September 14, 1998. Interview with Howard Brody, MD, PhD, Director of the Center for Ethics and Humanities in the Life Sciences and Professor of Family Practice and Philosophy, Michigan State University. The interview is being conducted by Judith Swazey at Dr. Brody’s office at the Center.

Swazey: Let me ask you a little bit about your family background, and professional history and entry into bioethics.

Brody: Ok. I was born in Chicago. My father was a lawyer and a judge and is now retired. I grew up in the north side of Chicago and gradually moved into the Chicago suburbs. My family is Jewish but we weren’t practicing or observing religious observances. I never had a bar mitzvah so I sort of grew up in a non-religious background. My mother was at home most of the time when I was growing up but she started going back to work as a dietician. She’d originally worked as a dietician, so she was sort of my health care person in the family and she actually helped me get my first job as an orderly at the hospital, which I did for a while I was in college.

Swazey: Started you in early, right? When you decided to go to medical school, had you decided at the same time to work towards a PhD?

Brody: Yes. Let me go back and do that story a little bit. I went to Michigan State and I started as officially declaring my major as premed. At that time, and I think still,
you need a specific major so I said my major was biochemistry. So I did the usual
biochemistry course work until I got to the beginning of my junior year. Then I
got very discouraged and became frustrated with this sort of reductionism, or what
I interpreted to be the highly mathematical approach at the molecular level and the
atomic level in the courses I was taking, and I kept thinking there was a reason I
went into science that this wasn’t getting at. I took a series of courses called Great
Issues and the various interdisciplinary faculty taught those courses. One science
professor had been in charge of the course on human sexuality, which of course
every college student wanted to take in the 1970’s, so I enrolled for that course.
At one time I wrote a paper that had something to do with ethics. It was the first
time I was really exposed to a course in ethics. We read, among other things,
Joseph Fletcher’s Morals In Medicine and the note he scribbled at the bottom of
the paper was, “see me if you want to do graduate work in philosophy of science.”
I didn’t even know there was such a thing as philosophy of science. It was the first
time I had ever had a suggestion that maybe there was a philosophical connection
with what I was interested in. So the long and the short of it is I started taking
some philosophy courses and I mostly emphasized philosophy of science. I did
what was, in effect, a minor in philosophy, although I never actually completed
quite enough credits for an official minor. So when I started medical school, I had
already come in with this background in philosophy, although not in ethics
officially because I had never taken any courses in ethics.
Swazey: Were there many ethics courses at that time?

Brody: Well, of course, in the philosophy department there were the standard ethics courses, but there were not courses in medical ethics. We didn’t have anything on campus. I did sit in on an interesting course. I had to do a senior laboratory project as part of an honors college requirement. It was recommended that I work with a particular molecular biologist who had an appointment in the medical school. He was teaching a course in one of the residential colleges on campus called Science and Human Values. I sat in on that course, I think in the middle of my senior year, and that was probably as innovative a course as there was then in any U.S. university about bioethics generally, construing “bio” as the biological sciences rather than as medicine. That was another formative experience. But when I came to medical school I hadn’t really figured out how to use that background. As a matter of fact, I remember asking one of my undergraduate professors would it be possible to do an MD and a PhD in philosophy? And he said no, you just couldn’t do that, no way, don’t even think about it. I did my first year of medical school and pretty much did the standard medical school thing, but I had continued to have contact with the professor who had been my laboratory supervisor when I was a senior. He had gotten me aware of the Hastings Center and I started to subscribe to the Hastings Center Report. At the end of my first year of medical school, in 1972, he showed me a notice he had gotten for the First National
Conference on Teaching Medical Ethics, which was to be held at Tarrytown, sponsored by the Hastings Center. Originally, he had planned to go to it, but a conflict came up so he asked me if I wanted to go. And he said if I wanted to go, the Department of Human Development in the medical school, which later became the Pediatrics Department, would pay my way. I went, and got to meet people like Ed Pellegrino and basically all the leaders in the field at that time. Paul Ramsey was there and Bob Veatch, and Henry Beecher. Of course, at that time you could get almost everybody in the U.S. who was seriously interested in bioethics in one room. It didn’t have to be a large room. It was a phenomenal experience for a student.

I came back from that meeting with basically two goals. One was I wrote up a proposal on how you could teach medical ethics at Michigan State University in the medical school; and second, I sort of dusted off my idea of possibly doing a joint degree. During the second year of medical school I talked extensively with my faculty in the medical school and also with the faculty in the philosophy department. One of the philosophy faculty later told me that if I had just come over, and we had never seen you before, we would have imagined that some idiot medical student had decided that of all the PhD’s to get, obviously philosophy is the easiest, and we would have just thrown you out on your ear. But because you had had courses with us as an undergraduate, some of us knew you and we knew you were a serious student so we were willing to listen. Probably, in 1972-73,
99% of medical schools, if approached, would have said you can’t do this degree. Michigan State had labeled itself a new, innovative medical school so the reaction of the faculty was, “gee, we’ve never done that before.” And people were pretty excited about it and very supportive.

Swazey: When did the medical school start?

Brody: The medical school started in 1966 as a two year school and it expanded to a full four year school. When I started in ’71 we knew for a fact we were going to graduate from this medical school, but no previous class had been absolutely sure that they would be able to get their degrees from MSU. It was a pretty new medical school at the time. Then, I just pursued work from the summer of 1973 until the summer of 1977 to complete the MD and the PhD.

Swazey: You did both simultaneously?

Brody: Yes. I had a lot of fun with it, actually. The university calendar at that time was a quarter calendar, which made it really convenient. I could spend 12 weeks on the wards and 10 weeks in the classroom. I basically alternated quarters. I got all my requirements done.
Swazey: What did you concentrate in in philosophy?

Brody: I actually spent more time on issues in epistemology and philosophy of mind although I did take a number of courses in ethics. When I sat down to do my dissertation, it was on philosophy of mind. I wrote on the placebo effect. There is a chapter in the dissertation about the ethics of giving placebos, but actually the bulk of the dissertation is about mind-body relationship.

Swazey: Was the department analytically oriented at that point?

Brody: Yes. I would say probably the single most important influence I had in reading philosophy was in ethics influenced heavily by Kant, and I also had a really good course on Rawls where we read the Theory of Justice. The combination of those two, the Kantian constructivism of Rawls and the Kantianism of Kant, were probably my strongest influences at that point in time.

Swazey: Where did the medical humanities interest come from? Was it overlapped with medical ethics at that time?

Brody: I guess I’d have to trace that to a couple of things. I never particularly thought about it as a separate piece of what I was doing. First of all it was my training in
college, which grew out of a couple influential teachers I had in high school; probably it was my high school Latin teacher who had the most influence on me in that regard. I was heavily influenced by the classic idea of the liberal education. And so the notion of an interdisciplinary type of scholarship was always sort of in the back of my mind. And then, after I became involved specifically with a career in medical ethics... I can’t remember who I talked to at that time. I do remember that one of the people who was not present at the Tarrytown meeting was Tris Engelhardt, and when I contacted some of the people I had met there and said I was thinking of doing this MD/PhD program, they said, “Have you talked to Tris Engelhardt?” because he already did it, he had the two degrees. I did get in touch with Tris and he wrote some encouraging letters. I ended up, in 1975, doing a one month internship at Galveston, where I worked with Tris a little bit.

Swazey: One interesting thing is that you went on to become a practicing physician, in contrast to Tris.

Brody: Obviously I have a pretty strong academic bent, and I could see myself, at this point, giving up medical practice at some time to focus in on ethics and humanities. A lot of my medical colleagues, when they talk about their self-identity, can’t imagine not practicing medicine. I can. So I think in that regard I’m a little bit like Tris. But I’m really not like Tris. When I started medical school, I
started with the idea I was going to be a physician. I didn’t start with the idea that
this is something I’m going to study as part of my philosophical training, which I
think may have been how Tris approached it. At any rate, the reason I mention
Tris is simply because he was part of that sort of process of networking, of who
around the country is my future support system. People recommended very
strongly that I go to meetings and get involved with the Society for Health and
Human Values. It was the first organization that I became involved in, and I
started going to those meetings somewhere around ‘74-‘75 and definitely started
to come under the influence of that group. I’d like to think that that group had
something to do with my commitment to an interdisciplinary approach. The
Society was a very friendly sort of home at that time. It was a relatively small
group of people, fairly easy for young upstarts to get to know people like Al
Vastyan and Sam Banks.

Swazey: It was almost the only home back then. I had the same experience you did as a sort
of interdisciplinary mongrel, wandering around thinking, “Where’s my nest?” Had
you decided, by the time you got your MD/PhD, that you wanted to do medical
ethics or bioethics?

Brody: Yes. What led to it was very specifically that 1972 conference in Tarrytown. I
said, “I want to do this, I want to teach this, I want to write about this.”
Swazey: Anyone whom you would single out, or more than one person, as someone who
was an influential person in the development of your work?

Brody: There would be several people. One of the people I heard speak at Tarrytown was
Joe Fletcher, and he was quite generous. I had this very bizarre experience as a
student of actually writing a text book on medical ethics, and he was kind enough
to write a foreword for it when the first edition was published. He, from a
distance, was quite a generous person, encouraging me to pursue what I was
doing. Here on campus, probably the single most important person was Martin
Benjamin in our department of philosophy. Martin is simply the best lecturer on
philosophy I’ve ever met. He teaches philosophy in his sleep. He’s also a very
practical thinker and he works really well with audiences of professional groups
and lay groups to translate philosophical concepts into their language, so he’s
really quite an inspiration, both in terms of clear thinking and in terms of the
ability to bring philosophy home to people. The thing that he taught me somewhat
later was, I think, something I at least had on my mind. I can’t say how well I’ve
integrated it, but it was something I probably didn’t learn until I got back here and
started teaching myself: the importance of demonstrating, in one’s teaching, the
values that one is speaking of, rather than saying things about respect for persons
as a theoretical concept but preaching this to your students in a belittling way.

The importance of actually modeling respect for the student as you talk with them
in class about this concept of respect for persons was something that Martin does extremely well. You can just see him sort of *being* the ethical concept that he’s trying to talk about to the students as he’s talking to them about the ethical concept.

Swazey: Something medical students really need, too.

