Ethically Engaged
Unraveling healthcare’s knottiest problems

Doing what’s right isn’t the problem. It is knowing what’s right.
—Lyndon Baines Johnson

Emory’s vision statement declares that Emory is an ethically engaged university. This bold assertion is in keeping with higher education’s lofty ideals, and it also reads well. But does Emory walk the walk? Certainly well enough to have attracted a nationally recognized bioethicist to head up the Center for Ethics, whose spacious new digs in the new Candler School of Theology building opened in September.

“I had to be convinced that it wasn’t lip service,” says Paul Root Wolpe, the center’s new director. “It’s very easy to create a vision statement and put the word ‘ethics’ in there. It’s much harder to express that through a university’s actions. I was convinced before I came, and it has been validated in the month and a half I’ve been here that in fact Emory takes the question very seriously.”

The center’s highly visible and geographically central location on campus bespeaks the centrality of ethics in Emory’s culture, as do the very broad, public programs such as the Office of University-Community Partnerships, Volunteer Emory, and the Ethics and Servant Leadership program. But perhaps nowhere does ethical engagement have a more urgent, pragmatic, and personal impact than in the corridors of Emory’s hospital system. Hospital ethics committees have become commonplace and convene to sort out knotty problems. Much more unusual, though, is the on-call, pager-carrying hospital ethics consultant.

“If a family member, patient, physician, or nurse feels awkward about the ethics of a biomedical...
situation, they will call me for a consult, and I will help them look at it from an ethics viewpoint and guide them to a decision,” says Elwood Spackman, Jr., the clinical ethicist for Emory and Wesley Woods hospitals and executive director of Emory’s Center for Pastoral Services. “The most common dilemma we encounter is the appropriateness of withholding or stopping treatment and moving from curative toward palliative care when attempts at a cure become futile.” Often patients cannot speak for themselves, leaving Spackman to mediate between family members and the healthcare team to reach an ethically supportable decision. That might mean helping a family understand why it is ethically permissible to withdraw life support.

“On one side you’ll have the family saying, ‘do something,’ and on the other the medical team saying there’s nothing more to be done that can save the patient’s life,” says William Sexson, Spackman’s counterpart at Grady Hospital. “Sometimes it’s a matter of making sure that family members understand what clinicians are telling them, so that a decision can be made based on clear information.” Sexson, a practicing neonatologist, estimates that 180 to 200 formal ethics consults occur at Grady every year. This is ethics in the trenches, where the types of cases debated in a lecture hall play out for real, and where the goal is not just to find the right solution, but to identify the best right solution.

**MINISTRY OR MEDICINE?**

As ethicists, Spackman, a Methodist minister, and Sexson, a physician, face the same issues, but they approach them from decidedly different backgrounds. Does that matter?

“Dr. Sexson and I often look at things out of the same set of values, but the lens I look through has more of a theological bent,” says Spackman. “I have to rely on

**Researcher’s alleged transgressions lead to more ethics oversight**

In early October, the *New York Times* reported that according to Congressional investigators, Charles Nemero, prominent Emory psychiatrist and researcher, had earned more than $2.8 million in consulting fees from drug companies from 2000 to 2007 but failed to report at least $1.2 million to Emory and violated federal research rules. Nemero has also been accused of not disclosing to Emory approximately $500,000 he received from drug maker GlaxoSmithKline while heading a government-funded research project studying Glaxo drugs. According to the investigators, Emory had reportedly instructed Nemero to accept no more than $10,000—the university’s conflicts threshold—but that he far exceeded that amount. The National Institutes of Health subsequently froze $9.3 million in funds for a study on depression led by Nemero and instituted tighter rules on its funding approvals for Emory.

Nemero has denied any wrongdoing and stepped down as chairman of the psychiatry department while Emory conducts its own internal investigation.

In a statement issued on October 8, Emory officials said that they “take this matter very seriously and are working diligently to determine whether our policies have been observed consistently with regard to the matters cited by Senator [Charles] Grassley,” whose office led the investigation. And on October 10, David Wyne, vice president for research administration, sent a letter to the Emory research community announcing that Emory had instituted more stringent disclosure requirements for research funded by the NIH.

In a statement in the October 12 *Atlanta Journal Constitution*, Emory president James Wagner vowed the school’s full cooperation with the Senate probe and stressed that Nemero deserves a full and fair review of the facts before conclusions are drawn. “It would be improper to judge Dr. Nemero guilty of anything based on allegations alone. So while we must move with deliberate speed in getting to the truth, we will not proceed with irresponsible haste,” he said. Wagner added that it is essential “to manage properly any conflicts of interest that might jeopardize the scientific validity of the results of collaborations between private industry and the academy” (full text at www.emory.edu/home/news/releases/2008/10/Wagner-Statement-on-Senate-research-investigation.html).

