June 19, 2000. Interview with Patricia A. Marshall, PhD, Associate Director, Medical Humanities Program and Associate Professor, Loyola University of Chicago. The interview is being conducted by Drs. Judith P. Swazey and Carla M. Messikomer at the Park Ridge Center.

Messikomer: Can you talk a little bit about your family background growing up.

Marshall: I'm the middle of five children. I grew up in Dayton, Ohio on the west side of town, essentially on the wrong side of the tracks, in a very lower working class, Catholic-to-the-bone kind of place. My family is more unusual I think than some families, just the way we were raised and the sorts of things we were taught and how we functioned. We didn't have a lot of money but always had food. My mom was an excellent cook but we were the kind of family where people would give us food. I didn't understand until I was in the 6th grade that we were actually among the needy of the world. This is because from the time I was a young girl, I was involved with the Dominican Sisters of the Sick Poor as one of their helpers. They are home health care nurses who work with the poor. At the age of 11, I was doing volunteer work with them on the weekends, mainly. I had a Red Cross certificate, I knew how to change a bed with someone in it, how to give someone a bed bath, and we also would wrap presents for the "poor" kids. Part of my world was simple in those days. You were Catholic or non-Catholic, you were rich or poor. I was not a rich person, I knew that for sure. When it really came home is when we would wrap presents to give to
the "poor" kids; I was 13, and some of those presents showed up at our house under
our tree. It must have been a particularly bad year. I have three sisters, so there are
four girls in my family and one brother and my father would say that he was a man
who was rich in daughters. My mother was one of 17 children; I have 59 first
cousins, on my mother's side. I'm about 6 feet tall, average in that family. I'm
number 27 of my cousins. To say that our family is sort of off the scale on a lot of
normal scales is an understatement, and I really mean that absolutely truly. Our
grammie, my father's mother, was the only grandparent that I knew. She lived with
us even before I was born; we shared a room together, we shared a bed together for
years. She was born in 1879, and she died at the age of 87. She was a gift to me and I
think a lot of who I am as a person is partly because I have had this incredible spirit in
my life. My mom was Grace, we called her "Amazing Grace", but Grammie was my
guardian angel and protector, and used to say things to dad like, "Eddie, Eddie leave
this child alone." I am the only one in my family who has a PhD, the only one who
has excelled in academic success and whatever. One of my sisters is a skin care
specialist, she works in a salon. She graduated high school, so we are across a
spectrum here. I am the only one who has an academic career, but I'm not the
"smartest" one in my family. My mother used to say that my brother, Chuck, and
sister, Cheryl were the smartest ones, which in fact is true. Chuck had a National
Merit scholarship, and a track scholarship to go to college. He doesn't have much
money; he's a plumber. But his children go to places like Northwestern and Tulane
on full scholarship because they are pretty smart.

    Basically I am “above average”, and I come from a tradition where hard
work and excellence and commitment to the community and caring for others in need
is absolutely valued. I would not have said it as I was growing up, but just the fact
that I was doing volunteer work at the age of 11 and not thinking twice about how
remarkable it would be to other people that I was in someone’s home and knew how
to take care of a sick person who would be there laying in bed -- when I think about
that now that is pretty amazing. I could tell you a hundred million stories about
growing up; truly my family is unique.

Swazey: How did you go from that value complex to anthropology?

Marshall: I didn’t know what anthropology was. I never had heard that term until I was in
college. I took my first class in anthropology in New Orleans, at the University of
New Orleans. Many people assume I have this academic pedigree that is pretty
classy, but actually I am state school educated because in our family, we didn’t have
money. The only way we went to school was to pay for it ourselves. Which I did in
the beginning and then I was fortunate to get to get full support through a National
Institute of Mental Health pre-doctoral training program. I had that for four years. In
the beginning I went to the University of New Orleans, which was 800 miles from
home, and lived in the French Quarter, and supported myself. I discovered
anthropology there, and when I was a senior I knew I wanted to be a medical
anthropologist; at that point I got really focused. I was married quite young; I was 18
when I first met my first husband, and so I was a sweet young thing, working full-time
and going to school full-time, living in the French Quarter, basically having a great
time.

We moved to Kentucky and I finished off my undergrad work at Kentucky
and created my own degree, I called it behavioral science, so I took a lot of classes in
sociology, psychology and in anthropology, but it was in my last year that I discovered
medical anthropology. As a first year anthropology graduate student I applied for and
was awarded a pre-doctoral fellowship from NIMH. I still kept my focus pretty broad
in terms of my training. We had to do empirical research, and we had to take
additional classes if you had this NIMH scholarship in behavioral science. I was still
taking classes in medical sociology and psychology and my office was located in a
medical school. I’m firmly anchored in anthropology. If you say “what are you?” I
say, “I am a medical anthropologist.” However, I am unbelievably multi-disciplinary
so that if you look at my work over the years, at my CV, it just comes through so
powerfully how I am grounded in different disciplines. My primary anchoring is in
anthropology so it is in the social sciences. If you read something that I’ve written,
what you get is a sense of the social scientist underneath and specifically you will see
a cultural filter, you’ll see a cultural kind of filtering of information. I’m always
interested in cultural dynamics, group dynamics. But in addition I have been involved
with ethics since 1984, really 1983. Just last year I got off the board of the American
Society of Bioethics and Humanities. I had been on the board of the Society for
Bioethics Consultation, so I have all of that experience with ethics. In anthropology, I
was on the board of the Society of Medical Anthropology. I’m really multi-
disciplinary in this way.

I discovered ethics in 1983, when I wanted to earn some extra money and
took an extra job as a research assistant on an NEH funded summer-long institute on
ethics for applied health care workers. I got into it so much, I loved it, that they
actually began to include me as part-time faculty. I had just finished my PhD. In the
beginning my job was to collect the materials and help compile them, but I wasn’t just
collecting them, I was reading them saying, oh, this might be interesting. The three
people who really got me involved in ethics were Ed Pellegrino, Ruth Purtillo, and
David Thomasma. Those three individuals made me fall in love with this particular
area. They were involved in the summer-long institute; each of them came in for one
week at a time but they were also present for the planning meetings. I remember Ed;
he endeared himself to me forever because he sometimes can’t stand to sit for too
long so after awhile he would be standing up in the room, jumping up and down
doing jumping jacks. And I thought, here is a man after my own heart, let’s go out
dancing, let’s take a break here with these sessions. Ruth, to this day is such a good
friend and Ed will always be special in my heart and David of course has worked with
us for years now. Those three people inadvertently gave me an invitation to explore a
way of thinking about morality and dilemmas in health care that I had not thought of before. Because of my training in anthropology and generally behavioral science, what I brought to those discussions was something very different than what I was reading about. I know you know exactly what I mean. Sometimes, even to this day, reading analytic philosophy is very difficult for me, not a natural thing that I do; I have to re-read paragraphs, and I always feel a compulsion to make sure I’ve done my homework. I think it is because I grew up on Park Hill Drive (a very working class background) so I have this sense that I have to make sure I’ve done my homework.