Brody: The absolute value of trying to somehow convey to the students that if you’re talking about an ethical concept, that you’re actually trying to figure out how you’re going to live your life, as opposed to just playing around with ideas.

Swazey: Tell me how, as a medical student, you did come to write a text book, which certainly was one of the first.

Brody: Well, that was a very much by-the-way sort of thing. It gave me a very weird idea about writing books. It was only somewhat later that I found out it’s actually hard to write books. This first one was a piece of luck. The bottom line being that when I came back from Tarrytown, I produced a paper for dissemination within the college on how I thought we should teach ethics. This was the early 70s, this medical school was very new, and one of the hallmarks of the medical school was that the faculty was very student oriented. Relatively junior faculty were taking
on huge pieces of curriculum and revising them from top to bottom, inventing totally new courses and so on, and they were inviting the students in the courses to help them revise and perfect the courses. So it was not as crazy as it sounds for a second year medical student to write letters to the faculty to say “Here’s a proposal for how we should teach ethics at the college;” that was kind of the Gestalt of the institution. At that particular point in time, a lot of the teaching materials that we developed within the College of Human Medicine, the fad of the day, was programmed text, plus, a lot of our teaching was in the form of small group discussion with paper cases, and we had this so-called focal problem curriculum which Harvard later thought it invented and called the New Pathway, and we were doing here at the end of the 60s. Since that was the way I was being taught in my other medical school classes, the theory I was working under was it’s very important if you’re going to teach ethics, to have it be identified by the students as just like the rest of medicine, so how could we find a format that would allow the students to learn the ethics vocabulary and concepts? Of course this is all really crazy because this is stuff I am just learning myself, so I’m trying to think at the same time about I’m learning it and yet also how to share it with my fellow students.

Swazey: But also bioethics was really inventing itself at the time. There weren’t a whole lot of books out there.
Brody: As you say, it wasn’t a matter of let’s go find a text book. There weren’t any. At any rate, it occurred to me that we could probably design a programmed text in medical ethics that would also have case studies. At that time, the Hastings Center was publishing case studies and so there was starting to be a body of case material one could use. The bottom line was we put together, mostly I put together, a programmed text and we had it printed up and used it as a pilot for some electives that we did with the medical students. Somewhere along the way, a fellow who was an editor at Little, Brown and Co. somehow got my name and wrote me a letter and said he had been asked to give a talk on medical ethics for a community group, and he had heard somehow I had put together some materials and wondered if we had anything we could share with him. So I said, “Well, we have this programmed text” and I sent him a copy in the mail and I never thought anything of it and we went on working on it, playing around with it, trying to refine it, add to it and so on. Sometime later, quite unexpectedly, as a matter of fact I think it was when I was at Galveston, I got a sort of frantic phone call that was redirected to me from East Lansing--Little, Brown wanted to publish it. The long and the short of it was we then did a very detailed, extended revision of it and it was published in 1976. It came out just about the same time that Sam Gorovitz’s first anthology came out. I think it actually came out a year before the first edition of Beauchamp and Childress. There was one more edition in 1981 and then we just let it go.
Swazey: What was the reception at the time, because it was a novel text?

Brody: It was a mixed reception. I think some people found the programmed features to be kind of artificial and interfering with their abilities to sit down and read it. Others liked it and liked the cases and so forth and so on. As I think about it now, some of the ideas in it were so incredibly crude and ill-formed that it’s almost an embarrassment. But I suppose if any of us are still around who wrote stuff in the 1970s and now think back about what we wrote, it’s pretty scary!

Swazey: How did the Japanese edition come about?

Brody: I don’t even remember right now. I didn’t have very much to do with it, it just sort of happened. When I finally visited Japan in 1996, I didn’t find very many people who were even aware that there had ever been that edition so obviously it wasn’t very influential. I think it actually was premature because the Japanese interest in medical ethics is now increasing, but it’s only been in the recent years. I frankly think that when that book was published there just wasn’t a market in Japan.

Swazey: When did the MSU program begin? It was first a program for the medical humanities. Was that going when you were here as a student?
Brody: This sounds incredibly arrogant, but basically that program was sort of my replacement, because as a medical student working on my PhD, I’d been running around helping faculty set up ethics conferences and we taught this elective course; and then while I was a student in the philosophy department, Martin Benjamin and Bruce Miller had each independently gone to a major summer training program. I think they both went to Sam Gorovitz’s NEH program and they got a heavy dose of bioethics, and they started doing some rounds in the local hospital as a result of that exposure. Martin actually developed the first medical ethics course for the philosophy department and I had the privilege of being one of his graduate assistants when he first taught it. It was somewhat through me that people like Martin and Bruce got contacts with people in the medical school because I was basically the ambassador going back and forth between the philosophy department and the medical school.

When I talked about formative people I didn’t really mention some of my physician mentors, and there were several who were very supportive and certainly helped me see how they thought that ethics was related to actual medical practice. Bill Weil, who at that time, was our chair of pediatrics and on my PhD committee along with Martin and another philosopher, and Jim Trosko, who was the molecular biologist I worked with, who was in Bill Weil’s department. One of the other of Bill’s faculty, Art Kohrman, a pediatric endocrinologist, was very much involved in giving me a lot of support and encouragement. Dan English, who at
that time was in our department of surgery, and subsequently has written his own
book on medical ethics, and ended up retiring as a surgeon because he wanted to
do work in medical ethics, was very supportive and interested at that time. We had
at that time some faculty who, even though they were in specialty departments or
specialty areas, really approached medicine more like primary care physicians. So
as a medical student here I felt like I got a very heavy dose of a primary care
orientation, and these people were very human values oriented. Plus, and I don’t
know how much this relates to some of my later work, we did have a lot of
behavioral science and social science faculty input. The founding dean, Andy
Hunt, had worked at Stanford, and he had worked before that at Hunterdon and
various other places where team approaches with mental health and psychology
were stressed very heavily in his work in pediatrics. So he came here with a
model. He really didn’t know about ethics and humanities when he came here. He
wasn’t like George Harrell at Hershey who said there had to be a department of
humanities in the first floor of medical school. But he went department hunting,
he went around the university saying which departments would he grab and say
“You’re going to be in the medical school.” He grabbed biochemistry, anatomy,
and physiology, the obvious basic science departments. But he also grabbed
sociology, psychology, and anthropology, and made them joint departments with
the College of Human Medicine. When I was here, there was a lot of teaching,
some of my fellow students thought too much teaching, from the social scientists.
People like Lou Snow were here then and had a lot to do with my medical education from the get-go, so I think that was an influence that was good.

Swazey: This school then had a lot of very unique attributes.

Brody: Absolutely. Yes. I kept my letter of rejection from Harvard Medical School and framed it and at one time thought of putting it on the wall. It was somewhat, of course, reverse snobbishness, “so there Harvard,” but it was also a realization of how lucky I was, if I had by some freak... got accepted into Harvard, none of this ever would have happened. It really was dependent upon this setting.

Swazey: You were saying that the medical humanities program really got going when you were no longer...

Brody: Right. When I was getting ready to leave to do my residency, some people thought, “Well, gee, Howard won’t be here, who’s going to be doing this kind of stuff when Howard leaves?” So that led people to start talking about the need for some kind of formal program. Here at MSU you had all these units right here on the same university campus. You didn’t have what you’d have sometimes with a medical center away from the parent university by some geographic distance.

Philosophy was here, all the other arts and letters departments were here, social
science was here in the medical school. By then there were two medical schools
and so the planning for the program involved the deans of human medicine and
osteopathic medicine, and also at that time, veterinary medicine was involved.
From the outside, we were able to get funding from the Institute on Human Values
in Medicine, and previously I'd received a fellowship from them as part of my
PhD studies. We got Ed Pellegrino and Stuart Spicker and some other people to
come in and be part of the visiting team to make a report. They, of course,
encouraged the creation of a center. What happened at that point also was that
some internal university politics were going on. Basically, the dean, Andy Hunt,
was being forced out of the deanship. The department chairs were getting uppity
and they thought Andy was not a good manager and they really wanted him
replaced by the then Associate Dean, Don Weston, thinking that they could
probably manipulate Don Weston where they couldn't really manipulate Andy.

Swazey: Not a unique saga.

Brody: They later found out they couldn't manipulate Don quite so much as they thought.
Andy sort of helped them along by taking a year off as Dean in 1976, and they
made Don Weston acting Dean so Andy could try to run the new outpatient
facility that had just been created at MSU. He had been director of outpatient
services at Stanford before he became dean, so he thought of himself as a great
ambulatory care manager type of person. But he actually found himself relatively
unable to manage that system and no one who’s come since then has been able to
manage it either! The bottom line was when his year was up and he decided to go
back to being dean, the department chairs said, “Nope, Don’s going to be dean,
you’ve had your chance to be dean.” The system needed a pasture to put Andy out
to, and Don, the new dean of the medical school, feeling guilty about what they
had just done to Andy, was quite anxious to make sure he had a decent program to
be head of. So they made Andy head of the medical humanities program. That led
to a little more institutional support for the medical humanities program than
might otherwise have been the case. Andy was a natural person for that, of course,
because of his basic interest in human values in medicine and his strong
commitment to an interdisciplinary approach to medical teaching. So he got it
going, and at various times had Bruce Miller and Martin Benjamin from
philosophy be assistant to him in that new position. When I came back here in
1980, they made me Andy’s assistant. In 1988, we had discussions with the
Provost about where the program should be located. They were in the process of
creating a Vice Provost for Human Health Programs, which didn’t last very long.
Temporarily, we were put under this Vice Provost, and at that time the Provost
decided that...We had asked that the title be somewhat more reflective of our real
position, because a program here suggests a pretty low level thing. We were
relating to seven different colleges across campus and we thought we were a little
bit bigger than just a program, so they ended up making us a Center. In the
process, they expanded our name because the Provost wanted to signal that we
had a responsibility not just to worry about the medical schools but to worry about
the entire biological science area, so that’s how we got our somewhat unwieldy
name we now have.

Swazey: How would you characterize the ethos of the Center? What’s it all about?

