

Letters

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Medicine, Health, and Society An Interview with Matthew Ramsey and Larry Churchill

The 2003/2004 Fellows Program at the Warren Center, “Medicine, Health, and Society” investigates one of the most dynamic and rapidly growing areas of interdisciplinary research and teaching. This field, which we may refer to as MHS studies, has its roots in a tradition of programs and courses in the medical humanities that have long served to enrich and broaden the curriculum of future medical practitioners by connecting medicine to such fields as literature, the arts, history, philosophy, religion, law, and social policy. But this new approach to the study of health and health care moves beyond the focus on clinician-centered subject matter and patient-physician interactions, to look more broadly at how various societies—including our own—have understood, experienced, and responded to disease. MHS studies recognizes that health-related beliefs and practices are deeply embedded in particular societies and cultures, and that disease can be studied as a social and cultural phenomenon. This year’s Fellows program reflects this interdisciplinary approach in the diverse academic interests of its participants, who include faculty from such disciplines as medical ethics, history, human and organizational development, theology, English, and sociology. In addition, the program will include one clinician from the Division of Surgical Oncology. The program’s codirectors are Matthew Ramsey, associate professor of history, and Larry R. Churchill, Ann Geddes Stahlman Professor of Medical Ethics. In a recent interview with

Letters, Professors Ramsey and Churchill discussed the program, its integral role in supporting the initiatives of the new Center for Medicine, Health, and Society at Vanderbilt, and new directions for the expanding field of MHS studies.

LETTERS: This Fellows program emerged from a faculty workshop/planning group in Medicine, Health, and Society



Larry Churchill and Matthew Ramsey

studies that has been meeting for the last two years at the Warren Center. Could you say more about this group, the background of the members, and the kinds of intersections you see developing between this more private venue for discussion and the public interest?

RAMSEY: The group at this point has more than one hundred faculty members from all nine schools of the University, including the Blair School of Music. About half of them are from the

medical center—a group that includes both clinicians and researchers. The larger project of the group has been the construction of a major inter-school, interdisciplinary center for Medicine, Health, and Society at Vanderbilt. The new MHS Center, based in the College of Arts and Science, which I direct, is the first step toward this long-term objective. We now need mechanisms to facilitate

bridging the traditional disciplinary divides that have long been associated with this field.

LETTERS: Could you describe in greater detail the new curricular programs associated with the MHS initiative?

RAMSEY: In the Medical School, the old biomedical research requirement for first- and second-year students has been replaced by a menu of options, known as the Emphasis Program. One of the options is the medical humanities; we’ll be working through the MHS center to arrange for people from outside the medical school, mostly from the College of Arts and Science, to mentor these students. It’s a very exciting opportunity, but we need to give a lot of careful thought to how it’s going to work—not just the mechanics, but also the themes, the emphases, and the sorts of issues we want to address.

It’s certainly something that we’ll talk about here in the Fellows group. In the College of Arts and

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CHURCHILL: There is a rule of rescue in this country that says no one should die on the street, whether they have health care or not.

Science, we are close to having approval for an undergraduate minor in MHS studies, and the possibility of a contract major, in which students will design a program and submit it for approval to the Committee on Individual Programs. If the minor is approved early in the fall semester, we will offer a foundation course in MHS in the spring semester that will involve guest lecturers from across the campus. One product of this year's Fellows program may be designs for courses that each of us might individually want to teach for MHS studies.

CHURCHILL: The Emphasis Program that Matt just mentioned is an innovative program in the Medical School that will begin in 2004, and it is truly innovative in the sense that it is designed to add an independent scholarly emphasis to the curriculum. It will make Vanderbilt unique in allowing students to devote a year and a half of work in a particular subject of their choosing related to medicine and health care. There are eight different areas; one of these is medical humanities. We would expect about a dozen or so students a year to select this field, and we will be engaging faculty not just from the medical school, but also across the campus and in particular from Arts and Science, to be mentors for these students over that eighteen month period. That's something that we're very excited about, especially since Medical School Dean Stephen Gabbe has decided that the Medicine, Health, and Society Center will be the chief contact point for the non-medical school faculty who will serve as the mentors for these medical students. That expresses a lot of confidence in the initiative that Matt and his colleagues have put forward and also gives us a place to build on our interdisciplinary teaching. We're hoping that this will be an indication of the way in which the MHS center can actually assist interdisciplinary teaching and scholarship on the campus.

RAMSEY: We also plan to organize a national conference for the year after next on new directions

in MHS studies, with support from the Warren Center; this could become the model for future conferences organized by the MHS center.