On October 14, Emory announced the formation of a university-wide central office to oversee administration and enforcement of conflict of interest policies. The new office will report to Wyne. Further, on November 3, Wagner appointed the President’s Advisory Commission on Research Integrity and Professional Conflict Management to review policies and practices on conflicts of interest. Ethics center director Paul Wolpe is chairing the panel.

This is not the first time that Nemero’s relationship with industry has raised concerns. In a fourteen-page letter dated June 24, 2004, Claudia Adkison, executive associate dean for administration and faculty affairs at the medical school, warned Nemeroff to rectify substantial conflicts of interest the medical school had identified. In August 2006, Nemeroff resigned as editor of the journal *Neuropsychopharmacology* after he failed to disclose financial ties to a medical company whose device he had endorsed in the journal.

To read the Academic Exchange’s past coverage of conflict-of-interest issues, visit “Drugs and Money: Pharmaceutical companies, academic medicine, and the flow of funds and favors” (February/March 2007) at www.emory.edu/ACAD_EXCHANGE/2007/febmar/lead.html.
the physicians who are caring for the patient to get a clear medical picture and learn about issues of futility, for instance. I bring to the table the values of life, hope, and reality—that death is not the ultimate defeat—which is very helpful to families, who tend to trust clergy and appreciate a framing out of the emotional dilemma they find themselves in.” At times another chaplain accompanies him to an ethics consult to assume the role of nurturer, allowing Spackman to maintain a more detached, professional distance—to “be more in my head” and operate from objective clarity.

Sекссон, who underwent ethics training well after he began practicing medicine, recognizes that his training as a scientist may influence the weight he ascribes to the various factors in a particular case. “Physicians,” he says, “naturally predicate their decisions on statistics and empirical evidence: what’s going to have the greatest probability of working. When patients or loved ones make difficult decisions, those decisions are frequently based on emotion and are often faith-based. Many people don’t want or need statistics and evidence in making tough decisions.” Medical ethicists, he adds, must understand a decision-making process that may not rely on rational or logical processes. But neither Spackman nor Sекссон believe one foundation—science versus faith—is stronger than another for an ethicist, as long as fundamental principles are applied judiciously and equitably (those being autonomy, beneficence, nonmaleficence, and justice).

“The goal is always to bring people to some agreement and realization of what their ethical values are, not to impose [the ethicist’s] own ethical values,” comments Волпе. “An ethicist is not there to tell people what’s right and what’s wrong,” and an ethicist wedded to the doctrine of a particular faith conceivably runs the risk of doing just that. “In a pluralistic society, where people have very different kinds of moral perspectives they make decisions from, it is in fact immoral to impose one’s perspective on other people unless they are violating fundamental moral principles.”

**SAFEGUARDING INFORMED CONSENT**

Even rarer than the staff clinical ethicist is the staff research ethicist. “I’m asked to do research that ultimately improves research, and there may be only ten of us in the country,” says Rebecca Pentz, professor of research ethics at the Winship Cancer Institute. “It’s a very odd position.” Research involving cancer patients is fraught with ethical knots requiring great circumspection, because the stakes are so high. For instance, Phase I drug trials are designed to assess only an experimental drug’s safety, not its efficacy, and in a Phase I cancer drug trial, all of the subjects must have no curative treatment options; they will not benefit from the new drug at all.

“We can’t test cancer drugs for safety in healthy volunteers because the drugs are hugely toxic, so we have to use cancer patients, who are very vulnerable,” says Pentz. And it would be unethical to test them on cancer patients whose disease might be cured with available treatments. “Yet these often terminally ill patients still choose to enroll in a research study rather than receive palliative care that could make them more comfortable.”

In one aspect of her work, Pentz wants to determine whether such subjects fully understood that some of the procedures in a particular clinical trial are for research purposes and will not benefit the patient. “My hunch is that they really don’t all the time and assume that if their doctor asked them to do it, it’s in order to help their care, even though it’s not,” she explains. “The patients we want on these studies are those that do understand and just want to go out fighting.”

In her experience as both a research and clinical ethicist, Pentz has found that many patients harbor therapeutic misconceptions (particularly about non-therapeutic procedures such as a biopsy), believing mistakenly that any intervention being conducted is meant to help them directly, even after they’ve been told otherwise and subsequently provided their informed consent.