Brody: Of course we did our mission statement stuff, and we argued what we are about;
we actually had some pretty good discussions. In one sense, what we’re about is
doing as many things as we can all at once, in the sense that we’ve been lucky in
getting a faculty here who are good teachers, are quite competent writers for
academic journals and can get stuff published, and can do some research. They are
also very committed, in a variety of ways, to outreach and service. What I think
makes the Center the kind of place that it is is the way those activities are
reinforcing and supportive activities; so our faculty are out in the community
doing things with hospital ethics committees and with various other community
groups and then that informs and energizes their teaching and they take students
out with them when they go to these things. When they sit down to write
something academically, that community service interface informs the writing that
they do. As soon as we start dividing the Center up into what the University
administration want to account for, under the headings of teaching, research, and
c public service, and as soon as we accept those headings, we start to mis-describe
ourselves.

Swazey: How much is the Center medically focused, as opposed to the broader life
sciences.

Brody: It’s quite medically focused. Right now we are tentatively dipping our big toe into
the pool of the other areas. I think we are very interested and willing to go into
those areas but the opportunities have not been as great and the medical side is
clamoring for us to do more stuff. It’s been a disproportionate...

Swazey: Not as much receptivity in other biological areas?

Brody: Well, it’s not quite that because the other biological areas could be receptive, but
when they’re just sort of mildly receptive, medicine is saying you’ve got to do
more. There are residents who want a new series of ethics lectures or we need to
develop this new resource for ethics committees. The wheel is much squeakier on
the medical side. Len Fleck’s work here with the genome project may be the
pivotal thing that gets us turned more into...now that we’re finally on the genome
bandwagon. Julie’s project is another thing that could get us definitely more
involved in research ethics generally across the campus.

Swazey: What do you see as the distinctions between medical humanities and bioethics?

Brody: I guess I tend to be fairly traditional in my thinking about the categories. I think of ethics as grounded in either religious studies or philosophical ethics. I think I can identify a more or less pure ethics approach when you take a medical problem and then you analyze it. I think I could say, “Ok, that sounds like pretty straightforward ethics.” And then if I see signs of another discipline being brought to bear from the humanities, such as history or literature, or if I see the religious studies going beyond just an ethical analysis but getting more into deeper meanings of the human spirit and mortality and things like that, then I say, “Ok, now we’re starting to get into true humanities.” I guess in many ways, interdisciplinary and humanities become almost synonymous in my mind. Obviously there are ways to be interdisciplinary that are not humanities but in our area, the two are often in effect synonymous. Now in the social sciences, I guess I also tilt toward making a distinction between qualitative/quantitative approaches. So I tend to think of medical anthropology as taking an ethnographic or qualitative approach, or medical sociology the way somebody like Charles Bosk does medical sociology. While clearly it has a social science methodology, it’s so close to the humanities it’s hardly worth quibbling over where the boundary line might be. Whereas if
someone is doing a quantitative bit of social science, I could more easily see a
distinction in that social science and not to be confused with humanities.

Swazey: You would fold the qualitative ethnographic social sciences into medical
humanities?

Brody: Well, I would do it with what I hope would be adequate respect for the
methodology. I would understand that the people trying to do that work are doing
rigorous work that is informed by a specific scholarly canon on how to do this
properly, and they will be appealing to their disciplinary canon for the criteria for
their academic work. At the same time, the product of what they do is a text that
could be put on the shelf right next to the humanities texts, so a book like Bosk’s
Forgive and Remember could sit on your ethics shelf along side of many other
works, like The House of God, or Warner’s book about therapeutics in 19th
century American medicine. These works of history and literature and qualitative
social science can be put on the shelf right next to the medical ethics works and
read with great benefit by anybody who is trying to understand the issues. You
could say, ok, if you’re going to talk about error, what is error? Is error an ethical
problem? In the end, who cares? I mean, it matters to Bosk when he’s doing his
work that he’s a sociologist and he’s doing this research according to some
standards of good quality social science research. I have no idea what they are or
how to apply them, but he does. And so it very much matters in terms of the 
quality and the respect for the work as it comes out of sociology. By the time 
you’re all done with looking at medical error, whether you define it as an ethical 
problem, a psychological problem, a sociological problem, I don’t get that excited 
about the disciplinary boundaries at that point. I guess I’m committed to the idea 
that in the end, the more we can cross those lines, the better we’re going to 
understand an issue. I would also have to say that one of the things that has made 
me most pleased to be in the field of medical ethics in the past decade or so has 
been what I take to be the real, vigorous, critical self-reflection that the field is 
undergoing. Some of the impetus for that reflection has been from ethics and 
philosophy itself as the various analytic concepts have been exposed and then put 
on the table for debate. What do we mean by autonomy? Does autonomy really 
entail what we thought it entailed, and so forth? But obviously, the social sciences 
have played a role in bringing critical perspectives to bear. And to its credit, 
medical ethics, while initially perhaps fighting off this threat from the social 
sciences, has in the end, I think, embraced it. It is now richer and more interesting 
because it’s been willing to look at these criticisms of the first generation of work 
in the field. The more I read about cross-cultural comparisons now in medical 
ethics, the more excited I get. I think we’re really getting on to something. I guess 
because my basic commitment is to comparative studies; by taking a comparative 
approach, we’re probably learning something.
Swazey: How much of that is being done by “bioethicists,” and we’ll get to what a bioethicist is in a minute, without any real training in cross-cultural work, compared to social scientists who...

Brody: Fairly typical of the field. I think we’re seeing all of the above. Right now, there is, I think, very opportunistic work being done. Somebody may want to get a questionnaire study published to pad their CV, and we’ve got really good work being done by people who are trained to know what they’re doing, and everything in between.

END OF TAPE 1, SIDE 1

Brody: The journals are making space for the good articles to be published. The editors of the journals think these are worthwhile topic areas. This has happened before. We had all this empirical research on informed consent back in the ’70s that turned out to just be utter garbage and we got beyond it. We finally established what’s a good study in this field.

Swazey: You said seen as worthwhile to publish. Do you mean in the bioethics journals?

Brody: Yes. And the medical journals, like JAMA.
Swazey: Are medical humanities and bioethics starting to blend at all?

Brody: That tends to be more of an individual thing. I think individual practitioners tend to be more or less blending-type people, so for some it’s a natural thing to do and for others, they’re still over-trained in ethics and they want to do ethics.

Swazey: What about your own Center? Can you readily distinguish people who are doing medical humanities and who are doing bioethics?

Brody: Again, I think people are a bit more on a spectrum. Of my colleagues, Tom Tomlinson and Judy Andre are a little more oriented toward what I would take to be humanities approach; Len Fleck is focused on issues that have to do with justice and his interdisciplinary work is bringing economics and policy matters into ethics and looking at the interface between ethics and policy. He’s very open to a teaching method; if you show him an interesting short story or a poem that will help the students discuss an ethical issue, he’s all for including it in the course packet. But he’s not himself as tilted that way as much as perhaps the rest of us are. For instance, one of the courses we get involved in is the intro course: the Masters in Health and Humanities for the College of Arts and Letters. That’s a very deliberately designed interdisciplinary course. Judy, Tom and I have all taught that at one time or another, but Len has never taught that and probably
won’t teach that course.

What about the new merger? The Society for Bioethics and Humanities. What is your understanding of why it happened, first of all?

Why did it happen? My understanding of why was more having to do with the business end of running a society and running an annual meeting and the sort of inability nowadays to have that run out of an academic office like we used to run academic societies. I guess I’ve resisted seeing there being some deeper thing going on, except for the American Association of Bioethics. I’ve always been sort of anti the American Association of Bioethics, and suspicious of the motives of the parties that started that group up. I really felt at that time there was just absolutely no need for another group. I never did join the AAB; that may be unfair to the individuals involved and they certainly have in effect handsomely apologized to the rest of us for any misperceptions we may have had about them.

What were the misperceptions?

The misperceptions were that they were just a power hungry group who were upset that they were not the leaders of the other societies and they hadn’t been welcomed in, with open arms, to be the keynote speakers and the presidents and
officers of the societies, so they decided they would take the football and go play
their own football game someplace where they could be in charge. To their credit,
they had good quality meetings, they invited good quality people, and they were
concerned with the international aspect of bioethics which the other organizations
were slow to get on board. So they did some good things, and then they proceeded
to commit suicide as an organization, by doing what I think is ultimately going to
be the good thing of bringing the other societies together with them to create
something bigger and broader than any one of the organizations. So I think, in the
end, it’s going to be a good thing. I’ve been pretty optimistic. Obviously there’s
the danger that the humanities piece will be overshadowed by the bioethics piece.
I think that danger has been loudly enough talked about that it’s not going to
happen soon, because people have been sufficiently forewarned that everybody’s
worried about that happening and they had better try to make sure it doesn’t
happen. I think we’ve got some very powerful groups in the ASBH such as the old
literature subgroup, particularly. They’re going to be very careful to make sure
that doesn’t happen.

Swazey: The American Association of Bioethics was the philosophers’ group, right?

Brody: That was largely a philosophers’ group.
Swazey: So in some sense it was a turf battle. Philosophy, humanities....

Brody: In my own mind, I never thought of it as quite that. I thought that what became the faculty association within the Society for Health and Human Values, some years ago, started out as a turf battle. But when people sort of pinned them to a wall and asked “Are you just a group of philosophers upset because bioethics is now in effect being invaded by these non-philosophers?” they had to put up or shut up, and they basically said, “Oh, no, no, that’s not what we are.” So in the end, when they created that faculty section, they defined it so broadly that, if they had any goals of having that turf battle, they didn’t really carry through.

Swazey: What about the Society for Bioethics Consultation? How do you think that’s going to play out in this merged group?

Brody: I think it’s going to work out reasonably well because I think they have something to take and something to offer. I think what they have to take, as more and more people get involved in medical ethics, is they’re going to see the value of interdisciplinary approaches. Whereas there might have initially been some resistance on the part of some of the membership of SBC to things that look too interdisciplinary and humanities oriented, I think in the future there will be much more comfort with that. Secondly, they do definitely bring the practical, in the
trenches kind of way of thinking about bioethics. They do have a number of members who don’t have medical school or nursing school appointments but just work in community hospitals, and that sort of community group does have a different take on the issues and can be very valuable people to have around to make sure the rest of it doesn’t get too overly intellectual.

Swazey: Are you going to be at the ASBH Houston meeting?

