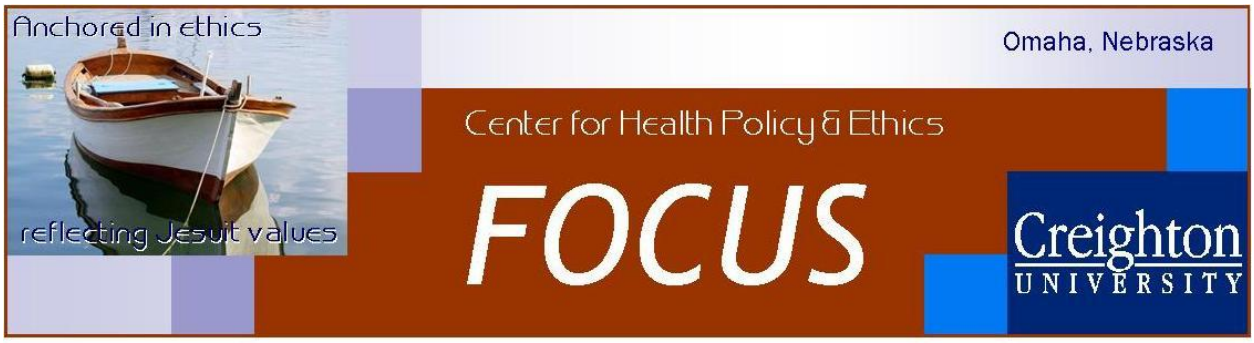

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Director's Report - Establishment of New MPH Degree at the Center for Health Policy and Ethics

by Amy Haddad, PhD

Amy M. Haddad, PhD, Director of the Center for Health Policy & Ethics

The Center for Health Policy and Ethics (CHPE) is pleased to announce the addition of a second fully online graduate program offered by CHPE. We will welcome the first students into the new Master's Degree in Public Health (MPH) program in January 2013. The program will provide students with a comprehensive introduction to the field of public health which is broadly defined as "what we, as a society, do collectively to assure the conditions for people to be healthy."[1] The MPH program will specifically focus on the "conditions" that relate to the determinants of health that play a critical role in disparities: environment, biology and genetics, human behavior, and access to quality care. To maximize access to geographically-remote and non-traditional, working student populations, course content will be offered online with the majority of course offerings in a fully asynchronous manner. The program will seek initial accreditation through the Council on Education in Public Health (CEPH), the nationally recognized accrediting body for public health programs.

The new MPH program will support Creighton University's mission, educational philosophy and goals in several ways. First, Creighton is a comprehensive university and strongly supports multidisciplinary and interdisciplinary education and research. CHPE is a visible result of this commitment. CHPE exists to advance Creighton University's mission as a Catholic and Jesuit comprehensive university committed to excellence. Additionally, CHPE graduate programs align directly with the mission of the Graduate School "to produce graduates who have the wisdom, judgment and faith to work for a more just society." Unlike other well-known bioethics centers such as the Hastings Center and the Kennedy Institute at Georgetown University (which focus primarily on scholarship), teaching is one of the most important missions of Creighton in general and of CHPE in particular. CHPE faculty members have been an integral part of the ethics education of health sciences students in all of the programs offered at Creighton since the establishment of CHPE in 1984.

The most visible recent outcome of the commitment to the teaching mission of the University at CHPE is the establishment of the Master of Science in Health Care Ethics (MSHCE) program in August 2009. The proposed MPH program, like the MSHCE program, requires multidisciplinary collaboration, which is the foundation upon which the majority of the work of CHPE rests. The interdisciplinary nature of the MSCHE and proposed MPH programs will enhance cooperation and collaborative efforts among the CHPE faculty and various schools at Creighton by integrating multiple resources in related areas. Also, CHPE has established processes and structures within CHPE for effective online education including marketing, course development and design, faculty development, student support services and course and program assessment that can all be applied to the MPH program.

Second, the specific focus on vulnerable and marginalized populations expresses Creighton's commitment to the Ignatian charisms of faith that does justice and developing men and women with and for others. "Creighton, like other Jesuit universities, places a special emphasis on service to the local and the global community. Ours is an education that promotes addressing problems of injustice and violence by advocating education for justice and peace."[2] Students will have ample opportunity in the MPH program to reflect on the meaning and application of social justice and, in some courses, to experience first-hand the manifestations of unjust societal conditions that adversely impact the health of certain populations.

Third, there is a pressing need for additional public health professionals to protect the public's health and safety. As noted in the 2003 National Academy of Science report:

> Public health professionals' education and preparedness should be of concern to everyone, for it is well-educated public health professionals who will be able to effectively shape the programs and policies needed to improve population health during the coming century. If we want high quality public health professionals, then we must be willing to provide the support necessary to educate those professionals.[3]

In presenting a values-centered, interdisciplinary program in public health, the program proposes to meet the need for public health professionals by recruiting faculty and students who will be excellent leaders in public health education and practice.