Informed consent is a bedrock ethical principle in human subject research. It provides that a person with adequate reasoning understands and voluntarily agrees to participate in a medical trial (or to receive medical treatment, for that matter). Safeguarding informed consent falls to an organization’s institutional review board (IRB), whose raison d’être is to protect human research subjects.

But by acting as a de facto judge of ethics, the IRB inadvertently removes the impetus for researchers to look intensely at the ethical aspects of their study design and relegates ethics to a bureaucratic hurdle, says Karama Neal, adjunct associate professor of biology. She tries to dispel the “all I need to do is get IRB approval” thinking in the two-day seminar on research ethics she teaches to post-doctoral and graduate students in the sciences. “They conflate ethics with regulations, and they often have the attitude that as long as they comply with the rules, whatever they’re doing is ethical,” says Neal. “It can be a challenge to get [students] to move from ‘tell me what I need to do so I don’t get in trouble’ to really thinking about the best way for them to behave.”

Regina Pyke, senior lecturer in psychology, agrees, noting that an unintended consequence of universal institutional review is that researchers may shift ethical responsibility to the IRB and feel comfortable that their research is ethically benign because they’ve met the regulatory criteria. Thus, an IRB provides essential vigilance and oversight, but it may

Continued on page 11
Is it reasonable for [a patient] to be able to demand everything be done regardless of what that does to the healthcare system financially, or to its ability to serve a wider population?

— ELWOOD SPACKMAN JR., EXECUTIVE DIRECTOR, EMMORY CENTER FOR PASTORAL SERVICES, CLINICAL ETHICIST, AND CO-CHAIR OF THE ETHICS COMMITTEE, EMMORY HOSPITAL AND WESLEY WOODS HOSPITAL

Academic Exchange: Describe your responsibilities as a clinical ethicist.
Elwood Spackman Jr.: If a family member, patient, physician, nurse, or other person in the hospital feels awkward about the ethics of a biomedical situation, they’ll call me and I’ll help them look at it from an ethics viewpoint and guide them to a decision, often a difficult one, especially around end-of-life issues. I often recommend family meetings where we bring the healthcare professionals and families together, which I moderate. The most common dilemma we encounter is the appropriateness of withdrawing treatment and moving toward palliative care when attempts at a cure become futile. We also run into ethical issues when a person can’t make their own decisions and there are no surrogates available to make them. Then we’re faced with the ethics of providing or not providing treatment.

Another major issue is the use of scarce resources, whether it’s blood products, expensive medications, or even the allocation of hospital beds, which is more a business ethics issue but which has bioethical implications.

AE: What specific ethical dilemmas have been memorable?
ES: A few years ago Emory had to decide whether to disclose that a number of surgical patients were possibly exposed to Creutzfeld-Jakob disease, though the chances were extremely low. We decided to do, in my opinion, the right thing and to make the disclosure, even though it might have brought on some negative views of the hospital. In another case we dealt with the appropriateness of withdrawing treatment and moving toward palliative care when attempts at a cure become futile.

I don’t think the main role of the ethicist is to tell people what’s right and wrong. One who does that in my opinion abdicates one’s responsibility.

— PAUL ROOT WOLPE, DIRECTOR, CENTER FOR ETHICS

Academic Exchange: How does Emory’s Center for Ethics differ from others across the country?
Paul Root Wolpe: The field of bioethics is very hot right now, and there are bioethics centers springing up all over the country. What’s different about Emory’s center is that it isn’t a bioethics center; it’s a general ethics center whose mandate is not only to concentrate on medical ethics but to think about ethics as broadly as possible. So it covers everything from social welfare ethics, environmental ethics, even creativity in the arts—whatever field we can think about in terms of the ethics of behavior and the ethics of social communication. That’s fairly unusual. There may be one or two others in the country. Thinking of things from an ethical perspective is very much ingrained in the DNA of the university. That’s reflected in our resources and the seriousness with which the administration takes the ethics center.

AE: What’s the role of the clinical ethicist?
PRW: One role is to facilitate communication and to help people elicit their own values, because an ethicist has much greater knowledge of the way these decisions have been made in the past, or at least the principles by which they’ve been made in the past. I don’t think the main role of the ethicist is to tell people what’s right and wrong. One who does that in my opinion abdicates one’s responsibility. That can be the role of pastoral care, when someone wants to make a decision and wants to know what their particular tradition has to say about it. In that case, someone might say, In our tradition this is right or that is right. I’m not an ethical relativist. One can evaluate behavior with certain kinds of moral values that are absolute, but within that realm is an enormous range of defensible ethical positions. In a pluralistic society, it’s impossible and wrong to impose any one group’s moral standards on the rest of the group.
transplant when the patient had no resources to pay for it. The transplant was done, and I remember that was one of the more difficult situations we’ve encountered.