Swazey: I don’t mean to editorialize, which I shouldn’t do as an interviewer, but I find most of the bioethic literature incredibly boring. The same issues, the same way for so many years.

Marshall: The rhetoric can kind of be stale. I’m always interested in the question of cultural grounding that underlies the abstractions. I want something juicy. I want to get to the meat of it. I am doing a lot of work right now in the area of international research ethics, and so I have concerns about how informed consent, for example, is obtained in a setting like Nigeria where they might be working on genetic epidemiological studies. It’s very easy for us to say “this mandate ought to be clear, we ought to make sure that every person is able to say for themselves that they want to participate in research or not.” We can all, sitting around a table, agree that this is a good thing.
But what actually happens in the field may be a far cry from that ideal notion of autonomy as we might want to see it expressed in informed consent. I can tell you how to get permission to do a study from a tribal elder or a tribal chief in the village of Igbo-Ora. I'm learning more and more about how this process is enacted with getting permission. In interviews I was told in this village there are town criers who go to different neighborhoods and make a public announcement. So the situation is much more complex than this neat representation of an ideal. I'm not saying that the ideal is bad; it's a good thing. I want people to have a sense of freedom about consent to research. But we do make a lot of assumptions in a research setting and clinical setting about something like autonomy. We prize a patient's rights. What interests me are the kinds of assumptions that we make.

Messikomer: What is your take on the cultural universalism vs. cultural relativism debate that has been going on in bioethics?

Marshall: As an anthropologist I'm often put in a position where there is an implicit challenge regarding universalism and relativism. So people might say, "what do think about female circumcision or female mutilation?" That's a classic example, an issue that is often raised...

Messikomer: It's also raising something that elicits some horror as opposed to kind of the
ordinary day-to-day differences between cultures and subcultures. That's kind of a
sensationalized example.

Marshall: It's sensationized and also it's almost a caricature of the issues. It's a way to try to
make something complex into something simple. I deal with that question matter of
factly. Do I like it that young girls are being circumized in villages in Sudan? No, I
wish that wasn't a practice, but on the other hand can I understand some of the
concerns that a mother might have about having her child uncircumized in a village
where she might be concerned about whether or not this child will be able to find a
husband? The thing about cultural beliefs, cultural values, ways of being in the world
-- the bottom line is that culture is dynamic, it's not static. Cultural elements, cultural
patterns of behavior are always in a state of flux, are always somewhere along a
continuum of change. This practice of female circumcision or mutilation, depending
on where you stand, those patterns are changing now and they're changing for a lot of
reasons: because of dynamics at the local level, because this issue is now a part of the
human rights agenda, because physicians who work in countries where it is common
practice are changing their attitudes. In the early 90's I spoke with a physician, an ob-
gyn, in Cairo, who said the way she was making a compromise with this particular issue
is that she is refusing requests from mothers to have the procedure done on their child.
She'll say, "if your daughter approaches me on her own when she is 18, then I'll do
it." To me, that's her attempt to live pragmatically in a world where she has to deal
with this constantly. She has come to a compromise position about it. I think that to
think about things in a polarized fashion is to simplify the complexity of the real
world. I think that there may in fact be different kinds of questions that you can ask
about the universalist- particularist continuum. Our moral life is practiced at the local
level. We live our morality in particular local worlds at particular biographical
moments in time. So who we are as human beings, as moral beings, is played out in
the context of our social networks, it’s played out in the contexts of the political and
social dynamics of our family, friends and colleagues at work. It’s played out in a
structural setting that necessarily brings a number of constraints to our world. For
example, here in the U.S. we think we have a lot of freedom, but if you are in a nation
where there are a lot of human rights abuses, where there is a political dictatorship,
your experience is going to be totally different. So for me you can’t get away from
the locality of moral experience, you simply can’t get away from it. It’s close up, it’s
in your face. It’s not in a book or an axiom or a moral rule that exists apart from who
you are in your relationships to the world and other people. I do think that there are
ways in which we learn how to be. For example, when I started talking about myself
at the age of 11 doing volunteer work, not thinking twice how remarkable that might
appear to other people: what I learned was something about the importance of being a
caretaker, giving back even when some people would say our family didn’t have a lot
to give. I was practicing at my life -- practicing an “ethic” really.
Messikomer: Pre-working of the next phase of who you are.

Marshall: If you would have talked to mom and dad about what I was learning, they might of been able to say, “Why are you even asking, this is just a good thing to do. This is good to help your neighbor.” I’m not sure how they might have framed it. In that sense, the point I want to make is that there is a way in which you can step back from the locality. We live, practice, work and play out a meaningful existence in our very particular local world, but then stepping back from that, I believe there are things that we believe in, that for the most part are unstated and perhaps come to our awareness when those beliefs or values are really challenged. That’s stepping back from the practice itself, and it’s a way of framing a value or an ethic. But for the most part I think we are not explicit or reflective about it, we just do it. I get frustrated about some of the philosophical rhetoric. I don’t know if that makes sense...

Swazey: It does to us. We certainly have talked a lot, the three of us, about the exportation of Beauchamp and Childress around the globe. It’s a fascinating development which most bioethicists in this country think is the way it should be, but it strikes us as a mighty peculiar set of assumptions.

Marshall: But you know, this is part of the whole globalization of biomedicine. There is globalization of medical ethics or bioethics. There is a way in which that brand of
bioethics, the principles approach, fits in nicely, it mirrors very well the kind of paradigm that operates in biomedicine. What I am thinking of here is that in biomedicine, if you think of the disease model, you identify the problem, apply a certain set of skills and understandings about the disease etiologies. You make a plan and figure it out. It is that same type of precision that I associate with a principles approach to ethics. I think one reason why in ethics consultation, for example, it's been easy to incorporate a principles approach is because you can say, okay, here we have a clinical problem, what is the primary conflict? You can say "It relates to autonomy," or "This is a beneficence issue," or "It's social justice." There's a way to frame the problem that's precise. It just gels, really gels. In a place like Nigeria where concerns might be very different you can still apply that approach, but it needs a much more robust framing. Thank god these days in bioethics people are talking more explicitly about narrative, or feminists ethics; it's a different kind of perspective -- more contextual.