Brody: It used to be SHHV that was my annual meeting; no matter what else, I tried never to miss that meeting. I would occasionally go to SBC, but I didn’t mind too much if I missed SBC. I made it an issue not to go to the AAB. But the ASBH will, I assume, be the replacement meeting for the SHHV.

Swazey: It will be very interesting to see how large it is and how the dynamics work.

Brody: We had the mega meeting a couple years ago in Pittsburgh, which I think scared a lot of people, in the sense it was so big. But I don’t know what you do about that. There is an issue that I’m a little worried about, though I think we’re attending to it ok, of how do you bring the new people into the field? I definitely had an experience in the ‘70s of being welcomed as a young student-type person and being able to go the SHHV and rub shoulders with the senior people in the field.
Now, I worry that the students coming in are not as able to break into the old boys
court, which thank goodness in SHHV was never exclusively a male old boys club.

I think there is some of that issue of the old club, the old people’s club. It’s a little
harder but we’ve been working on that because I think the SHHV student group
has been a good creation; they’ve been active and effective. I think, in creating a
little home within for the students to be there. Once they’re there, they start to
make contacts with people and they have brought in some of the more senior folks
to come and mentor the students. I don’t think we can turn the clock back to the
70’s when that happened just naturally by osmosis. Now it takes some
organizational effort and attention to make it happen. But I see people wanting to
put that effort into it. At this point, I don’t feel too badly or overly anxious about
the issues of new people. Again, when I was doing my work here at Michigan
State as a student and I had some people like Martin Benjamin and Bruce Miller
and the people in the medical school to turn to for help, but they couldn’t
effectively mentor me into this new field because they weren’t in it or trained in it
the way that people like Al Vastyan and Tris Engelhardt could and the people who
went to SHHV meetings. But today, a student coming here to Michigan State,
who can talk to Tom Tomlinson and Judy Andre and Len Fleck, who else do they
need to mentor them? It’s not as much of an absence of mentoring at the
institutional level. There’s not quite the same need for the national organization
from the student point of view, although I still encourage the student to be
involved and I think it’s very good for them to go to the meetings.

Swazey: It will certainly broaden their contacts.

Brody: Even if they do nothing else but meet the students from the other places.

Swazey: I was very struck in the ASBH meeting program that they are having formal sessions on mentoring, which is very unusual, I think, for a professional organization. I assume that’s one of the organizational developments you said people were seeing as needed now.

Brody: Right. I think one of the relatively good things about the field of both bioethics per se and medical humanities has been this relatively intense scrutiny of our discipline and also a similarly intense scrutiny of our methods. I think there’s been relatively more attention to teaching methods. In the 70’s at least, people were accusing bioethics of being X, Y, and Z, which was bad, and then bioethics would be really agonizing over, “Do we do that? Do we teach that way? How can we be doing this? How can we do it better?” If you went into any of the other classrooms in the first two years of medical school, almost all the other basic science departments were committing those sins and no one was calling them on it. But everybody was saying, “Well, gee, such and such a thing is happening in the
bioethics course. That means, we really aren’t sure we should be teaching this in medical school or maybe we shouldn’t spare these hours of the curriculum for that. That should be used for something else.” Whereas anatomy could do that and nobody would ever say anatomy should be kicked out. So bioethics had to prove it deserved to be in the medical school curriculum. And what that led to, I think, is a very productive scrutiny of teaching methods and the quality of the teaching. Generally, just a more exciting place to be than a department that figures it had its teaching hours by natural law or by divine right, and therefore why should they bother to think about teaching method or whether the students learned anything in the course.

Swazey: It’s been interesting watching the evolution in the medical school curriculum. Every medical education reform report ever written points to the need to humanize the physician, broaden their education. We’ve gone through the social and behavioral sciences being displaced by bioethics. Now the medical humanities are coming in to nudge bioethics. You wonder what the next step in the cycle may be.

Brody: There’s a beautiful quote from Carl Elliot. He basically listed all the sins of American medicine that are deeply, deeply ingrained in the very fabric of academic medical centers and then he says, “And then we think we’ll bring in a
few hours of humanities and somehow that will make it all right again.”

Without a doubt, there are very, very powerful forces in American medicine that
don’t want to look at the basic questions about “does this enterprise make sense
and is it really good for the people it claims that it’s serving?” And as long as they
don’t want to look at that, there is going to be a sense that bioethics and
humanities is a vain bit of window dressing.

I would like to say something that is in my mind right now because I was
asked to write a chapter for a book that John Fletcher and Frank Miller were
putting out. They were doing an interdisciplinary book on bioethics and they
asked me to write a chapter about medicine and bioethics. That sort of knocked
me over at first. I said, “How could you even have bioethics without medicine?”

I did go back and think about some of this history and I thought about what I
reacted to when I read Rothman’s Strangers At The Bedside. As far as I know,
he’s written a very good book, and obviously he’s been criticized. He’s sort of a
sitting duck because he didn’t wait for us all to die before he wrote his book and
that’s obviously what he should have done. Since we’re still alive we say, “I was
there, I know.” We can sort of take pot shots at him with no data, just with our
impressions. But as a person who was fairly young starting out in this field and
who was very much being enculturated into the medical culture, I think there is a
difference between the way the medical profession in the U.S. reacted to this
threat that is substantively different from the way other professions in the U.S. or
other powerful interest groups in the U.S. would have and did react. I want to give
some leaders of the medical profession credit for their willingness to open the
door to the bioethics movement. I think there is a reason for this which I try to
develop in this chapter. It’s quite speculative and it’s quite incompetent in social
science, but I was impressed when I read Sharon Kaufman’s book The Healer’s
Tale. She interviewed a population of senior physicians, who were the leaders in
American medicine at the time the bioethics movement was starting to knock on
the door. She described the leadership of that generation as having gone into
medicine in the 1930's and early 1940's with a very strong commitment to a
scientific ideal and then becoming relatively disillusioned with what that scientific
ideal was doing to medical practice in the ‘60's and ‘70's. They found that instead
of adding scientific tools and scientific knowledge to a solid base of what I would
take to be a primary care model, a generalist model of good medical practice, the
technology was taking away the credibility of that model and substituting a very
specialized, technological model. And so the science that they looked to to help
them be the kind of doctors they wanted to be was actually undermining the
critical values that had attracted them into medicine. I would hypothesize that
when people like Paul Ramsey and Joe Fletcher showed up in the wings and
started to raise some questions, and started to become available, this generation
was very willing to say, “Well come on in” and saw these people not as threats but
as allies. Because they had seen the medicine change from the ‘40's to the ‘60's in
ways that they had profound questions about. And even if they didn’t understand
the difference between ethics and sociology, they nonetheless knew there were
some serious questions that their younger colleagues in medicine were not
addressing. If their younger colleagues in medicine were running away from the
most important questions, maybe these outsiders could come in and could help
them articulate and raise those questions. Clearly there were medical leaders who
fought tooth and nail against the outrage of these upstarts coming in and telling
doctors what to do. But I think there were others who were very concerned about
the conscience of medicine, who saw there being real value in inviting these weird
folks.

Swazey: Thinking of the history of the Society for Health and Human Values, there
certainly was a profoundly receptive and hard working group of physicians there
who probably were more concerned about the human values dimension than some
of the more formal, bioethical approaches. I think of people like Paul Beeson.
Paul never got involved in humanities or bioethics per se, but he was deeply
concerned, and even more so in his ‘80’s today, about what’s happened in medical
education and the role of physicians in mentoring medical students. I think that
made a whole group receptive to human values, except at some places like
Harvard, as we noted.

Do you define yourself as a bioethicist?
Brody: Yea, I guess. I still have trouble with that and I’m not even sure the word is in the dictionary, so I always have trouble defining myself by a word that isn’t in the dictionary. Now you’re going to go ahead and ask me what that means.

Swazey: You are absolutely right, Howard.

Brody: Oh God! Why did I agree to do this?! What’s a bioethicist?

Swazey: Or, how would you characterize bioethics, without pinpointing you for a moment? You said awhile ago it involved religious ethics or philosophical ethics.

Brody: Yes. That’s historical. It just happens to be the way we did ethics in the ‘60's when this all started and we said, “What’s ethics?” I guess I saw it as a shift. It used to be a sense that whatever doctors needed to know about what is right and wrong in practicing medicine they could study themselves, merely by looking at their practice. So physicians ought to, in effect, contemplate their physicianly navels, and therefrom deduce all the ethical principles one needed for the practice of medicine. And there was some sense no one else could because if you weren’t indoctrinated into the business of medicine, how could you possibly say anything about what is right and wrong in medical practice? That was the sort of Hippocratic tradition. The AMA code was definitely the Percival tradition and
that, to some extent, was a Humean model, which was sort of the British
gentleman model that a gentlemen just knew how to do the right thing, all they
had to do was investigate their own sensibilities to be sure that they knew what
was right. The new bioethics model is that there are others who are not trained as
physicians who can help to expand and articulate a statement of what is good and
bad and right and wrong in medical practice, and that whatever medical practice
is, its fundamental features are not opaque to the non-physician. And in a way you
could say I’ve come full circle, in the sense that Frank Miller and I, in some of the
work we’ve done lately, have been trying to articulate the internal morality of
medicine lest people think there’s absolutely nothing there—that all medical ethics
is nothing but the application of general ethical principles that apply across society
to medicine. Medicine is a moral practice, and as a moral practice it has internal
standards. These internal standards count as an internal morality. But I think what
we want to do is say that the scope of that internal morality may be relatively
limited, that of all the ethical issues that come up in medicine, maybe 90%, can be
addressed better by moral principles that apply across the board, like autonomy,
and maybe for only 10% of the moral problems that come up in medicine do you
need to invoke this internal morality. So we’re trying very hard to distinguish the
appeal to the internal morality from some retreat back into the Percival AMA
model.

But I guess I’ve been influenced enough by philosophers like Richard
Rorty to not get too grandiose about this, and to say if you want to define bioethics, you could say for the past 30-odd years, a group of people have been having a conversation about the controversial human value, apparently ethical problems that come up in medicine and the biomedical sciences. What the field of bioethics is is that conversation. Books or journal articles or courses taught in schools or professional meetings are all different aspects of this ongoing conversation, and you can come in to a conversation at different points along the way and leave the conversation at different points. To the extent that a conversation has a kind of organic identity about it, there is this bioethics conversation that’s been happening, so people who have spent a significant portion of their time listening in on this conversation and contributing to the conversation are the bioethicists. And that’s always been taking place against the backdrop of other conversations going on in society and in the profession.