**AE:** Your background in religion differs from that of your counterpart at Grady. How much of a difference does that make in your approaches to the work?

**ES:** Dr. Sexson and I often look at things out of the same set of values, but the lens I look through has more of a more theological bent. I have to rely on the physicians who are caring for the patient or other colleagues to get a clear medical picture and learn about issues of futility, for instance. I bring to the table the values of life, hope, and reality—that death is not the ultimate defeat—which is very helpful to families, who tend to trust clergy and appreciate a framing of the emotional dilemma they find themselves in.

**AE:** What influence does Emory’s historical foundations in the Methodist Church have on your approach?

**ES:** It doesn’t directly inform my approach as an ethicist. But the healthcare system, by nature of being attached to and having grown out of the university, has emerged as a very caring, person-centered healthcare system that is guided by the historic values of the Judeo-Christian tradition and is being influenced by the changing nature of the religious communities and other values as well. For instance, we are very sensitive to fact that there is a large Muslim population in Atlanta that we serve, a growing Buddhist population, and other faith groups that are emerging and bringing their own wisdom to the ethical dilemmas we face.

**AE:** How do you avoid falling back into the traditional role of a clergyman when interacting with people in great distress?

**ES:** Sometimes I do act as a counselor, but I try to bracket that in my role as a clinical ethicist. Sometimes I bring a chaplain along with me—even though I am one—who takes on the role of nurturer so I can be more in my head and operating from an objective view.

**PRW:** One of the most important in clinical ethics is simply healthcare access, delivery, and payment—people who can’t get proper healthcare because they don’t have the resources. That’s part of our Byzantine healthcare system. Economic problems figure very highly in some of the ethical dilemmas in hospitals. Organ transplants always have hosts of ethical issues around them. In pediatrics, another issue is parents who don’t want their children vaccinated, or questions of how far you go trying to save a child’s life when also causing enormous pain and suffering. Some issues are very specialized. I was asked once to go talk to dermatology residents. They told me about some remarkably interesting and troublesome ethical issues I haven’t heard before or since that are unique to dermatology. One was about skin tags—small flaps of skin that can develop on the body. Some people have many of them.
In academia we sometimes forget that medicine is both an art and a science, I could even say an art embedded in science,” Bill Eley, executive associate dean for medical education and student affairs, once said of what it means to teach compassion. Most of us, whether we live within the medical world or not, would agree that competence and compassion are cornerstones of excellence in healthcare.

About 40 percent of Emory’s undergraduate students pursue pre-medical curricula, most commonly through majors in neuroscience and behavioral biology, biology, or chemistry. Their majors and medical school admissions recommendations dictate 70 percent of their graduation requirements. Indeed, our students’ brains are primed to apply memory and recall to scientific content. Their minds are further challenged through studies in social science, some required by Emory and others highly recommended for medical school admission. But what about our students’ hearts? In this essay, we offer our insight on teaching medicine and compassion to undergraduates based on our experiences developing and teaching Medicine and Compassion, an undergraduate medical humanities course that is part of the cultural studies in Italy summer curriculum.

The word “compassion” literally translates from Latin as “to suffer together.” The word “patient,” again from the Latin, reveals both “bearing and enduring without complaint” and the “suffering or sick person.” Linking these two words is the idea of suffering. The person offering compassion is offering to share in the sick person’s suffering. Do healthcare professionals need to be reminded, or perhaps even taught, that compassion reflects true listening and speaking with our brains, our minds, and our hearts? Most importantly, can we teach these concepts to students considering careers in healthcare?

These questions took on an immediacy six years ago when Judy Raggi Moore of the Emory College faculty asked Ruth Parker of the School of Medicine faculty to design a course that would integrate an undergraduate medical humanities course with the cultural studies in Italy summer curriculum. In other words, propose a class that would both help prepare future healthcare professionals and engage the cultural immersion they would experience. Parker surveyed colleagues and leading medical faculty around the country: if they could offer one course taught in Italy to pre-medical students today, what would it be? The sense that Emory’s popular pre-medical curriculum lacked “education of the heart” led them to try to create one essential pre-health career course.