The genesis for the MPH program arose several months prior to establishing its home at CHPE. Early in the spring of 2011, Dr. Donald Frey (Vice President of Health Sciences), Dr. Barbara Braden (Dean, University College) and Patrick Borchers, JD (Academic Vice President) as well as Dr. Gail Jensen, Dean of the Graduate School, determined that the

development of a MPH program would best be assigned to the faculty and staff of the Center for Health Policy and Ethics.

A Steering Committee was established in April 2011 to provide oversight to the development of a proposal for the MPH program consistent with guidelines for new programs at Creighton, the Commission on Education in Public Health and the Higher Learning Commission. Members of the Steering Committee are: Douglas Benn, BDS, DDS, MPhil, PhD, (SOD); Deb Fiala, MD, JD (Compliance Director and Associate General Counsel); Beth Furlong, RN, PhD, JD (CHPE); Marybeth Goddard, MOL (CHPE); Amy Haddad, PhD, MSN (CHPE); Tom Hansen, MD (SOM); Chris Jorgensen, MSLIS (CHPE); Linda Ohri, RP, BS, PharmD, MPH (SPAHP); and Paul Turner, PhD (SOM). The Steering Committee reviewed the pre-proposal and the final proposal for the MPH program that was approved by the Graduate Board at Creighton in December 2011.

Simultaneous with the establishment of the Steering Committee, a Search Committee for the MPH Program Director was organized under the leadership of Christy Rentmeester, PhD (CHPE). Members of the Search Committee were: Jeanne Burke, MSLIS (Health Science Library); Judy Gale, PT, DPT, MPH, OCS (SPAHP); Kelly Gould, RDH, MA (SOD); Steve Jackson, MPH (Douglas County Health Department); Dee Sledge, MA (CHPE); and John Stone, MD, PhD (CHPE). The Search Committee developed a position description and reviewed dossiers as they were submitted. Through a series of phone and on-site interviews, the Search Committee made final recommendations regarding the candidates to CHPE Director, Dr. Amy Haddad. The new MPH Program Director, Dr. Sherry Fontaine, will assume responsibilities on-site in May 2012.

CHPE is deeply appreciative of the assistance that all of these individuals on the Steering and Search Committee have provided at this critical juncture in the MPH program's development. It is our belief that establishing a Master's Degree in Public Health will support the mission of Creighton University and will provide a unique learning experience for our students.

[1] Institute of Medicine. *The Future of Public Health.* Washington, D.C.: National Academy Press; 1988, p. 19.

[2] Schlegel, J. 2011. The Creighton Identity: A Legacy to Cherish and to Live. Creighton University, p. 13.

[3] National Academy of Sciences. *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century.* National Academies Press; http://www.nap.edu/catalog/10542.html; 2003, p. 26.

Does the Nation's Survival Depend on a New EOL Conversation?
by Helen Stanton Chapple, PhD, and Katherine Irene Pettus, PhD

In March 2012 we presented a paper at the Association for Death Education and Counseling Conference in Atlanta entitled "Does the Nation's Survival Depend on a New End of Life Conversation?" We argued that the premise of rescue that underlies the current health care system is based on concepts that reflect the dominant national ideology. In order to alleviate the ruinous economic effects of health care built on rescue and on market competition, the national conversation needs to deploy a different set of less prominent national ideals. These ideals are expressed in what we identified as the "minor key" of American citizenship, and include such ideals as courage, friendship, communication, and truth-telling. These ideals are also central to the practice of palliative care.

Currently US culture assigns value (financial and symbolic) to the technological rescue and stabilization of terminally ill patients (Chapple, 2010). To die without participating fully in the communal enmity towards death is considered deviant. Meanwhile, a shared understanding of society's commitment to its most vulnerable members is in tatters. The rescue paradigm, designed as a robust demonstration of that commitment, has instead produced an expensive and inefficient medical delivery system. Moreover, when rescue fails, society forgets this overarching mandate and blames the now-deceased patients for costing too much at the end of their lives. This reaction is especially ironic when a fight to the death for every life was expected in order to prove the vitality of national compassion and egalitarianism. The counter-narratives presented by advance care planning, palliative care, and hospice in the years since the SUPPORT study (SUPPORT Principal Investigators, 1995), remain outside mainstream medicine despite their growth. They are still associated with "giving up." In 2009, media reaction to a newly proposed mechanism that would have reimbursed physicians for exploring their older patients' goals regarding care at the end of life (EOL) brought a firestorm of reaction over "death panels," a sign that rational political deliberation about EOL policy at the community, state or federal level is virtually impossible. American abhorrence of dependency, government regulation, and death through any diminution of rescue together scuttle the chances for social reasoning on a policy level.