LETTERS: In your proposal, you identify three areas of investigation that current scholarship tends to engage: medical pluralism, the provision of health care, and the



Larry Churchill

impact of new diseases and technologies. What are your current research interests, and how do they inform the larger body of scholarship in these areas?

RAMSEY: Much of my work over the last decade has focused on what we might call medical pluralism—differences in medical practices and beliefs within and across cultures. In particular, I have done quite a bit of work on the divergences in health practices of particular historical populations, most specifically, those of eighteenth- and nineteenth-century France. I'm interested, for example, in the process through which certain practices that were widely shared over centuries (such as the inspection of urine to diagnose disease) persisted in some populations and disappeared in others over the course of one hundred years or so, from the mid-eighteenth to the mid-nineteenth century. A very clear distinction emerged between official medi-

cine, which was grounded in science, and other kinds of medicine, which sometimes claimed to be grounded in science but clearly had a different cognitive basis. I am currently completing a large book on the development of professional monopoly in French medicine. I am interested in the ways in which some of the people who practiced what we would now call non-official medicine were excluded from the medical field, even though many patients continued to consult them. I am also currently engaged in some other projects that connect less to medical practice and more to therapeutics. I just gave a series of lectures in France that I expect will become a small book on the therapeutic uses of the human body. One lecture covered the use of excremental remedies; a second one concerned the therapeutic use of human body parts, sometimes called "medical cannibalism"; and the third was on the

history and pre-history of blood transfusion and organ transplants.

CHURCHILL: Most of my background and training is in ethics and so most of what I do in the medical school concerns ethical questions and issues, particularly those that have an impact on the provision of health care. One of the things I have been preoccupied with studying is the mechanism for distributing health care resources in this country, and the ways in which mechanisms have changed over time. My predominant framework considers questions of justice and the allocation of resources, and interrogates who gets health care services, who doesn't, and why this is the case. For instance, emergency health care resources, like access to emergency rooms, are typically open to everyone. There is a rule of rescue in this country that says no one should die on the street, whether they have health insurance or not. On the other hand, very basic pro-

visions for primary care such as the ability to see a physician to get your diabetes or hypertension under control is the kind of thing that's bought and sold on the market. These are really interesting questions to me because they illustrate an aligning of values in relation to how the health care system works. Obviously, such questions involve issues of financing and distribution, but they also involve the cultural issue of what Americans think about health care, and what dimensions of it they think are important. These are critical questions in terms of understanding the system that we now have. In asking ourselves why we have the system we do, we must realize that our sense of ethics as well as our cultural values tend to give the system the shape that it has. One of the things that is always on my mind when I am thinking about Medicine, Health, and Society is the ways in which the health care system reflects our social and cultural values. We have the particular system we do because of the way we have organized and distributed a lot of other social goods, and it's important to put all of this into context. We're fortunate to have the diverse group that we have for this year's Fellows program, because diverse perspectives are crucial to understanding the full picture. And, actually, one of the geniuses of the whole effort in Medicine, Health, and Society at large is this understanding of disciplinary diversity as organic to this field of study.

RAMSEY: I also have a broader interest in how cultural and social differences affect responses to disease in different societies, including our own. In the case of the provision of health care, it is interesting to see how various industrialized societies confront the problem of containing costs. Even countries with very generous national health insurance programs, such as France, are seeking more effective ways of containing the cost of health care. They have been wrestling with it for a generation, but the government is now thinking about much more

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significant reductions in benefits, and that is going to provoke a strong social reaction. There are also differences in how various societies deal with new technologies, with organ transplantation, and the use of knowledge about the human genome. For example, in France, it is illegal to sell blood products, unless they come from umbilical cord blood, because the umbilical cord is not considered a part of the body belonging to an individual; of course, the situation in the U.S. is very different. Another case in point is the difficulty of working with embryonic stem cells in the U.S. for political reasons. The U.K., not operating under these same constraints, has offered more opportunities for such research, and is now a leader in this area. This is a rather obvious illustration of social and political constraints on scientific research and innovation.

CHURCHILL: Matt's cross-cultural, historical work has been very important to me in thinking not only about how the U.S. health care system sits in relation to the systems of other countries, but also how it has changed over time. It is interesting to note, for example, that in the 1920s, the American Medical Association was supporting universal access to health care and was very much in favor of a kind of policy in which the government played a substantial role. That, of course, has been anathema for the last sixty years. It is important to see the way that things change in relation to the social and historical context, and to understand the forces that were in play then, in comparison to what we're doing now. It is of tremendous importance in correcting one's disciplinary provincialism to establish a dialogue with people who have been trained in different ways and who have had different experiences. The potential to compare is one of the chief bases for making judgments, and as long as one is inside of a particular set of experiences and ignorant of the rest, thinking critically is a practical impossibility.