Swazey: Have you seen those other approaches making much inroads into principlism?

Marshall: I don't know. Academically, I think that principlism is like a straw person that gets set up and then we can react to it. I don't know how much of an inroad other approachers are making. The tidiness of the principles approach makes it exportable to so many different settings and makes it easy to teach in a biomedical setting, to
medical students. Medical students would be much more amenable to a principles
approach than to a feminist or a narrative ethics approach.

Swazey: When you say it’s a straw man, does that imply it’s not the dominant paradigm?

Marshall: I think that it still is the dominant paradigm, but there are a lot of other voices
demanding to be heard. I still get frustrated sometimes as a social scientist in
bioethics. I’ve chosen a career in biomedicine even though I’m involved in
anthropology nationally. I’ve always worked in a medical school or done research in
biomedicine, so I understand very clearly what it means to be at the margins
professionally or to be a “foreigner,” on someone else’s ground. I don’t have any
problems with that; if I did I wouldn’t have lasted, I wouldn’t be as happy as I am.
Basically I enjoy so much of what I do. So I’m comfortable with being in that
marginalized position. Ironically, in bioethics even after all these years I still feel
somewhat, not marginalized, but at the periphery because the dominant voices in
bioethics are philosophy, theology, law, and medicine. It’s only been recently that
social scientists or the talents that social scientists have to offer have been recognized,
that the gifts that our disciplines have to offer to bioethics have been recognized to
any extent. But in spite of this there is way in which they are not really understood. I
feel in some ways “ornamental” in bioethics in the same way that I feel “ornamental”
in biomedicine.
Messikomer: What are your thoughts on what seems to be so many bioethicists jumping on the ethnography band wagon.

Marshall: It’s not just bioethicists. I think there is a general trend now among many disciplines to embrace the ethnographic paradigm. My concern, of course, is that people might call themselves ethnographers when they don’t have a clue about what it means to ask a question, to do a in-depth interview, so the result is a level of superficiality that comes through even though people will claim this method. But they don’t have a sense about what it means to conduct ethnography. There is a way of asking questions and observing. There is a way you learn how to be attentive to what’s happening. I’m talking up a storm right here, but I know if I’m in your shoes I’m doing exactly what you’re doing. I have a callus on my finger because I do exactly what you do—if I’m taping I take notes. So I have serious concerns about people who are doing ethnography, who don’t have the training to do it or the understanding conceptually of how to use it as a tool, or how robust it is as a process. I have concerns about products that result from people who want to be hip and cool and do the “ethnographic thing.” But if it’s not done well it can be weak, superficial; someone didn’t take the questions far enough. In this case, the least that would happen is that you would get a superficial reading of something, but the worst that might happen is you might miss the whole point or misrepresent what was going on because of your inability to see the situation clearly.
It seems to us, talking to people in medical humanities and reading that literature and the overlap with bioethics, that there is huge confusion between narrative and ethnography. Which is very troublesome because they are not the same.

They are not the same at all. In my mind a narrative approach to ethics is one thing, and conducting an ethnographic study of a particular issue is working from a totally separate paradigm. There are certain things that each paradigm shares: an interest in the story itself, in what someone is saying to you about how this particular event has unfolded in their life. But conducting ethnography means much more than listening to someone’s story, it means more than bearing witness. It means observing, watching, looking at the full picture, hearing a story in the context of their broader life, placing that life in social and historical contexts, being attentive to structural issues institutionally, locally, nationally.

A related tendency that also bothers us is equating a clinical medical history with a narrative story. I mean, it may be part of a story but it has a separate methodology and objective.

That is one way to look at it, to view clinical medical history taking, as a story. Rita Charon is so important in this regard, and Bill Donnelly too. But again, the narrative method is its own method and it is a part of ethnography, but if you’re doing
ethnographic work in the field then that is a different thing. Some bioethicists are
teachable, others are not interested, they want to wear the cloak of that kind of
empirical approach that ethnography will bring to bioethics.

Messikomer: At the last ASBH meeting, the influence of social science I thought was felt very
strongly in who the keynoters were and what their topics happened to be. My
observation was is that they had one keynoter, David Hilfinger, who basically did this
piece on poverty and how his own transformation came about working at the Saint
Joseph’s House in Washington, D.C., and how poverty was really a critical issue for
bioethics. To me that really set the stage on the connection between poverty and
ethics, etc. Then we moved on to a board luncheon where Al Jonsen was the recipient
of the award. It was just amazing to me because his address basically was social
science content without any allusion to sociology and anthropology, from my point of
view.

Marshall: That’s right, I remember that. I agree you whole heartedly. I’m remembering that
now. For me, when that happens there is a way in which as an anthropologist I just
shake my head, and step back from it because I find myself getting defensive. You’re
going to claim our methods and now you’re claiming our rhetoric but you’re not
doing your homework, you’re not giving credit to this unbelievably rich tradition, this
incredibly rich literature that exists on poverty and health, for example, in sociology
and anthropology.

Swazey: They don’t know the literature. As you said yesterday, they’re talking the talk but they don’t know how to walk the walk.

Marshall: No, that’s one difference for the very few of us who are social scientists active in bioethics. I have to know it, or I don’t succeed. I need to know it so I can be effective in my research in ethics and anthropology, but no one has to read the stuff I read in sociology or anthropology.

Messikomer: On the cover of the program they had ASBH with these bubbles or balloons coming from each letter, indicating all the various disciplines and fields that are included. Interestingly enough social science wasn’t one of them. There was everything else in world....

Marshall: I didn’t even get that. I missed that.

Messikomer: They had nursing, clinical ethics, law, they had philosophy, and so on down the line, and empirical research, they even had that. Which is another little piece we would like to talk to you about. And finally, Dan Brock gave a talk....
Marshall: I was going to say that Dan Brock also gave a talk that was very social science.

Messikomer: I guess my comment to you after reviewing all of this, is that one of the things we have become aware of in looking at the meetings and talking to people and so forth, is who’s doing the writing about what. Maybe you can enlighten us further about this. It seems to us when bioethics invites in the subject matter and content of social science it comes in though the voice of a philosopher or a physician. In these cases this material was not presented by a social scientist. They were philosophers who were speaking something of a social science language and beating the drums, and that’s about it. We also were at the Belmont Revisited conference, and did some field notes on that conference as well. It struck us, for example, that for this whole business of communitarianism, flag is being laid by Zeke Emmanuel, and in his whole conceptualization of what “community” is there is never a reference to social science literature, and community is the basis of sociology. It’s almost as if social science concepts can be brought in but only if they are given legitimation by someone other than a social scientist.