In our presentation, we proposed chaos theory and complexity science as an alternative grounding for scientific inquiry. We also drew on the classical political theory of citizenship in the Aristotle-St.Thomas lineage, advocating in favor of the now dormant citizen virtues that nurture embodied rather than ideological leadership. The original virtues of citizenship developed in the ancient Athenian democracy: courage, honesty, and friendship, are embodied in modern palliative care (Pettus 2013). This type of care is no less heroic, but it does so not by rescuing and engaging in dramatic, death-arresting feats, but by facing death courageously and by opposing fear.

Thomist thought captured and enhanced Aristotele's observations about citizenship and the common good, recognizing that the most stable polities put the good of the whole before the "partial" good of the individual or the clan. This legacy of citizen virtue is available to 21st century Americans, and can inform our national EOL conversation. The EOL conversation must be made more dynamic and expansive through the embodied leadership of patients, families, caregivers, policy makers, and others. A citizen body that is driven by virtues instead of fear can develop and model a health care system that honors the dying and the living by institutionalizing quality care for all its members throughout their life spans.

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Alumni News – Spring 2012

We have asked the graduates of our MSHCE program to keep us posted on their new ventures. Here's what we've heard . . .

From Kate Baxter:

I am currently a first year law student at New York Law School in New York City.

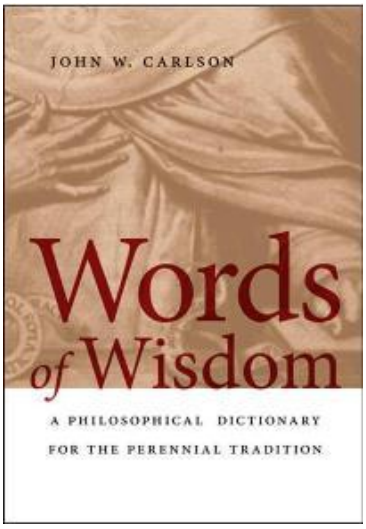
I was recently selected to be a Research Fellow in the Institute for Global Law, Justice, & Policy at New York Law School. I will be working with the Institute full time this summer. (See, http://www.nyls.edu/centers/harlan_scholar_centers/global_law_justice_and_policy/about_the_institute)

From Larry Cook:

Larry J. Cook, DMD, MSHCE, FACD published an article entitled "My Journey in Dental Ethics" in the *Journal of the American College of Dentists* (2011, vol 78/3: 7-10), in which he reflects, amongst others, on his time as a student in Creighton's MSHCE. The article can be downloaded here: http://acd.org/_jacd/JACD-78-3.pdf

Congratulations to Jack Carlson, CHPE Faculty Associate, on the publication of his book:

Carlson, John W. Words of Wisdom: A Philosophical Dictionary for the Perennial Tradition. Notre Dame, IN: University of Notre Dame Press, 2012.



Here are some comments from the book cover:

"This volume beautifully fills a serious lacuna. In the explosion of research tools for philosophy, we have seen dictionaries and encyclopedias on virtually everything. But it has been decades since there has been a comprehensive dictionary of philosophy that takes special consideration of the topics, terms, and perspectives prominent in the *philosophia perennis*. This volume not only provides accurate accounts of terms from across the spectrum of philosophical schools but it includes coverage of many items that are absent from its counterparts." — **Joseph W. Koterski, S.J., Fordham University**

"The introduction to this work shows how carefully its aim and method have been thought through. The rest of *Words of Wisdom* demonstrates how well the aim has been achieved and the method employed. An invaluable resource." — **Aidan Nichols, O.P., University of Cambridge**

"Inspired by the call of *Fides et Ratio* (# 85) to inject the great tradition of Christian Wisdom, especially the perennial thought of Aquinas, into current philosophical and theological discussion, Carlson has composed much more than a dictionary. Though I could not think of one idea that did not receive an enlightening entry, the dictionary also includes a most helpful listing of Aquinas' works in English, a most representative bibliography of contemporary Thomists, and a most fair bibliography of important non-Thomists. It is an inviting portal into the perennial philosophy for today's college student. Carlson's dictionary may prove to do more to advance a Thomistic renaissance than many a Thomistic monograph." — **John F. X. Knasas, University of St. Thomas, Houston, Texas**

CHPE Faculty Participate in Second Cambridge Consortium for Bioethics Education in Paris

by Amy Haddad, Ph.D.