LETTERS: You mention briefly in your proposal that the work of Bruno Latour has offered a theoretical framework that some scholars in this field have found useful. But you also note that many scholars who work in this field do not necessarily employ a specific theoretical lens. Could you say a bit more about the role of theory in this field and in what directions you think the field will be heading? In what ways is theory enabling and promoting new ways of thinking about Medicine, Health, and Society? How might it prove limiting?

RAMSEY: On the whole, I think the social and cultural study of medicine is about a generation behind the social and cultural study of science, or what is now sometimes called science studies, in the application of theory. It's not a coincidence that Latour, even though he writes about medical topics, is primarily approaching the subject from the point of view of the philosophy and the anthropology of science. There is, however, a common foundation that we can build on. Most people who study medicine and health from the perspective of the humanities and social sciences are aware of the ways in which society and culture influence the experience of illness and the ways in which health care is provided. In one sense or another, I think everyone in the seminar would accept some form of the notion of the social framing or the social construction of disease, and I think that even our one clinician from the medical school, Scott Pearson, would subscribe to that as well. He is interested in finding new ways of constructing patient histories that take into account the ways in which individuals experience disease, as opposed to considering simply the biology of disease. I don't think that any of us has the expectation that we are going to evolve a theoretical model or approach that will be novel and will embrace all the things that we are doing. What we end up doing will probably be very eclectic. But I suspect that

one thing that will come out of the seminar, at the very least, is some exposure to different theoretical perspectives.

One potential theoretical framework for our discussions can be found in the work of Michel Foucault, who greatly influenced an entire generation of scholars working on the sociology and history of politics and disease and provided a way of talking about power relations, and also a way of analyzing texts that has been widely influential. But his influence has been on the wane. Someone whose star has been on the rise is Norbert Elias, the German sociologist and philosopher, and author of *The Civilizing Process*. Even though it seems that everyone who borrows from his work begins by saying that it's too crude



Matthew Ramsey

and lacks nuance, I think there is a great deal of interest among those who work on the body, and on health and disease, in the notion that there is an interconnection among societal attitudes toward the body—views of cleanliness, order, politeness, and even violence. There's a sense in which all of these things are interconnected. The implication for people who study health and health care from different perspectives is that there are parallels with other

areas which involve the policing, controlling, and regulating of society, the body, and human behavior.

LETTERS: There seems to be a trend among some patients in seeking alternative treatments and healers, a practice that would seem to undermine the status of medicine as the exclusive domain of the elite professional. How does your work take this trend into consideration?

CHURCHILL: The relation between traditional and non-traditional medicine is a subject of rigorous debate—one spawned by David Eisenberg's article in the *New England Journal of Medicine* that discussed unconventional therapies in the United States (January 28, 1993). And in fact, I'm currently involved in an Institute of Medicine study group that's looking at this very question—the question of why 50 percent of the American population uses some kind of alternative therapy or medication, or seeks alternative healers such as chiropractors, traditional Chinese healers, acupuncturists, acupressurists, and other non-allopathic, or non-traditional practitioners.

RAMSEY: The French talk about "parallel medicine." In English, we have talked about "alternative medicine" and, more recently, "alternative and complementary medicine." The latter is the title of a center at the National Institutes of Health, and it implies that non-conventional medicine is not simply the opposite of official medicine, but rather, constitutes something that can connect to—and work with—biomedicine. Clearly, the question of vocabulary is an important one.

CHURCHILL: Yes, and the most recent term I've heard is "integrative." There are a couple of centers for complementary and integrative medicines in this country that are working very hard to do traditional research in these fields—to try to figure out, for example,

whether a non-allopathic treatment such as acupuncture is going to work just as well for certain kinds of problems or illnesses as traditional, allopathic therapies. I think that the idea that this is such a force in terms of the experience of some people is an indication of the enormous pluralism of approaches with regard to health and the way in which it is conceptualized and understood. Even without going abroad, you can find nuggets of complementarity as well as conflict with regard to people's practices, and the philosophies and peripheral philosophies that shape them. This is a terribly interesting issue to me because it approaches the pluralism question in a different kind of way. It is a worthwhile subject of study, because for most people, health and seeking health services is not just a matter of seeing MDs in a clinic. The much broader and holistic notions of what a symptom means, and how patients understand what is happening to them, affect the kinds of providers that they subsequently seek for treatment.

