman) and will critically address it and medical resident education during the last 30 years. For further information, please visit <http://litmed.hiram.edu>.

2007 ASBH Annual Meeting Exhibitors

ASBH gratefully acknowledges the support of the following exhibitors at the 2007 ASBH Annual Meeting held in Washington, DC, in October.

ARS Medica: A Journal of Medicine, The Arts and Humanities

Berman Institute of Bioethics

The Bioethics Program at Union Graduate College/Mount Sinai School of Medicine

Bioethics.net and *The American Journal of Bioethics*

Cambridge University Press

Case Western Reserve University

Georgetown University Press

The Healing Muse: A Journal of Literary and Visual Arts

The Johns Hopkins University Press

The MIT Press

The National Reference Center for Bioethics Literature at the Kennedy Institute of Ethics, Georgetown University

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