Swazey: Have you seen changes in the nature of that conversation over the years you’ve been involved in it? That is what we would call phase movements in social science terms.

Brody: Yes, definitely. I think there was the anti-principlism that we are seeing more evidence of. That’s always a good example of phase movement. I think some of that is a little bit dangerous in the sense I always wonder about things like
casuistry and narrative ethics in the back of my mind. I’m intrigued by those two things and I believe they are positive developments from an intellectual point of view. But at some point along the way, a little nagging voice raises itself that says, “Am I interested in doing narrative because it truly is the case that principles are flawed and need to be supplemented or replaced by something else, or is it just that I did principles for some years and now I’m bored and I’m looking for something new to excite me?” I don’t always know the answers to those questions, but I think if we were to trace how we became so in love with these principles and now why people are reacting negatively against them we would see the history, internally, of that kind of phenomenon.

Swazey: But if you take casuistry in a fairly general sense, without getting deeply into its long history in Roman Catholic theology, bioethics has used this method in its case studies for a long time. So in some ways, I guess I see it as an alternate approach that suddenly has loomed larger partly because of Jonsen and Toulmin and the reaction against principlism.

Brody: Right.

Swazey: But you can also say, “What’s new?”
Brody: You have to be a little careful of that because I think casuistry is actually rather more complicated than what a lot of people make it out to be. In particular, unfortunately, I have to say that some of casuistry’s defenders have put forward versions of casuistry that may not be the best version, and they’ve made claims for casuistry which may not, in fact, be defensible. I’m imagining that some day I’d like to write a little book about casuistry, or a series of articles, that would try to put forward a slightly different version of casuistry and claim that this is a better thing than the specific version that Jonsen and Toulmin used. But that’s a minor quibble. To be more specific, I think the problem is that a case study can be invoked in so many different ways and it can play so many different roles within one’s reasoning process. For example, you can look at Baruch Brody’s book, Life and Death Decision Making, which is a self proclaimed book of casuistry. And yet when you read carefully what he is doing there, I think you will find that he has a framework that prejudges every case. There is no wisdom to be gotten from any case from the concrete context of the case. All the wisdom comes from the preexisting framework and cases then are chunked into little spaces. The framework leaves open spaces and any case that comes along has its designated little pigeon hole that it goes in. And once it goes in that pigeon hole, you know exactly how to judge a case. So even though it’s called casuistry, it’s something extremely different from what somebody like Tom Murray means when he talks about casuistry as bottom-up reasoning so that the case itself brings wisdom and
enlightenment. If you were to just look at the preexisting framework and not to
look sympathetically and carefully at the details, the case would never receive the
wisdom. So I think the word casuistry covers a range of models, some of which
are really highly structured principlist models. If we were going to do good work
in casuistry we would have to first say if it’s truly an old model or not, we’d have
to get clear right away on those issues. And that’s getting back, unfortunately, to a
Roman Catholic tradition point of view because as I understand it, and I frankly
don’t know squat about natural law theory, the version of casuistry was not
separable from natural law theory.

Swazey:   How would you characterize bioethics today? Has it become a discipline or field?
You used the word conversation.

Brody:    I guess I still kind of resist “discipline.” I was in the Society for Bioethics
Consultation group that was recently convened to talk about standards for
bioethics consultation. You could see how everybody was walking on eggs
because they didn’t say standards for bioethics and they didn’t say standards for
bioethics courses or teaching or education. They were very, very specific about
saying this is standards for consultation. Walking on eggs was pretty typical of the
way the conversation was held in that group. The group, I think, was very
conscious of the tension between trying to define bioethics as a discipline versus
hanging on to the historical value of the interdisciplinary and multi disciplinary
modes of entry of the practitioners. In the first, second, and maybe third
generations of bioethicists in the US, no one “trained” as a bioethicist. They all
trained as a philosopher, theologian, chaplain, lawyer, what have you, and a few
social scientists, and then came together into this mix of folks and started to have
this conversation. I think, and a lot of people agree, there is a danger of narrowing
the conversation unduly by proclaiming some disciplinary boundaries. Without
any doubt there are people today being trained as bioethicists and of course the
particular model for that is the fellowship model, the folks who are doing the post-
residency fellowship or the equivalent, with Mark Siegler, et al. I don’t want to
say those people are inadequately trained, or they don’t have valuable things to
contribute to the conversation, but I’d be reluctant to say that that model now
becomes the model and that is how everybody should be trained in the field.

Swazey: I also noticed that the final draft of the SBC statement went from “standards” to
“guidelines.” Does that reflect the same concern?

Brody: Yes. There definitely was a political thing, which was what if we claimed that
somehow or other these “standards” would have any teeth in them at all other than
their internal persuasiveness. I think there was a general flight from the idea and
to a large extent, I think the flight was because of trying to imagine what kind of
bureaucratic superstructure would be required for the field in order to “enforce” any standards. I don’t think anybody had a stomach for trying to implement that kind of superstructure.

Swazey: I think I hear you saying that you hope bioethics is not defined as a discipline because it will narrow the conversation.

Brody: Yes. I like the fluid boundaries. For example, I would defend the idea that the good stuff being written about cross-cultural approaches to bioethics, and for that matter the greater use of ethnographic research methods within bioethics—particularly some of the things Patty Marshall and Barb Koenig are doing strike me as very valuable contributions to the discipline and particularly valuable to holding up a critical mirror to the developments of bioethics in a new way. Would those have happened and would those have been accepted as part of the conversation had we not had these relatively more fluid boundaries? Because, again, I hear some of the voices of the ’70’s in my memory saying “Well that’s social science, not ethics.”

Swazey: Renée Fox and I heard a lot of that, believe me.

Brody: You can sort of see where that came from, too. When the field was starting out
and getting its own act together, people keep coming after you saying, “We know all about bioethics,” like Elizabeth Kubler-Ross. You can see how some of that came along and it served the purpose temporarily. Temporarily there were some good things to be gotten from that, but now I hope we are beyond that.

Swazey: I take it, particularly from reading the bioethics consultation report, you don’t favor certification.

Brody: No. I frankly wanted no part of that. I actually almost didn’t become part of the task force because when we first talked about having one some 4 or 5 years previously, I thought I would have time. Then when it finally got funding so there really was a task force, suddenly I didn’t have any time, and I almost said no I won’t do it, let somebody else do it. But part of me insisted that I had to be on it, specifically the part of me that was worried that some of the other members would be for certification. I was frankly surprised to see how little push there was. There were maybe a couple who sort of danced around it a little bit but by the second or third meeting there was virtually no one who was talking seriously about certification.

Swazey: It’s something I’ve thought about off and on and have talked to people about, per John Fletcher’s earlier push, and thinking of my own reasoning I suspect people
kept saying, “How in the world are you going to certify people as a bioethicist or a
bioethics consultant? What are your criteria going to be?” At which point I would
throw up my hands and say it sounds like a silly idea.

Brody: I frankly was rather pleased with the standards document. I don’t know what the
total impact will be; I was actually worried it got such good reviews. When the
draft was first published, I began to get worried that it was really a rotten
document if everybody agreed to it. How could it possibly be any good? If there
didn’t a contingent jumping up and down, how horrible, what’s wrong with this
picture? I do believe that there are some very, very substantive things in that
document that certainly have made us here at Michigan State think in a whole new
way about how we train future people to do this work. The range of skills and the
different settings in which people probably need to acquire those skills, and how
you might go about evaluating and assessing those skills.

Swazey: Is that what you primarily see yourself doing here in terms of your teaching?

Brody: No. The training of bioethicists is a very small part of what we do. The main thing
we do is train medical students and people who are going to be health
professionals, that has got to be our main agenda, so replication of ourselves is a
small piece.
Swazey: You’re not into cloning?

Brody: No. But it’s an important piece in the sense that it is where we struggle with our own identity the most; so even if we do it with a small percentage of our time, it’s one of the most personally rewarding things a faculty can do.

Swazey: Do you anticipate that some of the medical professionals you’re teaching, whether they are nurses or physicians, will become bioethicist consultants, either on committees or as individuals?

Brody: Yes, on committee. That’s the explicit model we use. We tell our medical students when they get into their second year class, what we’re going to try to do is to teach you to be a good member of an ethics committee. And we use that model to form our teaching methods. We very much want that, but relatively few have expressed an interest in a degree in bioethics. I’m frankly kind of puzzled. I would have thought, for example, if we admit 100 students, that one a year or every other year might want to get a degree in bioethics, given that we attract students who have a tilt toward the humanities and human values in medicine anyway. I’ve been rather struck that so few of the graduates have.

Swazey: Factoring out your interest and drive when you were a medical student, do you
think that some of it has to do with just how overwhelming it is to be a first or second year medical student?

Brody: Without a doubt. We’ve had some students who have started with some ideas like that and they’ve pulled back because they found themselves getting overwhelmed.

Swazey: Let me come back to the question to which you said, “Oh God.” Do you think of yourself as a bioethicist?

Brody: Yes, I do.

END TAPE 1, SIDE 2

Swazey: Do you define yourself as a bioethicist, at least in part, because you are trained in philosophy, which you said is one of the foundational fields?

Brody: Yes, that’s a way of getting the ethics piece, there’s some confidence that the way you are doing ethics is more than just a gee whiz, superficial way of doing it. You have all the problems of defining ethics given that everybody makes ethical decisions every day without any training in philosophy. It’s not terribly clear that the people who are trained in philosophy and then proceed to make ethical
decisions every day, make those decisions the way they do because they were
trained in philosophy, as opposed to that’s just the way we make ethical decisions.
I try to be aware of all those caveats and qualifications.

Swazey: But do you bring to the table a particular skill in teaching people how to recognize
and analyze and ethical problem?

Brody: I hope so. What I like about the level playing field that somebody like Richard
Rorty proposes in thinking about philosophy in a more pragmatic fashion, is the
idea that there has been this conversation going on and now there’s this little
conversation call bioethics, but there’s this big conversation call Western
philosophy; someone who has paid attention to that bigger conversation in some
systematic way for a period of time can relate this little bioethics conversation to
some much broader ideas. There’s a lot of wisdom in that big conversation;
people like Plato, Aristotle, Kant, and Mill and all these other folks have all
participated in it so there can’t help but be some really juicy ideas there. It is a
value to be able to be able to relate to the background and the context of that
larger conversation when you are talking about the smaller conversation of
bioethics. And you do bring something to the field.