In April 2010, Drs. Amy Haddad and John Stone attended the first Cambridge Consortium for Bioethics Education in New York sponsored by Cambridge University Press. The first meeting opened the dialogue about ethics education in its broadest sense including professional education in the health sciences, graduate medical education, continuing professional education and graduate education. Drs. Haddad and Stone participated in the planning of the Second Cambridge Consortium for Bioethics Education in Paris, France, the aim of which was to build an international community of bioethics educators.

Dr. Haddad was asked to participate on a panel on using technology. Her paper was titled, “Designing an Online Graduate Ethics Program: Some Practical and Concrete Steps.” Fellow panelists were Dr. Nada Gligorov from Mount Sinai School of Medicine and Dr. Kenneth Goodman from the University of Miami. Dr. David Bennahum from the University of New Mexico served as moderator of the panel. The group discussion that followed the panel presentation was lively and diverse considering the range of countries that were represented at the conference including colleagues from USA, Western and Eastern Europe, South America and Russia.

Dr. John Stone moderated a session on student exercises that included colleagues from Michigan State University and the University of Texas at Houston. Dr. Ruth Purtilo also attended the conference and served as a moderator for a session on partnerships and alliances including presentations by colleagues from the Weill Medical College of Cornell University in Qatar, the University of Tartu in Estonia and the Karolinska Institute in Sweden.

From left to right: Nada Gligorov, Ph.D., Mount Sinai School of Medicine; Amy Haddad, Ph.D., Creighton University; and David A. Bennahum, M.D., University of New Mexico (Moderator).

Related website:
www.cambridgebioethics.com

One Week's Snapshot of Cuba
by Dr. Beth Furlong, Associate Professor, CHPE

Mr. Rodgrio; Mr. Elias Asser, General Manager of Callejon de Hammel (a street cultural center); and Dr. Benjamin-Alvarado

Paradoxes abound. In March 2012, together with 19 other residents of Nebraska, Missouri and Florida, I had the opportunity to visit Cuba for one week and catch a snapshot look at life there. With the leadership, knowledge and experience of Dr. Jonathan Benjamin-Alvarado, a Professor in Political Science at the University of Nebraska-Omaha (UNO) and his counterpart colleague in Havana, Mr. Rodgrio Gonzalez, Program Director of Cuba Girasol, our small sub-groups of UNO faculty, UNO students, community members such as myself, and a four-person national documentary film crew had the opportunity to experience a week long observation of Cuba.

As a public health nurse of 45 years, my frame of viewing Cuba was focused on the following concepts of public health nursing: 1) social justice and other public health ethical theories; 2) a population focus versus an "ill individual" focus; 3) Social Determinants theory of health; 4) a priority of prevention, public health and primary health care; and 5) seeing the strengths in others. While many public health providers, globally, are aware of the many positive outcome indicators of the Cuban health system, there is a paradox in that many health professionals and lay individuals do not acknowledge such accomplishments (Cooper, Kennelly, & Ordunez-Garcia, 2006). The public health statistics place some of the Cuban health outcomes in ranking at a median or higher point when compared to the Cuban geographic region (the Caribbean, Central and South American countries); Cuban statistics are actually the same as or better than some U.S. health statistics (Offredy, 2008; WHO, 2011). The challenge for policymakers, ethicists, and health providers is to study the Cuban health system and to maximize and replicate some of its strengths in other developing and some developed countries. Can we, for example, learn from Cuba's health system's emphasis on public health, prevention, and primary care? If Cuba is able to sustain this emphasis while also meeting ill individual patients' needs at the secondary and tertiary levels of care in polyclinics, hospitals, and rehabilitation centers, the US should be too.

Dr. Miqeul Paneque, a Primary Care Physician

In the past 50 years Cuba has met population needs successfully in the areas of education and health care. However, there are many challenges and paradoxes to be addressed. The challenges include: 1) meager salaries; 2) food ration cards; 3) a chronic scarcity of consumer necessities; 4) state control versus individual freedom; 5) crumbling housing and other infra-structures; 6) increasing unemployment; 7) the suffering caused by the U.S. blockade for the past 50 years, etc. The paradoxes include: 1) Cuba's inability to turn its gains in education, skills training, and positive health status in high level employment; 2) a long history of oppression and economic hardships that is matched by great resiliency and adaptation during times of suffering, such as, most recently, during the early economic crisis in the 1990's when support from the former Soviet Union ended, and, 3) an emerging entrepreneurship in a socialist republic.

The Institute of Medicine (IOM) in the U.S. released a report in mid-April 2012 which calls for a population focused health system in the U.S. with an emphasis on public health and prevention versus the current focus on care of ill individual patients (Institute of Medicine, 2012). This call for change is based "…on the nation's poor health performance…compared with its high-income peers." (IOM Report, 2012, p. S-1). The release of the April 2012 IOM Report provides another opportunity for U.S. policymakers, ethicists, and health providers to study, analyze, and reflect on the strengths, challenges, and paradoxes of two health systems that are, geographically, only 90 miles apart.