For the past five summers, Emory undergraduates enrolled in Medicine and Compassion have spent six weeks asking, “What is compassion?” The main goal of the course is for each student to understand how compassion relates to the profession of medicine. Using moral imagination as a tool for inquiry, students examine historical and recent work from the humanities: literature, philosophy, the arts, and numerous cultural and social renditions of complex concepts such as love, care, mercy, pity, sorrow, death, and healing. They are asked to explore compassion and medicine both as private individuals and as professionals called to the work of healing. Faculty from the School of Medicine (Parker) and the CDC (Cantey), along with Raggi Moore and faculty from the humanities, social sciences, and sciences provide cross-disciplinary insights.

Why Italy? Paul Cantey feels that first and foremost, teaching the course abroad provides cognitive estrangement. Our opinions on what compassion is and is not, as well as our opinions on how we should treat one another, are just that—opinions. Although we can base them on underlying principles, we often base them on assumptions we learn from our families, friends, and culture. Examining one’s own assumptions can be a difficult task, particularly for students still seeking to define themselves and their own beliefs.

Medicine and Compassion
Reaching across the silos to teach the “art” of healing

Paul Cantey, Assistant Professor of Medicine; Ruth Parker, Professor of Medicine; Judy Raggi Moore, Director of Italian Studies Program

Learning the art of medicine requires students to make a human connection, build trust, and respond to the often unspoken and sometimes unrecognized needs of patients.
Italy pulls students out of their familiar environment, where they possess an innate understanding of cultural rules, and thrusts them into an unfamiliar environment, where they must learn to recognize the unspoken rules of another culture. As they learn to recognize the new rules and identify the underlying cultural assumptions they represent, they are better able to examine their own underlying assumptions about how people treat one another. A key component of the course is developing their ability to examine all sides of an issue, recognize their own biases and assumptions, and identify principles that help resolve conflicts between varying points of view and assumptions.

The past and present of Italian culture, the cradle of Western civilization, lend themselves to discussions on compassion. Through the study of ancient and modern history of medicine and public health-care, commissioned art and public buildings, the state and church, popular beliefs and traditions, and integration of regional realities within a national unity (just to name some of the avenues of inquiry), the course offers scenarios that transcend time and context and deal with the universal and human. Discussion of how a society observes and experiences disease and epidemics, ancient Greek and Roman thought and practices, medieval Christian world relationships between thoughts of bodily sin and the practice of personal hygiene, Renaissance innovations in the sciences and arts coexisting with devastating outbreaks of plague, the stimulation yet dangers of trade and travel—all these scenarios provide introductions to current discussions of AIDS or SARS and social reactions and responsibilities.

Further, for more than two thousand years, Italian culture has been tied to the ideals of Christianity: Christian culture and the Catholic Church in their essence focus on the care of others. In Christian thought, illness reflects the sufferings of Christ who is portrayed in his dual role as both sufferer and healer. The first Council of Nicea, held in 325 AD, formally linked the Church with the care of the poor, orphaned, sick, and widowed, and it recommended the construction of a hospital in the shadow of every city cathedral. The message of compassion is expressed, for example, through the parable of the Good Samaritan, the poetry of Saint Francis, or the writings of Christian philosophers such as St. Augustine and St. Thomas Aquinas. Such works become more meaningful read in situ and offer the opportunity for challenging discussions for students of all creeds and heritage. Civic texts also offer excellent class opportunities. Students are not surprised to learn that the first state to abolish the death penalty was the Granduchy of Tuscany, with its new penal code promoted by granduke Pietro Leopoldo in 1786.

While learning the science of medicine requires students to memorize, understand, and use vast numbers of facts, learning the art of medicine requires them to make a human connection, build trust, and respond to the often unspoken and sometimes unrecognized needs of patients. Teaching the science of medicine is relatively straightforward and predictable. The art of medicine is much more difficult to teach, if it is taught at all, and much more difficult to learn. Why should a pre-health professional student read Boccaccio’s introduction to the Decameron? Not necessarily to learn the nuances of the Black Death, but perhaps to experience what it would be like, for both physician and patient, to live in an outbreak of life-threatening illness.

In the course, students often realize they lack the academic tools to frame their investigations of compassion. When they say, “Tell me what you want me to learn,” we give them a reply they have, sadly, rarely heard: “You need to think.” Stripped of their familiar yet one-dimensional learning tools, students react with confusion, consternation, indignation, even belligerence (“I don't have time to think; just tell me what you want me to know so I can learn it and move on”), and finally acceptance of the challenge. What these initial reactions say about the health of our liberal arts ambitions is an important question.