Swazey: Who then can be a bioethicist?
Brody: There are, I think, self-taught bioethicists. There are two people here on campus I would put in that category: Bill Weil, who was on my PhD committee, and Joy Curtis in the College of Nursing. Out of their own interest they developed a certain skill in dissecting and analyzing arguments and putting arguments in a broader context, so I consider them colleagues in bioethics even though they have no formal philosophical or ethical or other equivalent training. So again, one of the things I think has been a strength of the field is that people come to bioethics from very different backgrounds. We have lawyer bioethicists, we have a few social science bioethicists, we have the religious and secular philosophical bioethicists, the occasional historian bioethicist, and it seems to work. There do seem to be these different entry points which seem to work. That raises the question of how much being a bioethicist is a personality trait rather than a bit of academic training, because there are obviously philosophers who can’t possibly be bioethicists even though they have all the philosophical training they might need; they are just not practically oriented or they are just not interested in medical type issues, or they can’t relate to a non-philosopher specialized audience.

Swazey: How much of it, at least until we started to get degree programs, has been self-defined? People saying, “I’m a bioethicist because I’m interested in these ethical issues.” Has that been part of coming to the table?
Yes, I think it also has been that. If you are interested and you label yourself a bioethicist you can come to the table in the sense you can join organizations or occasionally get an option to teach some courses, at perhaps a lower level type institution. And then if you take advantage of that opening and really educate yourself, if you didn’t have certain knowledge and skills when you started, you acquire them as a result of having come to the table. I also imagine there are a few frauds in the field, who very deliberately portray themselves when they know they aren’t really. They just once went to a weekend seminar, and they thought, “Gee, this is fun!” and they don’t honestly know what they are doing and are not really trying to find out what they are doing. But I think there are very, very few of those.

If you do the Kennedy short course, you’re a bioethicist.

Right. Most people I know did the Kennedy short course. For a lot of settings, that’s good. If you did that, you know more than some of the people around, you can do useful things, and you don’t necessarily portray yourself fraudulently because you don’t claim any more than that. The fear that there were a lot of frauds, I think, was one of the things that led to that SBC standards report. But nobody has yet come up with data that makes me convinced that there are a lot of frauds. I’ve heard anecdotes about individual cases that might be fraudulent.
Swazey: Here, you’re talking about clinical bioethics?

Brody: Yes, mostly people who go to a hospital CEO and say, “I’m a bioethicist so hire me as a clinical ethics consultant.” You are not as likely to get away with that at a university or even a community college because people are going to say, “Well, show us your academic credentials if you want to teach.”

Swazey: There has also been the phenomenon of people being defined as bioethicists, primarily by the media. For example, virtually every time George Annas is quoted, which is a whole lot, he’s defined as an ethicist or bioethicist and George keeps saying, “I’m a health lawyer who is interested in ethical issues.” One of George’s theses is that, in the media, health lawyer is a sort of a dull thing, and it’s much sexier to call people bioethicists. But I think there has been a tendency for anybody who is deeply interested in health and human values and ethical problems in medicine to be labeled as a bioethicist, and that’s probably more prevalent than self-proclamation.

Brody: It’s interesting how the media has sort of glommed on to bioethics and bioethicists and run away with it.

Swazey: Let me come back, briefly, to degree programs. From all you’ve said about the
value of bringing different disciplines to the table, did you say that you worry
somewhat about that gradually restricting or constricting the field, because you
will have to have a degree?

Brody: Yes, I think so, though I think there are still ways of doing the degree that would
make it relatively good. We have a masters program in health and humanities
which is very specifically designed to give one interdisciplinary breadth. And if
one were to do that masters then go, for example, into a philosophy PhD, one
would hopefully have the best of both worlds. You’d have good disciplinary rigor
in one area and you’d also have this breadth of background from having at least
once been exposed to an interdisciplinary survey of the field. I think it would still
be desirable not to have one bioethics degree, but you could come in with a law
degree, you could come in with a PhD in religious studies, you could come in with
a PhD in philosophy, if they ever got to the point where a degree was somehow
important or needed. I advise people today, more than I used to, that there are
going to be so many people out there with PhD’s in the future that you might be
putting yourself in some danger if you don’t get a PhD. You just might not be
marketable because who knows what that future market is going to look like. I’m
tending toward advising students that if they really are serious about bioethics
they might want to get a degree, beyond the MA.
Swazey: Do you know where your MA students are going? Do you track their jobs?

Brody: Good question. The way we recruit them, we would expect about a third of them to go on to graduate school for a PhD; another third are already employed out there and they come into their masters as an extra credential so they go back to their existing jobs and hopefully got a raise because they have a masters. And there’s another group that will actually be job hunting based on their masters. So only about a third of our students will actually be looking for employment as a result of the masters but I haven’t recently heard where those people are.

Swazey: I would guess primarily hospitals, maybe staffing IRBs...

Brody: That would make sense in terms of where the people are coming from and where they seem to want to go as a result of their work here.

Swazey: I think you also said you have some concerns about how adequately or how well people are being trained in bioethics degree programs. Would you like to enlarge on that?

Brody: I was saying that was one of the strengths of the SBC standards document, talking about the practical experiential piece and the sort of “in the trenches” training that
people ought to have, especially around issues like negotiation, mediation, interpersonal relationship skills. Just sitting in a classroom is not the right way to do it.

Swazey: When you think about it, that document presents a fairly daunting list of competencies. If someone wants to be a “bioethicist”, whether it’s academia or clinical, and come out of a masters or PhD program, how much knowledge do they need to get of the world of medicine and clinical medicine?

Brody: I think they need to have some knowledge; I’d want to avoid saying that they need a lot or that they need none. It doesn’t take all that long to figure out some very basic things about how health care institutions work; physicians would love to think these are eminently mysterious places and in fact they are not. We hear all these interesting stories about somebody who never got an MD degree who manages to disguise themselves as a doctor, and do it pretty well for a long time. So obviously, there is something less to the level of mystery than what we want to put on ourselves. And yet at the same time, there are some real things there and if you had not been around the setting at all... I think what you gain from being in the setting longer is, again, more sense of the interpersonal dynamic, and maybe a better sense of the negotiation, mediation aspect rather than you gain more medical knowledge by hanging around longer.
Swazey: It seems to me, partly from what you’ve said and what other people have said, that a lot of what the bioethics consultant does in an individual consult is very much akin to what liaison psychiatry used to do when it was flourishing. What a very good social worker does or a chaplain. It’s a mix.

Brody: Right. And I think that’s where I see that standards document as being valuable, because it makes relatively more explicit some of those subject areas that were or maybe already are explicit in the social work literature, the chaplaincy literature, but had not yet gotten translated into bioethics literature.

Swazey: So how much of what a bioethics consultant actually does would you say requires training in ethics, given all these other roles they are performing.

Brody: In some ways, it’s relatively small. We hear commonly the comment that about 80% of what I do has something to do with communication. Some of those communication skills can come from a study of ethics, but a lot of it doesn’t; so I wouldn’t be uncomfortable with an 80-20 model or a 70-30 model. I want to acknowledge that it is easy to overestimate, and of course we all have these little war stories that people tell, where how little their fancy ethics training served them once they got into the actual hospital setting. I think those are basically right.
Swazey: Some of that is certainly the everyday ethics, whether it’s in the nursing home or two or three days you are in the hospital or the everyday ethics that medical students face.

Brody: In the U.S. we have to make it all out to be such fancy expertise, so that I could charge you a hefty consulting fee to tell you something you already knew. A lot of it has to be common sense. A lot of ethics consultations go, “common sense tells me that this is what we ought to do with the patient, but let me call the ethics consultant to make sure there isn’t some bizarre thing that I’m missing.” And the ethics consultant comes running in and says, “Nope, I can’t think of any bizarre thing.” Your common sense probably told you the right thing to do.

Swazey: Where I raise the question of how much medical knowledge or competence you have to have is, for example, if you are going to review a chart and have absolutely no medical competence, can you do an adequate job, do you know what questions to ask about the relevant aspects of diagnosis, prognosis and so forth?

Brody: The weasel word is “some.” I would want to argue that you need some medical competence. It’s less than what you need going to medical school and it’s more than none. Among my non-physician colleagues, and this is another research project that somebody should undertake, just how do these non-physicians and
non-nurses get enough knowledge just by hanging out most of the time? How do they get a nose for when there is more out there than meets the eye and you start asking questions and you read one chart and you say, “This is pretty straightforward. It seems like the patient had such and such a disease and then they had this operation and then this complication arose and now they’re on a ventilator.” And another chart you read and say, “Something just doesn’t make sense here, I’d better start asking some questions.” And it turns out there is, in fact, an undiagnosed medical problem, without which one could not come to the proper ethical conclusion in that second case. But what made you say the first chart looked fine and you didn’t need to ask those questions, but the second chart... So there is something about the ability of my colleagues to get a nose, apparently without any formal training in it, that this is the chart I should be asking the questions about. Even back in the ‘70’s when it was early days in the bioethics game, I was struck by how seldom you caught a non-physician bioethicist making any kind of real medical gaff. You just didn’t. When they got up to talk about bioethics and they gave you, for example in such and such a case, in persistent vegetative state, blah, blah, blah. And generally, they would be right on. No physician could find fault with what they said because they didn’t understand the medical condition.

Swazey: Let me go back to bioethics and humanities and the interfaces. One thing that we
find interesting is this current push for narrative ethics and wonder what sort of
mixing together, or mixing up, I’m not sure which is correct, that really represents
between humanities, ethnography, and ethics. I guess I’m not sure I fully grasp
what narrative ethics is meant to be and why it seems to be in florescence right
now.