Marshall: My experience of that is that it is very much analogous to what happens with social science in a medical context. The social sciences are laundered in a biomedical or bioethical detergent and it comes without being grounded in this rich history that exists in the social sciences for things like communitarianism. So for me it’s very
much an analogous experience. For me it goes back to what I was saying earlier
about recognizing my position as being on the periphery in both bioethics and in
medicine. Even though many of my bioethics friends will say, “What are you talking
about? You’ve been on the board here.” I had a interesting talk with Ruth Macklin,
who is also involved in international research ethics. She just wrote this book, in
which she sets me up as a straw woman. In one of the earlier chapters, she says, see,
Patty Marshall really does have “principles”, she really does have a view about what
“ought” to be done. Well of course I do in relation to a clinical setting. Anyway, I
was talking to Ruth in Geneva; we were both involved in helping to revise the
CIOMS guidelines for WHO, the international ethical guidelines for research. I was
talking about this notion of marginality or being on the periphery. Ruth said, “well
what are you talking about you’re not on the periphery; we all feel that way.” I said,
“Ruth, come on, you are not on the periphery, you are front and center. You have the
bioethics pedigree that sets you out front. I’m very much on the periphery. I have a
totally different tradition than you do.” The voice of social science for the most part
has been silenced until recently. Renée was writing about this stuff early on. You
and Renée wrote your paper on “Medical Morality” in 1984, Judith; you guys were
involved from the get go. But your voice was definitely marginalized. There are a
few of us now, people like Barbara Koenig at Stanford, Betty Levin in New York,
Kate Brown who is more involved in public health than in mainstream bioethics. I’d
say Barbara, Betty and I are among the ones really involved in bioethics. I’ve worked
in a medical humanities programs, I'm joining a bioethics center at Case Western Reserve University, Barbara has a center for biomedical ethics, so we are mainstream in that way. Yet what we bring to this field is something totally different. So when Ruth said, "Come on, we all feel on the periphery," I'm not buying that for a minute.

Swazey: Two comments. One, a lot of what Renée and I did in transplantation could be used as descriptive ethics, but it really hasn't been in bioethics even though people say they are classic works. Where we really haved turned people off in bioethics was with something like that "Medical Morality" paper, where we were looking at bioethics and its practitioners. As various people we have interviewed have said, that's been very threatening. That's a different type of social science.

Marshall: Absolutely. It's more in your face.

Swazey: Some of it is descriptive but it's about bioethics.

Marshall: Exactly, and that's where it is provocative. Thank god you all were writing about this stuff then in the mid-80's. Recently Barbara and I have written some stuff but I'm not sure how much of it gets read by bioethicists. I have to send you our piece on anthropology on bioethics. Sometimes I know that the older I get the more pragmatic I am about some of this stuff that gets played out and I just take it with a huge grain of
salt, like when people say I’m not on the periphery because I go to the meetings and I have a place at the table. I never for a second forget where my roots are.

Swazey: You are below the salt.

Marshall: Yes, and that’s not a bad thing. I will never forget where my roots are and where I grew up. There is no denying the Park Hill Drive that lives in me.

Swazey: It seems to me that as long as analytic philosophy is the king at the bioethics round table, it’s not going to really make room for social science. Because if your perspective is that your mode of analysis has to be purely rational, your only concerned will the *ought* not the *is*, and not the so-called non-rational things much less the a rational, why do you need the social sciences? You don’t.

Marshall: Not at that level of discussion. It doesn’t make any difference.

Swazey: I think that is where so much of bioethics has come from and still is, so we shouldn’t have expectations that talk about the importance of social science is much more than rhetoric.

Marshall: The way that I feel personally is that the best that I can do is to keep pushing my own
observations, or my own sense of things wherever I can, but I’m always prepared for
people not to able to listen to it. For example, I was asked to give talk on qualitative
research at an invited conference a few years ago. I pulled out my slides that I have
for my talk on qualitative research; I do both qualitative and quantitative. I gave my
talk, and I thought, these people here don’t give a shit about this stuff; they don’t care
about it, they’re not that interested in how it works specifically. They are going to
claim it, and in fact my piece was written up by someone other than me. I used to
take stuff like that personally, now I think, okay, where do I want to make a
difference? For example, with the international research ethics it’s very important to
me to help contextualize issues related to informed consent, in part to counter balance
the sort of heavy duty “oughtness” that comes through among certain philosophers. If
I can help ground policy issues, and this is a policy issue, federal regulations may
change, certainly the CIOMS guidelines will be changed. Helsinki is being revised
now. What’s important to me is the application of my paradigms in areas where I can
make a difference. If I find myself involved in a discussion or a setting where I
recognize I’m not being taken seriously, or my skills aren’t, when I’m like a second
class citizen, I let it go. I can’t win in that situation because I’m not an analytic
philosopher, I’m not an expert in that dialect.

Swazey: There are more younger people coming into the field that at least show signs of
appreciating social sciences. Are you in part working for that?
Marshall: Exactly. I'm definitely in that group where this was unchartered territory except for you and Renée. When I think of people writing in the 80's, no one else comes to mind who is a social scientist. It's you and Renée. I don't know of anybody else. Now I am more familiar with people like Chuck Bosk, Peter Conrad, Bob Sussman at Amherst, and some others.

Swazey: I think apart from people coming in with social science training, some of the people who are entering from other fields like law, medicine, nursing, are more aware that social sciences may have a role.

Marshall: I do think you're right. They are more sensitive about recognizing the importance of social science in their work and research. At the very least they are recognizing it. I wonder how much money issues have to do with it? If you're a social scientist you have the possibility of getting research grants. That might inadvertently be a factor that helps change the landscape of bioethics because bioethics programs may rely more on external funding. I hadn't thought of that before, this is just speculative. As resources begin to become more scarce in academic settings and simultaneously there is a broader recognition of the importance of social science, it seems to me that those two things can work together to reinforce the importance of a social science component in a bioethics program. It's beneficial. That's very cynical.
Swazey: No, it’s realistic. It’s the way the world turns. Your grant to study informed consent in Nigeria is a perfect example.

Marshall: It’s a classic example.

Messikomer: What is your understanding of what philosophers mean in bioethics when they say they are doing empirical research?