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Spring/Summer Graduates in Class of 2012
by Chris Jorgensen, MSLIS

The Center for Health Policy & Ethics is proud to announce its Spring 2012 and Summer 2012 candidates for the Master of Science in Health Care Ethics degree:

Spring 2012

- Adinamarie DeWitt*
- Jeffrey Hood
- Brent Lubbers
- Jay Malone
- Sara Oxley
- Jan Schnack*
- Jennifer Tedesco*

Summer 2012 (anticipated)

- Noah Bernhardson
- Heather Fitzgerald
- Marla Flores-Mursinna
- Jennifer Jackman*
- Karen Lang
- Kimberly Leslie

Left to right: Adinamarie DeWitt, Jennifer Jackman, Jan Schnack, Jennifer Tedesco

**In attendance for Spring 2012 Commencement Activities*

Graduation activities were held the weekend of May 11-12, 2012. Four MSHCE graduates took part in the Graduate School Hooding Ceremony on Friday evening, the M.S. in Health Care Ethics Graduation Brunch on Saturday morning, and University Commencement on Saturday afternoon.

After August 2012, the MSHCE program will have a total of 29 graduates. The success of our program and students would not be possible without the work of our CHPE faculty and staff, nor would it be possible without the contributions of other Creighton University faculty who serve on our program sub-committees. Specifically, we would like to recognize the former and current members of our MSHCE Curriculum Committee and Assessment Committee, many of whom have appointments outside the Center and yet serve in these important roles. Thank you to each one of you for your assistance in creating and improving our program!

MSHCE Curriculum Committee

- Christy Rentmeester, PhD Chair 2009-
- Joan Norris, PhD 2009-
- Beth Furlong, JD, PhD 2009-
- Katie Huggett, PhD 2010-
- Bob Sandstrom, PhD 2011-
- John Davis (student) 2011-
- Gail Jensen, PhD 2009-2011

MSHCE Assessment Committee

- Amy Haddad, PhD Chair 2011-
- Teresa Cochran, DPT 2011-
- Linda Gabriel, PhD 2011-

Bioethics Education in India

by DeenDayal B. Reddy, MS, MA, PhD, Contributed-Service Faculty, CHPE

With over one billion people, India is the most populous democracy in the world. Since its independence from the British *Raj* in 1947, India has made stellar progress in the fields of mathematics, medicine, and science. But the same may not be said of bioethics.

This is not to say that bioethics is not cherished; there is a vast reservoir of ethical thought that springs from Hindu religious-philosophies which continues to shape and form the contemporary bioethical discourse. But bioethics is seldom taught as an independent subject across schools and colleges in India.

In spite of having access to a fund of ancient knowledge there has *not* been measurable progress made in the field of bioethics. But why? I do not have all the answers, but I should like to offer the following few. (1) Moral Inertia. As much as 30%-35% of Indians (Dalits, Muslims, Sikhs, Buddhists, Jains, and Christians) espouse a different moral perspective than the one emanating from the Hindu religious-philosophies. This has precipitated a failure to reach a national moral consensus on a variety of important issues such as allocation of resources; organ transplantation; human rights; and animal rights. In turn, these conflicting and seemingly irreconcilable moral views held by multiple religious factions have provoked a paucity of systematic education and scholarship in bioethics. (2) Lack of Expertise. A majority of Indian philosophers and physicians have not developed corresponding expertise in bioethics—at least, not to the extent of their counterparts in the West. Judging by the number of Indian publications and textbooks on bioethics, one may infer that it does not enjoy a priority status—at least, not to the extent of mathematics, medicine or science.

Yet there is a palpable and growing interest in bioethics in India. It is gratifying to note that regulatory bodies such as the Medical Council of India (MCI) and Indian Council of Medical Research (ICMR) are initiating measures* to educate medical professionals in bioethics, based on universalizable principles. Hopefully these regulatory bodies will ramp up their efforts, make bioethics a *compulsory* subject, and engage or import enough qualified *ethicians* to accomplish the task.

The task of introducing bioethics to an audience already predisposed to learning is comparatively easier. As the field of bioethics is open and ready, I should like to believe that this is an opportune time to introduce the subject *systematically* all across India. Still the challenge remains to create a culturally sensitive curriculum, sans the bid or bias of any one religion.

The initiatives taken by the MCI and ICMR confirm that it is possible to address this challenge. If pursued, its rewards include a *trans-religious* ethical framework to analyse and address the increasingly complex issues that continue to challenge the Indian medical community: new reproductive technologies, clinical research, organ transplantation, genetic engineering and allocation of scarce resources. Other rewards include an accountability-tool for legislators and regulatory bodies (MCI & ICMR) to institute a uniform code of conduct of various individuals, groups, and institutions with divergent views or agendas.