Brody: One of our master’s students is trying to get his thesis written about narrative
ethics and say what it is and what is special about it and try to tie it to cognitive
science. So I’ve been working with him on this dissertation and struggling with
this. Narrative ethics is kind of like an accordion term that could be like casuistry,
there could be this complete range where one extreme is just write a short story.
“The next time I teach this course in bioethics, I’ll give them the short story to
read because I know they will get more excited about the issues than if I give them
this dry, academic case study.” Or it could be all the way to the idea that when
you reason ethically, you are basically telling yourself how a story ought to end;
and there is something about the narrative cohesiveness of one set events as the
ending of the story that one could develop some intellectual criteria for saying this
is the better ending for that story. Something like that is how people actually
reason about their ethical duties and obligations. If I did this, it would make the
story come out the better way than if I did this other thing. So there is this
complete range from, on the one hand, narrative is an essential way to find out,
ethically speaking, what one ought to do, to the other extreme of narrative is this nice little spice we'll sprinkle on the top of bioethics. And there is a range of positions in between.

Perhaps the most extreme version of narrative ethics says principlism is nothing but disguised narrative because all a principle is, like respect for autonomy, is a condensation of many, many, many narratives over centuries of how you treat other people. When we look to see what all those narratives seem to have in common, we come up with this abstraction of respect for autonomy, but this abstraction would be no place and would never have evolved if it had not been for these concrete narratives that preceded it and that it summarizes. On that reading, there is no conflict between narrative ethics and principlism. All ethics is narrative. It's just that principlism is another way of doing narrative. Now, what's going on here? Well, I think clearly part of what is going on is feminist ethics; I think feminism has had a very strong role to play here. I'd like to see a role here for cross-cultural ethics as well, but I'm not sure, historically, if that really has been a moving force as opposed to a beneficiary. Some of it is the reaction against principlism, which to some extent is a reaction to the analytic difficulties of trying to apply principles. You find yourself using a hefty dose of intuition and judgement exactly when, according to a principlist framework, you're supposed to be able to avoid the use of those because principles are supposed to be so informative. In the end, you're finding yourself unable to describe it in any
rigorous fashion. How do you decide whether principle A or principle B applies in 
this case? So I think there is a confluence of different forces that make narrative 
the fad of the hour.

Swazey: When bioethics seemingly now is embracing social science in the form of 
ethnography, are people in medical humanities and bioethics conflating 
ethnography and narrative? Is that why it’s more acceptable than it has been?

Brody: Some of that might be happening, but my suspicion is that those are actually 
slightly different trends. Both trends coexist, but I think they are slightly different. 
I’d like to think they are separable and that people are in fact separating these 
concepts, that they’re not just confusing ethnography with narrative. Although, 
there’s a lot of ethnography about narrative, which I think is quite appropriate, and 
some narrative is almost ethnography. You could almost say that some of Kathryn 
Hunter’s work, for example, is medical ethnography, arguing that narrative is one 
of the activities in which this culture that calls itself medicine engages. One of the 
intriguing aspects of this medical culture is the active use of narrative and the 
simultaneous denial that what one is doing is using narrative. So you could say 
that it is sort of amateur ethnography that she is doing. But I think people are 
tending to distinguish those rather than conflate them.
Swazey: That’s encouraging.

Brody: I guess the concept of “thick description” is one often used more liberally. You can apply that to narrative. You can apply that to ethnography. But I think there is something more general, which I call contextual ethics, not because it’s the right thing to call it, but because I was struggling to get a label for it. I see something like narrative ethics or feminist ethics as more concrete examples of this larger thing called contextual ethics. So when you talk about thick description, you could be talking about doing ethnography or you could be talking about this contextual ethics.

Swazey: Thick description is a very major sociological, methodological concept.

Brody: I guess what I’m saying is that in some sense, thick description is being used as a methodological term, and probably there are other uses of it right now where it pops up in bioethics used as a metaphor. So applied to narrative, contextual ethics is probably metaphorical.

Swazey: Are there some major shifts possibly underway in bioethical foci or bioethical values, now compared to the ’60’s or ’70’s? For example, is there a greater emphasis now on responsibility and community, and less emphasis on rights?
Brody: That's a little hard because my first instinct is to say, "Yes, of course." But my other tendency is to want to say, "Well, is that really so?" Because one of the things you find when you look back at some of the work being done in the early days of bioethics is people were talking about these other issues. People were trying to do some of this; it's just that it didn't catch on for a while. It got temporarily eclipsed by principlism and the autonomy-rights craze. But it never was completely absent, it's not really as if this is a brand new strain in bioethics today. Where, for example, we get some guidance and some good stuff that appears in the standards document, is the tilt toward organizational ethics in ethics consulting. What kind of claim is being made there? Well, it's sort of interesting. One piece is that we're making a claim but we're aware that this is a preliminary claim. We cannot give you a set of developed case studies like we can about clinical ethics, that would sort of capture the method of how to do organizational ethics or even the range of issues within organizational ethics. We're very much aware that this is a new door being opened and five or ten years from now, we'll know a lot more about it, but right now, we can only guess what that might be. Second, however, we are making a strong claim that if bioethics consultants ignore this, they are not doing their job. Third, we're making a claim that this is especially going to tax the skill of a bioethics consultant because these are going to involve business, economic policy, a lot of other issues are going to be involved here. And the need for you to go get special consultation on the facts of the case
and what’s at stake in any one particular case, is going to be greater than in
clinical ethics. In clinical ethics, once you get a certain amount of clinical
background, you’ll know that the next clinical consult you’ll get is likely to be
something you’ll know how to handle. Whereas in organizational ethics, you
could have six organizational consults and then consult number seven might be in
a whole new area that will cause you to have to go ask some people what’s going
on here, as if you’d never done it before in your life. It’s going to be harder to get
the skills involved.

Swazey: How much of the emphasis on organizational ethics is coming about because of
the impact of managed care and also the ascendancy of corporate ethics
consultants?

Brody: I think some but not all. Organizational ethics is a good example of something
that’s never been absent but it took a while to percolate. It had to bubble up to the
level of consciousness and had to accumulate to the point that there was a sense of
unavoidability about it. I don’t think anybody who took on serious ethics
consulting in the early days, if they were at all reflective and self critical, ever did
that for any period of time without thinking about the impact of the organizational
framework and background on how they did their clinical consulting. Most
people, at that point in time, probably said, “This is one I’ve got to put on the back
shelf because I just don’t have the tools or the time or the energy or the courage to deal with it right now. It’s just too quick a way to end my career in the field of ethics consulting, to go out tilting at that windmill right now.” Now I think people are saying, “Well okay, we’ve avoided that set of issues but look how they’ve accumulated over the years. Look at how more complex they’ve gotten because of things like managed care but not exclusively managed care. In the meantime we’ve gotten a little bit smarter about what we do, there’s more of us now so we can kind of band together. They can’t fire us quite so readily, so isn’t it about time we looked at some of these issues.”

Swazey: A point that one of our other interviewees made who’s done a lot of bioethics consultation and teaching bioethics consultation is that there’s been a glass ceiling. Bioethics consultation was relatively welcome at the bedside or in the clinic but stay away from the boardroom door. That’s not your business. Do you sense any greater organizational receptivity?

Brody: I don’t know that I sense greater receptivity. I think there is less receptivity and increased courage/arrogance/whatever on the part of the people down below the glass ceiling. So they’re pushing through from the bottom. I don’t think it’s the top opening up the glass ceiling to let you in. Individuals, of course, are there in all levels of management who are ethical people, who are worried about their
ethical well-being and would love somebody to have an ethical conversation with.

So there are going to be individual allies on boards and in middle management,
everywhere up and down the line. A lot of allies at the lower level, not quite so
many at the higher level, probably. There was an interesting video tape made by a
fellow here from Michigan who is now with the St. Joseph’s system in California,
Jack Glazer. He was the first ethics consultant for the Mercy Hospital chain, the
Catholic chain here in Michigan; it’s a 4 or 5 state chain with about 22 hospitals.
He did several video tapes for his ethics committees on how to do ethics, but he
also did one on the board of trustees as the ultimate ethics committee of the
hospital. That tape was made years ago but he was reminding people that 1) the
board of trustees ought to see themselves as a kind of ethics committee and 2)
they are the ones ultimately responsible for the hospital. The buck stops there. It
sort of clarified the possible relationship between the board and the ethics
committee, and also was charging the board with thinking of themselves in a
different way than many of them had. And as a non-Catholic, I’ve come to admire
some of the work being done in Catholic institutions. I think the trustees’ ideal is
more amenable to that environment than in many other institutions.

Swazey: They often have put more espoused values into practice than many other
In a way that’s kind of spread. I think it was easier, in the early days, in a Catholic institution with this notion of mission effectiveness. You could more easily get the message across. “We have a problem if we say our values are one thing and we act in some other way.” And now I think more people are waking up to the fact that if that happens in your institution, you have a problem and the person who pointed it out to you, rather than being a turncoat or a traitor who should be punished, is maybe somebody who’s actually helping your institution.

Let me go back. You said that you thought people had been working in areas like responsibility and community in the ’50’s and ’60’s but it just didn’t catch on. Why didn’t it catch on?

I want to be kind of simple minded about it. I think there was a lot of work to be done in bioethics that was waiting for somebody to come along and do it in the late ’60’s and early ’70’s as a combination of the new technology and the way it impacted on people and the way that physicians had welcomed this new technology without carefully thinking about how it related to their more basic role as a human to human contact with their patients. It was just a lot of issues. A significant proportion of these issues could be dealt with easily by invoking some rather straightforward moral principles. As long as the moral landscape looked like it was littered with all these paternalism problems, where the way you get in
and solve them is by proclaiming the value of patient autonomy and patients’
rights, then everybody is going to focus in on autonomy and rights for a while.
When someone comes and wants to talk about virtue and community or narrative
or whatnot, you’re going to say, “Why are you bothering us? We’ve got all this
heavy work to do. Look at all these paternalists out there that still need to be beat
up over the head.” Then after a while, you’ve finally got the paternalists at bay
and you have sufficiently proclaimed patient autonomy so that people at least have
a clue. Then you look around the landscape to see what’s left and it turns out
much of what is left doesn’t respond well to that fairly kneejerk application of
these fairly basic principles. So at that point you start wondering, “What is
missing here?” And you start to think maybe community, maybe narrative. These
other things start to look attractive and each one of those concepts has a remainder
set of issues that are out there that it addresses, but in many ways they start to
shrink because now that you’ve dealt with the easy stuff, what’s left is obviously
harder. I think of it like--this is a crude medical analogy--when you go in with a
medical care system to a developing country, right away you can make a major
impact on the life expectancy just by cleaning up the water supply. You don’t
even have to do anything biomedical if you just give them clean water and a
sewer. Then if you really want to do great things, you can vaccinate people. And
then, as you get the infectious diseases under control, the further gains in life
expectancy get harder and harder and the dose-response curve starts to level off
pretty fast. I think we’re at the leveling out part of the curve for bioethics where
you really have to work a lot harder now to make some of these newer concepts
work for you because the issues that are left are just harder issues. The easy ones,
we’ve sort of got a handle on.