But does this exercise in moral imagination teach students to be more compassionate? Though a quantitative study on efficacy and results has not yet been undertaken, the anecdotal evidence is powerful. As current medical student and former undergraduate in the program, Arian Hatefi said, “In today's climate, students are often taught practical facts helpful in solving current problems like malaria or HIV, but there is little thought given to the human experience of suffering attributable to such burdens. The course, therefore, teaches students how to feel, rather than what to think, recognizing that each student will embark on a unique journey and will walk away without sharing the same fact set memorized by other classmates, but with a new approach to the collective subconscious of humanity. . . . One can stand in front of Michelangelo’s Pietà and in a moment learn more about compassion than he or she might in four years of college.”

Administrative barriers have challenged the continued life of this course. Differences in pay scales, curricular schedules, and job expectations complicate medical faculty involvement in the course. Additionally, they have had to develop expertise in areas not traditionally taught in medical schools, requiring a significant investment of time and money. Compensation for teaching the course does not even cover the cost of participation, much less additional costs. In fact, one faculty member has taken one to two

Continued on page 11
Within the last eight years, as a faculty fellow at Emory’s Center for Myth and Ritual in American Life (MARIAL), I have carried out primary research on the emergence in American religion of a new institutional form—the family life center. These centers are slowly replacing an earlier model for moral education that was based chiefly on the model of primary and secondary public education in the United States. Family life centers have become the way many African-American, Spanish-speaking, and white Protestant, Catholic, Jewish, and Muslim religious leaders in Atlanta and beyond often think of what they do for their adherents—they promote healthy family life. The notion of healthy family life varies somewhat by religion, but the core story is the same—the nuclear family is the unit of society most important, most stressed, and most at risk. Although this diagnosis may seem absolutely commonplace today, American religions’ foci have not always been the nuclear family, nor has “family individualism” long been the story of family life.

My research on growth of family life centers and the diffusion of the values of family individualism through communities of faith has been generously funded by the Sloan Foundation through MARIAL. Our director, Bradd Shore, has set a model of doing scholarship that has relevance. Sloan's funding and MARIAL’s support has allowed me to amass a stunning amount of data, these regular colloquies have made the greatest contribution to my scholarly identity. This intellectual community has shaped my own thinking about religion—in some ways, more profoundly than colleagues within my own discipline of sociology. But during most of 2007-08, as a drug-resistant staph infection invaded my spine and necessitated medical leave, I was unable to attend these gatherings. In lieu of attendance, the MARIAL website was a source of information and personal comfort.

During my time at MARIAL, I also had seven major surgeries and more than twenty-five separate hospital stays. Ill health sometimes made me unreliable and unproductive in an academic setting—both humiliating realities. Yet the intellectual resources of MARIAL enabled me to think about this personal experience in ways that helped me decide how to marshal my energies as I mothered a young daughter through my health crises, how to shape a story about what was happening in our family, and how to know when my nuclear family was stressed beyond its limits. This knowledge helped me be proactive in the midst of crisis, rather than simply allowing us to be buffeted by the constancy of calamity.

For many academics the move from data to practical insight is challenging. We mostly do not want to tell people how to live, except to say live out of your
As my family went through crisis, I looked to MARIAL’s academic findings to figure out how to weather what we could not control.

ily residing half a continent away from our extended kin, what family resources did we have?

My MARIAL colleagues’ research helped my family make choices and devise strategies during this time. My six-year-old thinks of the Emory Hospital cafeteria as our personal kitchen. The research of psychology professors Marshall Duke and Robyn Fivush showed us that eating together if possible around a table helps families deal with crisis and shape their stories. When I was unable to make it to the table, we made my bed a picnic spot.

Again following the insights about family narrative from Marshall and Robyn and their research team, I asked my daughter questions about what was happening for her, instead of primarily telling her what was happening to me. Co-construction of a story meant letting her trace her fingers over my “train tracks”—surgical scars— as she told me stories about where we would go together on the tracks that crisscrossed my body. “Where are we going today?” I would inquire. “Today it’s Africa, Mom. Get ready.” Since one of our family’s joys is traveling together, she turned a time of constrained horizons into a story of travel and adventure. This account would have been far from my own, as I bristled against my confinement. But as we took it on together, our family was able to treat the challenges of each day more like encountering a foreign land for the first time. We felt more confident that we could overcome the obstacles, just as we did when we encountered new realities in travel.

I felt the piling up of gender “inappropriate” roles in our family life as my husband was primary caregiver to my daughter and me. As a feminist I celebrated the fact that we could alter expectations. Yet I did not realize the challenges of my husband to maintain his gendered and professional identity in the process. But as I considered a presentation by anthropology professor Carla Freeman, I began to think of the historical and contemporary malleability of notions of respectability and consider its gendered reality. Her research on middle-class entrepreneurs in Barbados was a long way from our life. Yet she demonstrated how these business women address the stresses altering gender expectations in everyday life through religion and new ideologies about care of the body. I scheduled massages for my husband as he coped with the stress of unceasing caregiving. While he may have done this himself, I suspect he would not have because his Midwestern upbringing would not easily allow him to.

admit such a need for the care of his body. It simply wouldn’t be respectable.