Perhaps the ultimate reward of bioethics education is that it enables us to ascertain whether the ethical thought inherited under the aegis of history, recent or remote, is as ineffectual as an ancient potion or as precious as its sculptures. If it is the former, we should be wrong to take it seriously; if the latter, then to lose it would impoverish us. Anything less would seem to be quite unethical!

*To learn about other such initiatives visit: www.indianinstituteofethics.org

Moral Courage in Action: Individuals, Teams and Health Care Institutions

by Ruth Purtilo, PhD, Contributed Services Faculty, CHPE; Professor Emerita, MGH Institute of Health Professions, Boston Massachusetts.

Ruth Purtilo, PhD

Courage is a virtue portrayed in the western philosophic tradition primarily as bravery or fortitude in the face of danger. It is heralded by some as an overarching virtue that a person resorts to in order to persevere in maintaining the moral life when any of the other moral virtues are at the testing point. In his book *Moral Courage*, Kidder proposes five principles that, if perceived to be in danger of compromise or overridden, will call for an individual's courageous response: responsibility, honesty, respect, compassion and fairness. The person need not be a saint or hero to act motivated by courage; to the contrary, common ordinary people attuned to these principles are more likely to carry through courageous action than those who do not ascribe to them. The likelihood of action is raised further when there is support of others to do so.

Over the centuries this idea of an inner personal resource for facing serious moral challenges has continued to be developed, one avenue of inquiry being to question whether courage understood solely as individual valor fully conveys the bandwidth of its meaning or usefulness as a motivator to uphold moral values. This is a strikingly relevant question for health professionals whose skills today almost always are offered within teams in institutional settings. *Is* there an aggregate and collective dimension to this virtue, and, if so, how can it be engaged and discerned?

While health professionals' acts of moral courage often are undertaken by individuals who speak out, step up or stand firm when a basic moral value is at stake, a growing literature highlights two promising themes for further exploration at Creighton and elsewhere. First, health care teams can act as an aggregate of moral agents creating a moral community of discernment for courageous action, bound by the common cause of quality health care. (Austin) In a study of morally courageous professionals and others who labored to bring down the injustices of apartheid, they reported this aggregate phenomenon as one essential element of perseverance. Their awareness of supporters who were "there" spiritually and mentally, bonded by their common cause, sustained them, even while in solitary confinement or undergoing individual brutality. (Purtilo) Secondly, institutions provide a physical setting and ethical grounding for policies to take root (or not) at the individual and aggregate level. It follows that an institution's principles and values must align with its explicit social purpose and stated mission in order for a person or team to be empowered to maintain moral integrity through morally courageous action. (Rambur et al) Needed are institutions committed to supporting courage in the complex web of relationships involving patients, families, and the structures surrounding the delivery of health care.

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Community Partners and CHPE Explore the Experiences of African American Women with Breast Cancer

by Amy Haddad and Helen Shew

Beth Furlong and Amy Haddad flank the poster describing this research project at Creighton's All Things Ignatian Poster exhibit held on February 2, 2012.

Preliminary discussions between CHPE faculty, staff and African American women community partners including Jacqueline Hill, co-founder of My Sister's Keeper (a support group for African American breast cancer survivors), indicated that the significant distress at the time of diagnosis may be universal for all women with breast cancer but experiences may differ going forward as vital treatment decisions are made. Are the experiences of African American women with breast cancer different when treatment options are discussed? How does symptom management differ, if at all? Are African American women offered the option of participating in clinical trials? These discussions and questions lead to the development of a pilot study conducted by Amy Haddad, PhD, Jacqueline Hill, MSN, Elizabeth Furlong, PhD, Helen Shew, MS, and John Stone, PhD.

The purpose of this research project was to explore the experience of African American women breast cancer survivors in Omaha, Nebraska relative to received information about treatment options, symptom management, and participation in clinical trials. African American women have a higher breast cancer mortality rate at every age and a lower survival rate than any other racial or ethnic group in the United States. (Millon-Underwood, 2008) Meta-analysis of 15 studies addressed experiences of "diverse ethnocultural groups" of women with breast cancer, including African Americans. One common theme in these studies was the experience of being an "other" during diagnosis and treatment. (Howard, 2007) Literature also suggests that African American breast cancer survivors experience disparities in information received and participation in medical care decisions. Patients who are involved in their treatment care decisions are more successful at self-management and have better health outcomes than those who are not. (Royak-Schaler, 2008)

Gathering the Evidence

A qualitative/quantitative study design was used to investigate the experiences of African American women with received information on breast cancer treatment, symptom management and invitation to participate in clinical trials. The preliminary question route was used to assess, compare, and categorize African American women breast cancer survivors' experiences during the initial phase of treatment decisions. The focus group method was used to encourage description beyond bare reporting to get at the meanings and contexts of the experiences. A demographic data form was completed by the participants prior to the focus group session. Focus groups comprised the qualitative measure of the study. The focus group method emphasizing understanding of complex experiences was appropriate for studying the initial phase of treatment decisions since it involves subjective perceptions about the adequacy of information received about key treatment decisions, symptom management and invitation to participate in clinical trials.