RAMSEY: The question of alternative medicine is very complex, in part because the concept embraces a number of very different things. You have people who are members of what were referred to in the nineteenth century as "sects"—groups that have a quasi-religious orientation or alternative cosmology and often have an alternative physiology and anatomy and a very different understanding of disease. For many of these groups, the key principle is not to accept official therapies, which are considered dangerous. But that's a relatively small part of the phenomenon of alternative medicine. You also have large immigrant populations throughout the Western world, who come from non-Western societies that have very long established indigenous medical traditions to which they remain deeply attached. There is a marvelous study of Hmong immigrants from Laos by Anne Fadiman called *The Spirit Catches You and You Fall Down*. She focuses on epilepsy—the book's title is the literal translation of the Hmong term for this condition—but also deals more broadly with the problem of cultural incommensurability in medicine. In her account, the immigrant population cannot

understand how Western biomedicine makes sense of this disease and what it is that the doctors are trying to do. And of course, at least in the beginning, the doctors believe they are dealing with unalloyed ignorance and superstition. No communication between the groups is possible.

CHURCHILL: People don't have health insurance to cover alternative healers, so they're paying out of pocket; this is an indication of the significance of this phenomenon. One of the things that the studies that have been done indicate is that alternative healers do a better job of getting in touch with patients, of being empathetic and appreciating the world view and the values of the people who come to them. That is why they succeed—at least in part—though, of course, they actually may have some effective remedies. There's a powerful psychosocial component in shared assumptions about the causes of one's illness and what one might do to get better. Surveys that have been done with people who use alternative healers show again and again that this is the case. And this isn't surprising, especially considering the constrained time for physician visits and all of the things which have come with managed care. An efficiency motif has descended on health care practices, and practitioners have much less time to talk to people. People are expressing their dissatisfaction in the failure of medical professionals to recognize them in terms of their whole makeup, or to figure out what it is that they bring into this in terms of their individual model of illness. There's a wonderful distinction that I think is really crucial to understanding this phenomenon made by Harvard anthropologist Arthur Kleinman. Kleinman notes that physicians are trained to diagnose diseases in terms of an international classificatory system—a patient has diabetes, hypertension, or whatever it is. But in reality, patients also come in with an illness. An illness is their sense of why they got sick, what it means to them, and what they might do to make it better or to find help. These two things have to come together somehow. To me, that's a motif throughout this whole discussion in terms of trying to understand the variety of illness. This is part of

the patient narrative, and it's a narrative told by the person who is ill. But in trying to put this together, we must also ask how we might combine Western science and the kind of reductive biological orientation that it has, with a meaning system that varies across time and culture—even within a community. Part of what makes this interesting is trying to imagine how one might do this and what kind of advances one might achieve by studying and working on it.

RAMSEY: I think Larry's comments would apply to a wide range of traditional healers who are members of the communities where they find their patients. They would apply, for example, to curanderos in Hispanic communities in the American Southwest, and to traditional healers in many rural societies elsewhere. But there are also other patterns. Many people I've studied in the eighteenth and nineteenth century were itinerant quacks, one of whose characteristic features was that they didn't know their patients. They appeared in the town square, distributed flyers, and provided entertainment in order to draw a crowd. They promised to cure certain diseases and offered free advice to the poor, and then they sold their drugs and moved on. The healers were long gone before the patient was able to judge the outcome. Strange as it may seem, this is a model that is still with us in various forms. We have alternative medicines that are hawked on the internet—there's no physician-patient contact at all.

The internet has transformed alternative medicine and medicine in general by creating virtual communities of patients, a phenomenon that is very new and yet also, in a sense, very old. Sometimes a common disease defines these communities; in such cases they are often essentially support groups. Sometimes they are defined by a shared belief in a healing system. These kinds of communities can reinforce a set of beliefs and the reputation of a healer people have never met, much in the same way that word of mouth can reinforce the reputation of a village healer. Part of what interests me, as an historian, is how some of these patterns persist over time, taking new forms as technology changes and as political and social contexts change. There are

certain fundamental continuities in the human condition; one of them is the experience of having to deal with diseases that can't be cured—and ultimately with death. The ways in which various healers have responded to these basic experiences at a human level have always shaped the ways in which patients respond to them, in both Western and non-Western societies. It's not a role that contemporary biomedicine plays very well.