Religion has been a vital resource for my extended and nuclear families. Particular communities of faith have helped us move through the multiple medical crises we have experienced including my husband’s cancer and the many surgeries and periods of recovery I have experienced as a person with a lifelong and progressive disability. I connected intellectually and personally with Bradd Shore’s early MARIAL research on the Salem (Georgia) Camp Meeting as a family theater performing the desire for and the reality of connection to place. In his effort to make the work publicly accessible, Bradd and his research colleagues made a film. During my recovery last year, I watched it again and again. The vividness of those experiences broke through the fog of illness to remind me of childhood stories that I had yet to pass on to my daughter; they prompted me to focus more on our current connection to Atlanta and our specific neighborhood. The film helped me emerge from my haze.

Gratitude for such gifts of intellectual life and practical insight seems insufficient. But as I continue to integrate habits of work that will sustain me for the long run at Emory, my appreciation is all I have to give to my colleagues who gave me a chance to learn from them how to practice family life. While I was unable to analyze my data, idled in my writing, and restricted from our regular gatherings, I learned that putting their insights into practice did help us pull together as a family and create new strategies for calming calamity.
HOW A SMALL university museum won the greatest exhibition of ancient Egyptian art to come to the Americas has a long and fortuitous back-story. In November, Emory’s Michael C. Carlos Museum became the host for the American debut of the much-anticipated exhibition “Tutankhamun, the Golden King and the Great Pharaohs.” The exhibition consists of 130 masterworks from the Cairo Museum, including not only treasures from Tutankhamun’s tomb but also great monuments from every important era in Egyptian history, from the Old Kingdom to the Late Period.

The Carlos Museum’s ability to achieve this great honor goes back to a lengthy and intimate association with the Land of the Nile that dates to at least as early as 1920, when Emory theology professor William Arthur Shelton traveled to Egypt and the Holy Land to acquire antiquities that would inspire classes about the history of the Bible. Although Shelton also journeyed to Jerusalem and Baghdad (and recounted his exploits in his entertaining memoir Dust and Ashes of Empires [Cokesbury Press, 1924]), it was his Egyptian purchases that garnered the most public attention. The Atlanta Journal trumpeted, “Mummies from Ancient Egypt Given College: Said to Be the Greatest Collection Ever Assembled in the South.” The notoriety that Shelton’s acquisitions attracted soon earned Emory’s fledgling display the nickname “the Mummy Museum.”

Though not an Egyptologist by training, Shelton accompanied the great scholar and founder of the University of Chicago’s Oriental Institute, James Henry Breasted. Under Breasted’s watchful eye, even with a limited budget, he was able to purchase some important artifacts from the Egyptian Antiquities Service, which in those days did sell items from its excavations. One of the most interesting of these was a mummy of the late Old Kingdom (ca. 2300 B.C.), the oldest Egyptian mummy in an American collection. In addition to this there were painted coffins; a kohl tube inscribed for Queen Tiy, Tutankhamun’s grandmother; a beautifully carved alabaster headrest; and many other artifacts that were then, as they are now, among the best-loved material on display.

Over the intervening years, generations of Atlanta schoolchildren were entertained, educated, and inspired by the legendary “Doc” Woolford D. Baker, a biology professor who delighted in introducing Emory’s oldest alumni. The 1980s saw the arrival of Gay Robins as professor of Egyptian art in Emory’s art history department. Working with museum director Maxwell Anderson, and through the generosity of Harvey Smith, the Connoisseurs, and the Atlantes Society, a number of additional important works were added to the collection.

The Carlos Museum’s Egyptian collections were given their greatest boost in 1999. Through the generosity and foresight of James B. Miller and the Board of the Museum, and aided by the interest generated by Catherine Fox and the Atlanta Journal Constitution, the museum was able to acquire an outstanding collection of Egyptian funerary art from the Niagara Falls Museum. The long neglected and forgotten collection had been purchased by the private museum in Egypt in 1860 and was visited by Abraham Lincoln, Teddy Roosevelt, and Edward VII. Now known as the Charlotte A. Lichirie Collection, the exquisite coffins and mysterious mummies have proven immensely popular additions to the Egyptian galleries. One intriguing piece of the collection, a mummy that had already been suggested to have been a missing royal mummy, was identified by the Carlos—with the help of X-ray and CT-scanning undertaken at Emory Hospital—as most probably that of Ramesses I.