Marshall: I never know what they mean. Excellent question, because you know what, when someone says, “when I think of empirical research it’s the same understanding you all have.” As a social scientist, I think of the development of a protocol that lays out a research question that includes a strong background section, a statement of significance, a clear laying out of methods including a description of the sample if you’re involving human subjects. Clear objectives, clear methods, very specific goals that you attempt to achieve during a certain time period. When philosophers say “empirical research”, though I’m never exactly sure what they mean. I think what they mean is studying different types of theoretical positions, doing a lot of reading. Social scientist do that too; certainly we take a look at the literature. If a philosopher says empirical research it could mean they’re talking about an exploration of a philosophical topic or issue. It doesn’t necessarily mean collecting data.
Swazey: Was it Dan Callahan who just said to us that he really didn’t know what that meant either?

Messikomer: He didn’t know either. We have asked that question to a lot of philosophers because many philosophers claim to be doing it, but no one seems to know what empirical research by a philosopher means. Interestingly, we also have been speaking in our interviews about empirical research more generally. Those who have a conception of what empirical research is outside of its use by philosophers define it as quantitative only.

Marshall: Yes, and to me qualitative is so much more robust. I use both in my work, and to tell you the truth if I am doing a big investigation like for the informed consent the ELSI grant, that’s my favorite approach. I’ve got a big survey, first major survey of informed consent in international genetic epidemiological research. But if you look at the methods, I use about five different approaches, including qualitative approaches -- like doing direct observations of the consent discussion with a sub-sample of acceptors and refusers and setting up a network to have a discussion about these issues with investigators in Nigeria and Chicago. The survey for the study is something that a positivist -- someone who loves numbers -- will say “This is perfect. It’s great!” But then, it’s only going to get me so far. The real interesting piece will come from the qualitative methods that will help anchor those survey numbers, that
will help provide a real solid grounding.

Swazey: The best kind of research includes both.

Marshall: Yea, I think so. It’s a different study than the bioethics you are doing, which is actually a luxury right now to do this pure ethnographic work, that’s fabulous. The work I’m doing with informed consent I purposely wanted to use both quantitative and qualitative methods.

Swazey: You said a while ago you thought of yourself as a medical anthropologist, not a bioethicist.

Marshall: I do. I will often say, “I’m a medical anthropologist and I work in the area of bioethics.” Rarely will I say that I’m an ethicist. I will for the sake of simplicity in certain situations if I feel people need to hear that from me just as a handle on whatever I’m doing; it’s easier to understand. But you don’t often hear me say I’m a bioethicist. What I say is, I’m an anthropologist... this is who I am, this is what you get. You get an anthropologist if you walk through my door.

Swazey: How would characterize bioethics? Do you think it’s a field or discipline, as one cut?
Marshall: I think of bioethics as a field. I guess I’ve never thought about that before, precisely.

But I think of it as the study of the relationship between morality and biomedicine at the broadest levels and at very particular levels. People who do bioethics or who are interested in bioethics want to understand more about how our beliefs and values inform.... Well, here you see I’m speaking as anthropologist.

Swazey: You certainly started to. That’s alright though, that’s fair because that’s what you are.

Marshall: For me, if you are doing bioethics you are interested in the relationship between values and beliefs and they way in which these inform ethical practices in medicine and healing. For me, it’s not just what happens at a clinic, it’s how we think about being ill, being well, how we think about accessing health care systems of all kinds, it’s about meaning. Bioethics is about the meaning of morality in health and illness behavior. How’s that for a meandering way of getting around it? That’s a very anthropological take. For me, it’s much more about describing a system of beliefs.

Swazey: It’s more descriptive than pre-criptive.

Marshall: Yes, but to certain extent maybe it’s looking at the way in which our social practices are prescribed by our beliefs concerning what ought to be done in specific medical contexts. Does that make sense?
Swazey: From our biased perspective it does.

Marshall: It's very social science.

Swazey: That's who you are.


Messikomer: To the core. We are very appreciative of that.

Swazey: Talk some about bioethics and medical humanities.

Marshall: That's very interesting to me....

Swazey: You're in a medical humanities program. Is that because Loyola happened to have one?

Marshall: David Thomasma started that program back in 1981. I've been there for about twelve years now. When I think of medical humanities, I think of people, some of whom may be philosophers, some of whom may be historians, or have expertise in the area of literature and medicine. It's more about the art of healing, less about prescriptive
rational analytic paradigms and philosophy. Less about a principled approach to understanding moral dilemmas and clinical care and more about an appreciation for the broader grounding of what it means to be a human and face challenges in health and illness. I’ve done medical humanities for so long, again as a social scientst. I am not a Kathrlyn Hunter, or a Ron Carson. I have my own take on it. I’m different there.

Swazey: Is philosophy a part of medical humanities?

Marshall: I do think philosophy is a part. It does have role to play, but maybe that’s based on my own experience. In our program in Loyola we’ve offered seminars up to about thirty at our high point; it’s fewer now. In our humanities seminars we cover a range of topics, including ethical issues, end-of-life decision making; those are very humanistic classes.

Swazey: I ask because one of the divides we’ve seen is that most people in the medical humanities see it as a big umbrella that includes history, social science, literature, philosophy. But a lot of the philosopher-bioethicists don’t see philosophy as part of medical humanities. “Humanities is over there and I don’t want any part of it.”

Marshall: Someone like Ruth may be in that framework and yet she would be very
appreciative of humanistic concerns. For me, I think of it in a more inclusive way because of my own experience, teaching humanities in a medical school context. But over the years there has been this disciplinary divide, and I’m not sure there’s a way around it though we can try to bridge it in our organization.

Swazey: How do you think ABSH is fairing, because I don’t think you can take it for granted that it is going to be a happy marriage necessarily.

Marshall: I don’t think anyone has ever taken it for granted, so there is this huge sensivity about pluralism within the Society. If you remember, when the three groups were rolled into one they decided on a very precise way to have each group represented, so that three from each group were appointed to the founding board of ASBH. There were all of these formulations and great sensivity as to how these issues were represented in the program. There is a lot more sensivity about this issue than there is about social science.

Swazey: I know several people last year were telling me they weren’t happy because the phone at central headquarters tended to be answered “American Society for Bioethics.”

Marshall: That’s exactly the kind of thing....The bioethicists have the dominant hand, they’re the big ones here. The humanities are afraid of not being taken seriously, having a
diminished voice.

Swazey: Your bench may get crowded.

Marshall: It will and I’ll just keep on doing my thing. But yes, it’s problematic in bioethics.