Preliminary Findings

Demographic Data:

- 21 participants in 4 focus groups held in November and March
- Age: 31– 68
- Education: 38% had an associate degree or some college
- More than half worked outside the home and were married
- 90% had health insurance
- Survivorship ranged from less than a year to more than 5 years but three women had a recurrence
- Most cancer at diagnosis was at Stage IIa or IIb (38%)
- Almost all had surgery (90%), 76% had chemotherapy and 66% had radiation therapy

Themes that emerged from the focus group sessions were grouped into *Things Patients Should Know* and *Things Health Care Providers Should Know*. An additional need expressed across all focus groups was a means to record information relevant to diagnosis and treatment. The need for culturally appropriate educational materials and dissemination of information within the community utilizing the themes identified was also cited. With proper understanding of the experience of African American women breast cancer survivors and their input, we began to formulate hypotheses for culturally appropriate interventions. Specific ideas for development and dissemination from the focus groups include:

- Compile booklet containing focus group key points
- Prepare diagnosis and treatment history card
- Prepare script/condensed version of key talking points to effectively utilize media opportunities.

Next Steps

Focus group members' concern regarding occurrence of breast cancer among younger women with a generally more advanced stage at diagnosis shaped our thinking about implementing ideas from the focus groups. We plan to work with select focus group participants in a joint effort to:

- Develop culturally appropriate educational resources to assist African American women before, during and after diagnosis and treatment including quality photos featuring African American women in screening, diagnosis and treatment phases
- Utilize appropriate outlets to disseminate educational resources
- Develop and distribute educational materials helpful to healthcare providers treating African American women with breast cancer.

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Comings and Goings at the Center
by Marybeth E. Goddard, MOL, BS

Assistant Director of the Graduate Program to Pursue Passion

Chris Jorgensen

Chris Jorgensen, MSLIS, Assistant Director of the Graduate Program, will begin a new journey this fall. Chris and her family will move to New Jersey where Chris will enroll in Drew University Theological School and begin her pursuit of her Master of Divinity. Chris's ultimate goal is to become a Pastor in the United Methodist Church. The CHPE Faculty and Staff and the Creighton community will miss Chris and her good work but are confident this is the absolute right move for Chris and her family.

Dr. Amy Haddad, CHPE Director, states, "Chris's attention to detail and her ability to organize massive projects has contributed greatly to the success of the CHPE Master of Science in Health Care Ethics program. I have relied on her keen intellect, compassionate nature and sense of humor from the start of the graduate program and the beginnings of the new online Master of Public Health Program that will begin next January".

All the Best, Chris!

Master of Public Health Program Director Announced

Sherry Fontaine

Beginning in January 2013, the Center for Health Policy and Ethics will offer an online Master of Public Health (MPH) Program. The program will be an interdisciplinary degree that provides a comprehensive approach to the field of public health with a special focus on public health for vulnerable and marginalized populations. Effective May 14, 2012, Dr. Sherry Fontaine will join the Center and begin her duties as Master of Public Health Program Director.

Dr. Fontaine holds a PhD from Cornell University in City and Regional Planning with emphasis on Health Planning. After earning her doctorate, Dr. Fontaine was awarded a post-doctoral fellowship at The London Business School where she pursued research related to the National Health Service. Dr. Fontaine was able to further her research on comparative health care policy through a Canadian Faculty Research Grant. Dr. Fontaine continues to maintain a strong interest in a broad range of health care delivery issues in terms of both research and teaching.

For the past ten years, Dr. Fontaine has served in an academic leadership capacity for graduate programs in health care policy and health care leadership. In her most recent position at Virginia Polytechnic Institute & State University (Virginia Tech), Dr. Fontaine served as the Associate Dean of the Graduate School in the National Capital Region and Director of the National Virginia Center. In this position, Dr. Fontaine oversaw the administration and operations for over 45 graduate degree and certificate programs in the Washington, DC metropolitan area. In addition to her academic experience, Dr. Fontaine has been involved in a wide range of consulting, research, and program management projects with health-focused nonprofit organizations and local and state governments. Dr. Fontaine has been very active in both nonprofit and professional health care organizations, serving on the Missouri Board of Regents for the Association of HealthCare Executives and as a board member for several nonprofit, community-based health care organizations.