When the collection was first acquired we stipulated that if indeed the mummy that had been thought to have been one of the lost pharaohs turned out to be an actual royal mummy, it would be offered back to Egypt where it belonged—no strings attached. The mummy was returned to Egypt in 2002 with great fanfare as a gesture of goodwill to the people of Egypt from the people of Atlanta, along with fragments from the tomb of Seti I, the most beautiful tomb in the Valley of the Kings, that had also been part of the Niagara collection, picked up from the tomb floor nearly a century and a half before.

The Egyptian collection has continued to grow through a number of gifts, contributions, and bequests, but despite its great popularity, it remains a small collection—less than a fifth the size of the Classical, African, or Ancient Near Eastern Collections of the Carlos Museum. It has been our goal to expand the number, range, quality, and importance of this material, particularly in the area of ancient Nubia. The Carlos Museum has supported a British Museum expedition working with
Clinical Ethics
Continued from page 3

also absolve researchers from anything beyond a cursory deliberation of how well their research methods protect the autonomy and dignity of vulnerable subjects, whether the stresses to which they are subjected are excessive, or whether the risks are ethically justified and balanced.

The role of ethical engagement in psychotherapy is also undergoing a re-evaluation, says Pyke. One earlier social construction of psychotherapy was that of a judgment-free exchange in which patients could expect to avoid moral verdicts or concerns. But in the 1980s and ’90s, critics, some from within psychology, questioned whether psychotherapy had become a way that patients could relieve themselves of ethical responsibility for their actions and choices, such as such as being unfaithful in a relationship or neglecting obligations in other ways. “An ethical discussion doesn’t have to be off-limits in therapy,” says Pyke. “We don’t have to get anxious or change the language if a patient brings up questions that are ethical in nature.”

Ultimately, choices of ethical conduct rest with the individual researcher or clinician. “We depend enormously on these people’s integrity and goodwill and that they will know to do the right things for the right reasons and make hard choices,” says John Banja, professor of rehabilitation medicine a medical ethicist at the Center for Ethics. “Ethics is a discipline about working at those points where it is not clear what to do; where informed—and uninformed—opinions may differ, and where the stakes are high.”

Healthcare has become so technologically and medically complex, adds Wolpe, “that it’s very difficult to make the kinds of decisions one needs to make without looking at the underlying values that inform those decisions.” — S.F.

Compassion
Continued from page 7

weeks’ vacation time to cover the days not covered by salary support each year. It is encouraging, on the other hand, that college administrators such as Philip Wainwright of the Center for International Programs Abroad opened the doors to cross-silo teaching by providing support for further developing the curriculum and by partnering with the medical school and physician assistant program to help enable healthcare graduate students to participate as teaching assistants, thus giving undergraduates the unique opportunity to work with medical professional students. The authors hope to continue to explore innovative concepts for bridging the administrative and cultural gaps among the arts and sciences and the health sciences. We are convinced that our students are the true beneficiaries of faculty navigating the hurdles encountered when we truly collaborate to teach across our silos.
A Feast of Words to Celebrate Emory Authors: December 9, 2008

Please join the Academic Exchange and the Druid Hills Bookstore for this annual celebration of Emory authors and editors of books published this year.

On Tuesday, December 9, at 4:15 p.m., you are cordially invited for wine and hors d’oeuvres in the Druid Hills Bookstore.

Remarks and a toast from President Jim Wagner and Provost Earl Lewis.

Please R.S.V.P: Shannon Palma, 712-9497 or spalma@emory.edu

The Dominant Insect

[Ants] are the dominant insects. There are only fourteen thousand species known, and there are a million species of insects known. Ants all around the world make up about 15 to 20 percent of the biomass. They really dominate the world; they have for a hundred million years. They are the principal turners of the soil, they are earth movers, they are the principal predators of little creatures. If there were no ants you really would see bugs. They are our principal scavengers, they are the cemetery suppliers of the world of little creatures, and they are among the main balancers, thereby, of the land ecosystems. There’s something else about ants: that is they are the other pinnacle of socio-evolution on this planet. Their societies are extremely highly developed and sophisticated. They represent a form of social life so different from our own, so advanced, that it might be the kind we might expect to find if we did encounter advanced social systems on another planet.

—E.O. Wilson, Pellegrino University Research Professor Emeritus at Harvard University and Pulitzer Prize-winning author, in conversation with Rosemary Magee, Vice President and Secretary of the University, October 23, 2008