There are many people, like if you talk to Kathryn Hunter, she wouldn’t call herself a bioethicist; I don’t think she would. When Kathryn and I have talked about what we bring to bioethics and humanities we both recognize that we have this world that we live in that to a certain extent that may or may not have much to do with ethics. Her training is in literature; she can write critically about Virginia Woolf; she identifies herself as someone with expertise in literature. Both of us are really comfortable about being clear about those traditions (our professional expertise). This is going to be a problem in the future, I think. It’s been a problem historically and will continue to be. I’m not sure what the implications of that will be for humanities programs or bioethics programs.

At Loyola, we’ve got someone who has been appointed to our program. He’s a Jesuit priest, who knows very little about the medical humanities. He’s not a card carrying member of our organizations. When the new director of our institute was hired, our institute for ethics and health policy, who happens to be a philosopher, he was asking me about our humanities curriculum. I said, “Do you mean in the process of recruiting you, you were never shown any of our program guides from over
the years that show our curriculum?” No, he was not! I could feel the sense of incredible irritation; it was one of those moments when you're just filled with rage at a system. Most of the time I just take it for granted; it's like I work for a family business, work for the Jesuits, and I don't have any illusions about where the medical humanities fit in this family business. I definitely feel ornamental within that administrative context even though I have had a lot of freedom to do what I want to do. But in this case, here is a philosopher who is coming on board and was not given any of our program guides that lay out all of our requirements. Why wasn't he given it? Well, David took himself off of the search committee when he applied for the job, so we didn't have representation. The philosopher being recruited wasn't given the program guide because it was not something that was valued by the committee. Here I am as a social scientist but you could put me anywhere now and I could start a medical humanities program. This is what I do, this is my life. Most anthropologists don't know anything about that piece of what I do. But I fill a unique niche. So I'm a medical humanist who happens to be an anthropologist when I teach my class, for example, on social justice issues in relation to HIV prevention and drug use. The way the students learn about moral issues is very much informed by who I am as an anthropologist.

Messikomer: Could you give us a little information on the Society for Medical Anthropology and Bioethics Committee and the Bioethics and Anthropology Newsletter, just to give
us some background.

Marshall: Actually, I started the bioethics interest group along with Barbara Koenig and Betty Levin. The three of us decided to form that interest group back in 1989; we all were involved in humanities and doing research on ethical issues in different aspects of health care. Barbara, for example, was very interested in end-of-life stuff; I was the assistant director of the medical humanities program and my research projects were ethics oriented. The same with Betty. So in 1989 we were sitting around a lunch table, at one the anthropology annual meetings and made the decision to form an interest group with a newsletter. I agreed to take the lead on that. I published a number of newsletters and we created a list of people who we thought might be interested. We came up with about 130 names. In the beginning it came out twice a year; I can’t remember how many were produced. Now the three of us have backed off the leadership positions in the interest group. What’s nice is that there is a younger generation coming up; just like you were saying earlier, Judith, there are more people coming from the social sciences who have an interest in bioethics and medicine. We’ve got this dynamo young women, Elisa Gordon, who is actually interviewing for my job at Loyola. She has really taken the lead and done a great job. She and several others are organizing panels, and so forth. The interest group is still relatively small because there aren’t that many anthropologists who are involved in bioethics, but it’s been around for a solid ten years. There has been consistent
representation of ethics panels on programs at annual meetings, panels addressing
issues related to culture and ethics. Barbara, Betty and I have organized many of
those sessions but now other people are organizing them, which is a good thing.
There are a few regulars, just like there would be in sociology, the usual list of
suspects. My own work is very much public health oriented. I get so many offers to
give presentations; they kept trying to draw me into public health, but I was already
attending the annual anthropology meeting and then the Society for Applied
Anthropology because what I do is very much applied, so I have been involved in that
organization, the Society of Bioethics Consultation, the Society for Health and
Human Values.

Swazey: You can spend your whole life going to meetings.

Marshall: Exactly, so I resisted getting real involved in public health but I feel like we have
representation there because Betty Levin and Kate Brown have been much more
present, and that makes me feel good. We get to share some of the burden of being
the token anthropologist.

Swazey: Why would you hypothesize that sociology, to my knowledge, doesn’t have a
comparable formal group in bioethics?
Marshall: Ours is a formal group, but you have to understand it’s an informal one in the sense that it’s a small number of people.

Swazey: But I think to the extent that social sciences have infiltrated bioethics at all, it’s come much more from anthropology.

Marshall: Do you think that’s true? Because I’m thinking of people like Chuck Bosk for sure, and Bob Sussman wrote that book on intensive care...

Messikomer: Yes, but Chuck hasn’t been involved in it that long.

Swazey: It’s fewer and much more recently. My sense is that sociology is not in good shape as a discipline. I think there are problems on the sociology side as well as the bioethics side.

Marshall: Who the heck needs an anthropologist? I always worry if one of my nieces or nephews say that they are interested in anthropology. They look at me and say, “Aunt Patty has this romantic life, she’s off in India and Nigeria.” I’ve been very fortunate, and I’ve never taught in an anthropology program although this is who I am. I always think well, maybe my nieces or nephews can do it as an avocation. Why don’t you be a doctor or lawyer or do something where you can help people and make an actual
living? I’ve done very well, but I’m so unusual. Partly there has been this representation of anthropologists in bioethics because of the nature of our work and because of people who we came into contact with. For example, if you look at my case, I happened into bioethics, I stumbled into it. I was being my regular self from Park Hill Drive, and needed extra money to take a trip, so I took that job to make money, not because of it’s substance. In Barbara’s case, she was associated with Al Jonsen, she happened to know him as a gradstudent. Then Margaret Clark, another anthropologist who’s older than us, she’s more in the generation of my mentor, Margaret had an interest in bioethics. It was another Al Jonsen connection, and Bette Criger at the Hasting Center has training in anthropology. I’m not sure how Kate Brown got into bioethics; the man she lived with for years was involved in bioethics. Partly it’s a personal connection. None of us were introduced systematically, none of us took a class in bioethics. But we all decided, like when Betty, Barbara and I made the decision to form the interest group, that this was an area of importance for medical anthropologists; the philosophers and other people who called themselves bioethicists were missing a crucial dimension of the moral experience of health and illness. They just didn’t have enough exposure to a cultural perspective or a social perspective beyond what you all did in the 80’s. For us, looking through the literature, there weren’t a lot of places to go to where we could read things that would resonate with our sensibilities as cultural anthropologists, medical anthropologists. When we would read your work, what you and Renée had written together, it was like “Yea, this is
terrific! Where else can we go for it?” And there was no other place to go for it. The other thing is we are all definitely medical anthropologists so we are all interested in contemporary issues in medicine, policy issues, definition of death, organ transplantation, neonatal issues. We were encountering ethical dilemmas all over the place. For us, our understanding of these issues was always filtered through this cultural paradigm, always. In our discussions with our philosopher friends or bioethicists-physicians we would share a concern, but the training we would bring to it would lead us in different directions.