Welcome, Dr. Fontaine!

Former CHPE Senior Visiting Fellow Receives Appointment

Effective January 2, 2012, Father Melvil Pereira, the 2011 CHPE Senior Visiting Fellow, became the new Director of the North-Eastern Social Research Centre (NESRC), Guwahati, Assam, India. Father Pereira replaces the Centre's founder Father Walter Fernandes.

Founded in 2000, the mandate of the NESRC is to be a center combining serious intellectual pursuits with involvement with persons and groups active in social change in India's Guwahati region. In the context of ethnic and political conflict, it is to provide a platform for groups in conflict to meet and search for solutions.

Congratulations on your new position, Fr. Mel!

Fr. Mel

Contributing Services Faculty Growing

The Center continues to grow with the addition of the following new Contributing Services Faculty:

- Lea Cheyney Brandt, OTD, MA, OTR/L, University of Missouri
- DeenDayal Reddy, PhD, MS, MA, Indian Institute of Ethics
- Janice S. Van Riper, JD, PhD, Eastern Carolina University

Welcome to all!

CHPE Faculty Member Receives Promotion and Tenure

The School of Medicine has conferred upon Dr. Christy Rentmeester, CHPE Assistant Professor, effective July 1, 2012, the rank of Associate Professor with Tenure.

Congratulations, Dr. Rentmeester!

Christy Rentmeester

PRIME Meets in Louisville

by Christy A. Rentmeester, Ph.D., Associate Professor, CHPE

PRIME is the acronym for The Project to Re-balance and Integrate Medical Education. The weekend after the Kentucky Derby at the historic Brown Hotel in Louisville has been devoted to PRIME annually since 2010. A group selected by PRIME project leaders (Drs. David Doukas, Laurence McCullough, and Steven Wear) have met to discuss how ethics and humanities can respond to and help formulate national accreditation standards for professionalism in undergraduate and graduate medical education. After PRIME's session at the annual meeting of the American Society for Bioethics and Humanities (ASBH) in October 2011 in Minneapolis, it became clear that PRIME faculty needed to be expanded in numbers and disciplinary expertise and representation. This year, PRIME's palette of faculty leadership grew accordingly. The 2012 meeting welcomed about 175 educators in medical professionalism from across the country.

The conference program included presentations by faculty focusing mainly on pedagogy. Representatives from the Association of American Medical Colleges (AAMC), Accreditation Council for Graduate Medical Education (ACGME), and the Liaison Committee on Medical Education (LCME) also offered presentations and invited feedback. The goals of PRIME are best summarized in one part of the introductory letter to all conference attendees:

> Since 1998, the accreditation agencies and scholarly organizations of AAMC, ACGME, and LCME have promulgated a series of guidelines in education that promote professionalism. These guidelines endorse the central role for education in medical ethics and medical humanities in undergraduate and graduate medical education. The PRIME project will position the academic humanities and bioethics community to participate effectively in the implementation and critical appraisal of these accreditation guidelines. PRIME will support collaboration between medical ethics and humanities educators and accreditation organizations to support professional formation of medical students and residents.

Outcomes of the series of PRIME meetings are not yet clear, as these meetings will hopefully initiate long-term change through careful ongoing work and thoroughgoing cross-disciplinary collaboration.

Some important themes that emerged at the 2012 meeting hold promise for thoughtful follow-up scholarship. One of these themes is the pressing need to navigate pluralism among views of what constitutes professionalism. In general, we bracketed the common debate of whether virtues are innate or teachable and distinguished professionalism from virtue by characterizing it as patient-directed, patient-centered, and thus within the legitimate purview and purpose of medical education. This set of theoretical issues was considered along with a set of practical issues. One acknowledged as a starting point at the conference was strong resistance by some in medical education to robust integration of ethics and humanities into medical curricula, which often takes shape as a demand for evidence-based outcomes that ethics and humanities help to cultivate physicians' professionalism. Responses to this challenge might focus on showing how impulses toward professionalism have their motivational roots in notions of humanity and human flourishing that come from ethics and humanities disciplines. Another core assumption in-play throughout the conference was the value to professionalism of cultivating medical students' and resident physicians' skills of critical analysis and self-awareness. Finally, another important and influential core assumption was that changes in undergraduate and graduate medical education must address pervasive toxicity of the cultural and educational environments that shape the processes of socialization into medicine. Several pedagogical strategies in ethics and humanities were presented to address this set of themes.

PRIME has been sponsored by the University of Louisville, underwritten by the Patrick and Edna Romanell Fund for Bioethics Pedagogy, and also supported by the Gheens Foundation.

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