Swazey: It also seems, though, if you look at what was going on in the larger American
society in the ‘60’s, patient and autonomy and rights were part of a much larger
landscape of rights.

Brody: Yes. That’s an important corrective to what I just said. You have to look at the
tenor of the times.

Swazey: We’re trying to think through whether there’s a different tenor in the ‘90’s that has
been surfacing... larger value patterns in America that are helping to surface these
notions of, for example, responsibility and social justice in health care, with Norm
Daniels not being almost the lone voice out there forever and ever. Having
followed human experimentation for years, I think there has been a very profound
shift from the focus on protecting the rights of subjects, which is still important, to
the claim that pretty much started with AIDS of the right to be included as a
research subject. That’s a very big change. Is it reflective of larger value patterns?
Brody: Now that you say it, I would say yes, of course. I was wrong to have suggested that this is somehow within bioethics. But I guess I would go back and say within bioethics there is a force moving in this direction. It’s perhaps swamped by the larger force and the larger society that’s pushing us to think about things in that way, but that doesn’t negate the fact that there is this force within bioethics also.

Swazey: What we are struggling with is to try to tease out the value patterns that are going on now, because it’s harder to see them when you’re in the middle of them.

Brody: I have a great problem putting into context the so-called communitarianism of the ’90’s in relation to the philosophical literature I’ve read that would count as communitarian ethics. The part that I have read, or the pieces I’ve read, I have a hard time making sense of. I honestly don’t know if this is fundamentally a conservative reactionary trend, whether some of it is conservative and reactionary, or whether some of it is genuinely taking us forward in a way that I can recognize as a sort of left wing type. I certainly am fascinated with a certain amount of it and some of it really gets the hair on the back of my neck standing. I haven’t learned to figure out a way to make sense of it generally let alone apply it to bioethics.

Swazey: Are there issues that you think bioethics needs to address that it really hasn’t dealt with?
Brody: Well, I’ll give you a preview of this book chapter I wrote because I was recently looking at it again. When I had to talk about this for the chapter I wrote for Fletcher and Miller, the suggestion that I had for them, just because it’s one I’m trying to work on, is the whole issue of physician self-interest. What is fair and right for physicians to take home by way of monetary compensation for their work? I think it’s quite intriguing how actively we have avoided that issue in bioethics and how few people in bioethics have formally addressed it. Managed care has highlighted the issues, but it certainly didn’t invent them. In an important way, managed care has been the messenger bearing the news rather than the cause of the issues. The fact that there is potential conflict between the way we pay physicians and altruism to the patient is not news. Managed care is the messenger most recently that has let us see this in a very stark way, because when you pay physicians a bonus not to give something to a patient, it becomes pretty obvious. No reimbursement system ever paid physicians only when they were altruistic and withheld payment from them when they failed to be altruistic. Managed care didn’t invent the conflict between self-interest and altruism. If you want a specific reference, I’m struck by the fact, for example, that Al Jonsen wrote that little piece, which typically for Al had a title that kind of misled everybody about what the article might be about, called “Watching the Doctor” in the New England Journal back around ’85 or ’86. It basically said the fundamental ethical problem in medicine is the inevitable ongoing tension between legitimate self-interest and
altruism. How few people have turned back to and quoted that basic article is something I find intriguing. And about the same time, one year or so before, was when Norman Levinsky wrote his article, “The Doctor’s Master,” in which he proclaimed grandly that the physician must do whatever will benefit the patient regardless of cost. And I see Levinsky quoted at least once a week and I see Jonsen quoted not at all. Obviously Jonsen was a lot smarter than Levinsky in saying what the fundamental medical ethic was all about, but why is it that we don’t want to deal with that. We could sit here and come up with 20 reasons right off.

Swazey: What about the whole area of our health care delivery system? Is bioethics going to enter that arena more than it has? Talking about physician contracts with for-profit health care companies is not the John Rawls, Norman Daniels bigger social justice issues...

Brody: I guess I would struggle against the argument that it’s ignored health care and social justice, because that’s an area I, personally, have been working in. I read stuff.

Swazey: No, it’s not to say there’s been zero, but if you want to compare it to, as you said, autonomy/rights, the focus has been much more the dyad of the physician and
Patient.

END OF TAPE 2, SIDE 1

Brody: I would think the issues are becoming more unavoidable daily. And yet our society, the larger society, seems to be every bit as good at avoiding the issues now as they were seven years ago, if not better. Take one small example. We pat ourselves on the back as Congress passed Kennedy-Kassebaum. We thought we did something about the uninsured, and all the data I know of say we did nothing about the uninsured. Everybody’s pretending we sort of did something. I even heard Kennedy-Kassebaum mentioned at a conference I was at in Albany last week as if it meant something, as opposed to who cares now. In terms of the numbers of people and the numbers of articles written, there have been more people doing the one-on-one stuff. Why is that? Well, it’s not because there aren’t philosophical tools to deal with both sets of issues and it’s not as if there aren’t philosophical arguments going on. I use the example of Rawls as a work that was very important in my thinking. When I started doing medical ethics, I got excited about the possibility that Rawls could be informative about one-on-one doctor-patient types of questions. But what I had to do, of course, was remove Rawls from that area, because Rawls is truly at home with issues of social justice and issues of the large institutions of society. To try to modify Rawls to take it to the
one-on-one dyad is not really appropriate. It’s not really what Rawls is talking
about at all. But because I had read Rawls as a formative work in my
philosophical training, it’s relatively easy for me to now think about the questions
about health care justice and organizations as really where the action is. The other
thing, obviously, is that issues of how one person should treat another person are
relatively more amenable to what appears to be a resolution. Issues about how
institutions should behave and nations should behave are much harder to resolve
practically, and so you can more easily get burnout talking about the latter set of
issues.

Swazey: I think it’s Paul Ramsey, in one of his articles a long time ago, who said part of
the reason for the dyad focus was because the larger moral problems, like social
justice, are so intractable to moral reasoning that you almost don’t know where to
start.

Brody: I think there is clearly some of that going on as well. People get pretty tired and
demoralized pretty fast talking about the larger questions.

Swazey: Is bioethics going to be around for awhile? Is it going to continue to be a growth
industry?
Brody: Yes. I just don’t see any real way out of that. I don’t see the work-wanted ads being part of the newspaper my colleagues are reading.

Swazey: I can’t think of an issue that you’ve dealt with or that I’ve thought about, for 20 or 30 years, that’s gone away. It just gets more complicated.

Brody: That says something bad about what we’ve been doing but it certainly seems as if these issues will be with us for quite awhile yet.

Swazey: Do you think religion is going to come back or is coming back as a more significant player?

Brody: I think so. I can be autobiographical about this and say I never felt, early on when I was taking my training in bioethics, that the fact I didn’t have any religious background or religious studies background was any kind of deficiency. I really thought that was something I just didn’t need, it was quite superfluous. Now, I think about where I sit and I wish I knew a little more about some of the religious traditions. I find that’s an area that I can see myself doing more study in because I do think it is coming up and I do think it is valuable. I think it is valuable in a couple of ways, which may be totally idiosyncratic. The area of social justice that I find myself being interested in now, as a philosopher apart from bioethics, is the
role of religion and public dialogue in a democratic society and what is a liberal
position on religion. Because I think some of the liberal positions that would
exclude religious argument from the public square are unduly restrictive and in
fact illiberal, and so I find it rather intriguing myself to think about making more
of an opening within a liberal theory of social justice for religious arguments to be
voiced as part of the public discourse. Why am I motivated to do that? Well, I
wouldn’t be motivated to do that had it not been impressed on me that maybe
there is more wisdom than I first thought in some of those religious arguments. So
when I hear, for example, people from religious backgrounds talking about ideas
like stewardship, it seems to me there is a rich concept there that I only get an
outlying view of, but that somebody who’s trained in those religious traditions
really has a deep sense of what it might mean. I find myself saying there’s more to
it. I don’t have to convert to that religion to see the value of understanding that
notion of stewardship. So I’m convinced there’s a lot of wisdom for us secular
bioethicist if we would attend more to some of the religious traditions.

One of the things I think was an interesting dimension of public bioethics
was what I heard when I was able to be at some of the deliberation of the working
group on ethics that was part of the Hillary Clinton task force. One of the things I
was there for was the discussion about the list of American moral and political
values that the task force developed. The claim was going to be made that any
health plan should be grounded in these moral values, and if the Clinton plan was
going to be a good plan it was because it was grounded in these values. Values
like individual choice and individual responsibility were prominently on the list
and then people were arguing about where to put values about social solidarity
and community solidarity and intergenerational justice and things like that. The
group divided itself down the middle into the secular versus the religious
bioethicists. And the religious group was arguing, in the end successfully, for a
strong inclusion of the social solidarity value claimed that if you really look
carefully at American history, we’ve sort of misrepresented it as having only this
individualistic strain. If you really look back carefully at the history of this
country, they argued, you realize that individualism has always coexisted with a
sense of social community solidarity. It was primarily the religious folks who
were making that argument.

Swazey: I know Elliot Dorff was because I interviewed him about it. He got a lot of
support from Art Caplan on that.

Brody: In the end, they won over the secularists. And of course, in the end they lost
because they were dead wrong about public opinion. And the public said phooey
on that. We believe in individual choice and individual responsibility. Don’t give
us this community solidarity shit. That’s big government.
Swazey: I think it got wiped out before then. Elliot said it was a fascinating meeting when they discussed it.

Brody: We could go over the Clinton plan, but at any rate they lost. I would like to think it is a temporary setback. I don’t think it is a permanent loss. I pray that it isn’t. It was impressive to me that it was from the religious side that that came from and not from the secular side.

Swazey: I know you have other things to do besides talk to me. Thank you very much for 3 hours of your time.

END OF INTERVIEW