Messikomer: Can you talk to us a little bit about your views of the ongoing professionalization of bioethics in the development of masters program and the new push in some places for PhD programs.

Marshall: With the masters program in bioethics I think it is probably going to be important for someone to have another terminal degree and use the masters as an additional component in their training. You might have someone who is a nurse, physician, or lawyer who wants to become much familiar more with the issues and theories in bioethics.

Swazey: Basically not for just out of college?
Marshall: I don’t know that that would be the wise thing to do. I see it as a good thing to have in addition to what you already have training in, just in terms of thinking of getting a job. As for a PhD in bioethicist, I think something like Stuart has planned to develop, a doctoral program at Case Western Reserve University that hopefully will focus on empirical research, to me is a good thing.

Swazey: That’s one of the question we posed to Tom Murray and Stuart, and other places that are now saying we want to start a PhD program if we can jump through the university hoop. One of the questions then becomes, as a field or as a discipline, what is the methodology you’re going to train people in for a PhD in bioethics, as opposed to getting a PhD in philosophy or another discipline with a concentration in bioethics.

Marshall: When I imagine what I’ll be doing when I go to Case -- I’m going to ground this very concretely in my own expectation of what I’ll be doing should a PhD program be developed there -- I expect to be training people in empirical methods in qualitative and quantitative research that they can apply in the study of ethical issues in biomedicine, ethical issues in problems related to health and illness. I anticipate that the classes students would take would include a substantial amount of training in philosophy. Because Stuart will have me on board and others with research training, the students are going to have some social science. The mentality that Stuart has, and the people he is bringing on board, means that the program will be multi-disciplinary.
Swazey: Someone at another university, who also is thinking of a PhD program, said to me recently that their students will need grounding in medicine, social science, philosophy, some law, and economics. And my question was, how long is it going to take them to get a PhD, and how much competency can they get in everything in you’ve just reeled off?

Marshall: I don’t think that they need to be trained in medicine.

Swazey: Well, not an MD but they need to get some knowledge of the world that they are going to be working in.

Marshall: I think it’s possible to do that without sitting in on a class with first or third year med students.

Swazey: I agree. I think you can apprentice yourself, but you still need to get some exposure. So what would you see as these people coming out of the Case program?

Marshall: I see the people coming out of Case as empirical specialists. People who have the expertise to conduct empirical research on issues relevant to policy and practice in medicine. But I don’t think they need to be economists, or lawyers. If I do an ethics consult, I know what some of the laws are in Illinois. I’m not a lawyer, but I know
who I need to call to find out the answers to questions. The people coming out of
Case, for example, I think will end up working at research institutes or in academic
institutes conducting research, writing, developing policy, or working for the
government at the local or national level. At Case, the push is going to be not on
someone who just understands bioethics as a field, but someone who has empirical
skills, someone who can apply for grants and develop research projects. I really see
them as empirically trained.

Swazey: It’s going to be fascinating to see how that all plays out.

Marshall: I think it’s going to be an adventure. I’m not sure how it’s going to play out because I
still struggle with this issue of disciplinary background; it’s analogous to being a
family practitioner. How much can one person know? I think it will be extremely
helpful for the students coming out of Case Western Reserve to be able to conduct an
empirical investigation. That is going to be a good thing because the more people
who are really trained to do research in bioethics, that can only help us.

Swazey: Well, it’s going to be a chance for you to do literal participant observation.

Marshall: Yea, and I don’t know how it’s going to go. I was talking to Bill Stubing about it a
few weeks ago. He has some serious concerns about the masters programs, and we
also were talking about the PhD program, which he also has reservations about. I’m glad that I can say unqualifiedly that I am an anthropologist. What this PhD in bioethics person will look like, I’m less clear about that. I don’t have a clear vision. I know when the issue of certification has come up for ethics consultants, similar concerns have been raised about disciplinary backgrounds. In my own case, I’d have to be someone grandmothered in because I certainly don’t have the training, I have the experience... a lot of experience.

Swazey: Let me touch on that SBC Report on competency. One thing that struck us reading the Task Force Report is that if you took it seriously, someone would have to be at school for approximately two lifetimes and a true Renaissance scholar. It was almost laughable....

Marshall: I couldn’t do it.

Swazey: Nobody could. Who could say they have all those competencies, if you were really going to have licensure of some sort and that’s what you had to have to be competent?

I think Stuart said it was a compromise over being exhausted, then giving up the licensure/certification John Fletcher push.

Marshall: I don’t know about licensure. What I hope is that for all of us we are fortunate enough
to have good people around us when we are faced with terrible circumstances and crises in hospitals. When I’ve done consults, I’ve worked closely with different types of people, philosophers, physicians, ethicists, social workers, and I know I bring my own disciplinary background to the problem when I conduct an ethics consult. I probably take much more time, I know I do, than a our physician-ethicist. I know I’ll do things someone else might not do. A women dying of AIDS arrived on a door step, homeless, without any contacts, with burns on her lower extrimities. I asked the doctor to let me know when it seemed as if she was dying so I could be there with her, because I couldn’t imagine her dying alone. That is not a requirement of being an ethics consultant, it’s just being who I am. I made sure that one of the priests was there too, this wonderful Irish man, who is in his seventies. I’ve told him he can’t die, he’s got to wait until I die because he needs to be with me when I die. We stayed with her, sang to her, prayed with her, held her.

Swazey: That has nothing to do with ethics consultation; that’s pastoral care and being a human being.

Marshall: Exactly. That same week there was another consult, when a doctor tried to get rid of a patient. They wanted her off their service because, bless her heart, she was being noncompliant with her medicines. Nonadherent. I showed up there about 7 one night. This was an African American patient. I introduced myself, and I said, “I
understand there is a problem here” and she said, “What problem, there’s no
problem.” I said, “Did your doctor tell you that you were making him crazy because
your not taking your medicine.” But she said, “Well, I am taking my medicine.” She
was, in her own way, taking her medicine, I found out from talking to her. They had
said she was kind of slow; well, this woman did not seem slow to me. I’d asked for
the report of the neurological assessment, it said maybe she couldn’t read that well,
maybe second grade school level, etc. She said she really didn’t like that doctor who
ordered the test very much at all. I said did he tell you what the results of his tests
were? This makes me crazy because I’m getting one message here from the doctors
and charts, saying this person is slow, noncompliant, one picture is being painted, and
I’m talking to a woman who paints a totally different picture and doesn’t seem
developmentally slow. It turns out she didn’t have her glasses; she was taking tests
and didn’t have her glasses on. So of course the doctor is getting a skewed reading on
her. I said, “Did you tell the doctor that you didn’t have your glasses?” She says,
“No, why should I, he didn’t ask, anyway I didn’t like him.” Like this is a matter of
resistance. That’s my take on it, this is partly a dynamic about power, resistance and
control...

Messikomer: She exercised her’s in her own way with the tools she had. She used them wisely.

Swazey: That particular case illustrates a lot of what we see in what is now called bioethics
clinical consultation. There are roles that used to be performed by liaison psychiatry when that existed, pastoral care, good social workers, and by good nurses. The thought that you need an ethicist is interesting.

Marshall: I do think that I do have a different orientation to it, because I'm not sure someone like David, a philosopher, would have walked down that road about the glasses or said “Did you know that you were making your doctor crazy because you weren’t taking your medicine?” I think my approach is very much informed by my training to do interviews, talking to people, and how I engage people. It’s just who I am.

Messikomer: Certainly the kind of work you do helps you in that regard in terms of how you frame the question and how you talk to a person. But part of it is Patty Marshall. If we were to just plunk you down into the hospital whether, you had been in medical anthropology forever, my guess is you would have gotten similar information from her.

Marshall: I think you’re right. In regard to licensure I couldn’t meet the requirements now because part of what I do is just who I am. I learned from different people and I have my own articulation of it, and I think most people do.

Swazey: I think, flipping it around, the question I would ask is, does licensure make any
sense in terms of what might come out of the more philosophical ethicist? What are you going to license people for? I think it’s good that it’s been buried for now.

Marshall: I don’t feel strongly about the need for licensure. I do feel strongly about the need for advocacy for vulnerable people, and patients are incredibly vulnerable. I think there is an incredible need for good mentors at every level for our medical students, nursing students, philosophy students, social science students. I think we all need good teachers in order to have a more compassionate world. In whatever world we are operating in, good teachers make a difference, good role models make a difference. I feel that way in relation to my staff. How can I make a difference today in my world? The leadership qualities that I have my staff gets from me just from watching me.

Even that day I went over to be with the woman who was dying, all my staff knew that was taking place. That’s a good thing; it’s a way of walking the talk that is important. Maybe I’ll get lucky and somebody will be with me when I die. Maybe I’ll have the good fortune to have a good death. I feel like those sorts of practices in an everyday kind of way are so valuable in terms of what they say about the things that I think are important. But can you teach that? I don’t know.

Swazey: Well, you can help bring it out of people who have it in them. It’s like field work, you can’t teach someone to be a field worker who has absolutely no aptitude but they can learn a lot by working with a good field work teacher.
Marshall: I don’t know. I just know I’m sort of different. I don’t fit a mold for a bioethicist at all and never will. But it’s part of my world absolutely. This summer I’m working on a book in bioethics and anthropology for Cambridge University Press. I’m doing it with Barbara Koenig. I was asked to do it and then agreed to do it but only if I do it with Barbara, because she and I have written on this.

Messikomer: What do you see as the major issues or topics that bioethics should be addressing that it is currently not addressing?

Marshall: I think structural issues related to poverty and health are absolutely crucial for all of us to address because of their implications for community health, individual health, the health of our nation and so on. Again, as an anthropologist, we as bioethicists need to pay more attention to the cultural grounding of health care problems. Pay a lot more attention to the kind of assumptions we make about health care systems, the application of health care technology. You don’t need to look very far for examples: the whole genomics experience, organ transplantation and tissue replacement therapies and so on. I think we need to be a lot more reflective in our thinking about the assumptions we make about the appropriateness of some of these technologies and the way in which we push ahead without necessarily thinking about the consequences. You talked about this in *Spare Parts*; we have this appetite for human organs and I don’t think that is going to change. I’ve interviewed people in India who
sold their kidney. That’s not going to stop. There is a market out there and it will only increase. There is a need for it, there is technology to do it, and a group of consumers willing to pay for it and a group of people willing to participate in making it happen. We need to be much more critical about the assumptions we bring to the table and the issue of poverty and health is crucial. Every statement about ethics ought to include a dimension that addresses social justice issues. I’m basically a do-gooder. The issue of autonomy—for me it’s yea, yea, talk about autonomy and the ability of someone to make a decision, well don’t even walk down that road with me without saying, “Okay so what are we assuming here?” That someone here has the ability to make the decision, thinks that they can engage in a conversation that’s open and frank about issues related to end-of-life care or in a research project that is going on. Someone is not compromised by their gender or age, their emotional or cognitive development, their place in the village or household. We have a notion of an ideal patient in the same way I think we have a notion of an ideal of research participant, and for me that notion of autonomy, that experience is always anchored in the reality of social life. Most of us attribute incredible power to a physician. Regardless of all the rhetoric of patients rights, patient involvement in decision-making, we are not physicians. In most cases we are vulnerable because we are physically compromised. We are not doctors so we are dependent and vulnerable to a certain extent. The notion of trust and beneficence that David Thomasma and Ed Pellegrino talked about resonates in a much more real way with what actually happens. For me, autonomy is
absolutely anchored in a social reality, and that social reality always has a overlay of social justice issues. There are compromises. Power is negotiable and issues of power are present in every single...

Messikomer: .....Human interaction. No matter what the setting, whether it’s medical or in the street or friendship or anything.

Marshall: Exactly. I don’t know if that’s helpful, but those are the kinds of really broad general concerns. Obviously the whole genomic experiment is going to be right on the table, the development of artificial tissue replacement therapies, and all of that. Our medical world is going to change incredibly. And simultaneously we still are facing, globally, problems like malaria; TB is on an increase; HIV is devastating Africa, so we have all these infectious diseases. Those are in some cases so related to structural issues, issues of politics, economics, poverty.

Swazey: I’ve been impressed for so long that the things we focus on in bioethics in this country are the luxuries of an advanced, economically privileged society, when you look at issues for the rest of the world when it comes to health care.

Marshall: It’s so true. We have been fairly limited in our focus.
Swazey: Anything else?

Messikomer: I think that’s it. Thank you so very much.

END OF INTERVIEW