LETTERS: You note that our understanding of disease and our own bodies is undergoing a rapid transformation with the mapping of the human genome, genetic testing, and cloning. In what ways is this new knowledge both empowering and disempowering? In what ways do you see it both increasing and decreasing patients' control over their own health? What evidence have you seen that might illustrate this?

CHURCHILL: If you think about this as a pendulum swing between nature or nurture as the chief elements in determining our fate, our health, and our destiny, we're now swinging back very heavily on the nature side, and this is what genomics is all about. In its crude form, the popular image in the past was that there was a gene for every particular trait, so that people spoke seriously about finding a gene for homosexuality, or finding a gene for shyness, or for pyromania. I think we've moved away from that more simplistic and false notion into more of a balanced understanding. But I also think that the mapping of the human genome and the research that has been generated out of that in terms of hoping to find cures for genetic illness—and every illness is genetic to some extent—has spawned a renewed cultural sensitivity about genes. There's a precedent for this, in the work of Francis Galton, the early eugenicist. His idea was that one could actually identify a genetically inferior human stock and try to control for it. I think we're a long way from that, but many people think that somehow we might be able to allow individuals to make better choices if they had genetic knowledge—knowledge about the vulnerability of their offspring to certain kinds of illnesses. But our infatuation with genetic control is fraught with enormous hazards,

such as the potential for discrimination against people on the basis of genetics for health insurance or job qualifications. There is incredible promise in the possibility of finding ways of repairing genes, but we're a long, long way from that. It opens up a lot of old debates, rather than creating debates: debates about discrimination, debates about what makes us equal, and what makes us different, and the role genetics plays in that. There are also debates about what goals it is useful to achieve in terms of health, because if we can manipulate genes, there is the potential not only for making people well, but also, in some cases, better than normal. Carl Elliott, a philosopher at the University of Minnesota Bioethics Center, has a book out called *Better Than Well: American Medicine Meets the American Dream*, and it's about the ethics of enhancement. Suppose we could alter the human genome to enable all humans to get by on three hours of sleep a night. Would we be better off? Or suppose we could double memory capacity. Would we want that? What are the implications of such alterations? Not to mention things like having a longer average life span. If genetic manipulation of a therapeutic sort is available only to people who can afford it, then we will have done something dramatic not only to the already growing disparities between people in terms of health, but also to their economic opportunities, their social well-being, and their power. So unlike the period in which Francis Galton was advocating a societally-controlled eugenics program, what seems more likely today is discrimination based on genetic information. Often, such information is not even good information—it's misinformation. Here, I'm thinking about the genetic testing that insurance companies have occasionally tried to require for health policies.

RAMSEY: The British government has proposed collecting genetic information for all babies born in the U.K. It's worrisome, and there is an interesting debate that's beginning to emerge. But the utopian vision has been there for a very long time. Some of the utopias of progress from the late-eighteenth-century Enlightenment

deal not only with the advancement of learning and the improvement of society, but also with the biological perfectibility of the human species, moving towards immortality. In William Godwin's version, sex withers away because reproduction is no longer necessary.

The more we learn about the processes—both biological and social—that produce unique human individuals, the more we realize what we don't know, and I think it's becoming very clear that decoding the human genome is only the first step, not the culmination, in a very long process of discovery that may lead to the sorts of practical interventions that Larry is talking about. What we'll see sooner are the products of what is called pharmacogenomics—the tailoring of medications to individuals. This doesn't necessarily involve sequencing their genome; it may simply mean recognizing how genetic differences expressed in the biochemistry of the body affect a patient's response to medications.

LETTERS: This year's Visiting Fellow, Stephen Rachman, is studying the medical/aesthetic relationship between nineteenth-century Chinese artist, Lam Qua, and American physician and missionary, Peter Parker, whose patients were depicted in Lam Qua's work. Clearly the relationship between society's response to disease and its presentation in the fine arts and media is as important and relevant today as it was then. What role do you see cultural productions playing in changing the ways in which we think about disease?

CHURCHILL: I was thinking about a course that I direct for first-year medical students. We use a lot of literature in the course and my teaching has always used a lot of literature in conveying both the social and cultural components of illness and disease, as well as the ethics. There is a tremendous body of literature that deals with the fundamental human components of illness, death, disability, relationships between healers, patients, and families, and dealing with chronic illness. That has always been a very important part of this broader understanding and communication of what is actually happening. William Carlos

Williams' poetry and short stories are good examples of this, as is the work of Lewis Thomas, a popular writer who was the head of the Sloane Kettering Cancer Institute in the 70s. Thomas wrote a series of essays that were originally published first in the *New England Journal of Medicine* and were later put into books. *The Lives of a Cell* is probably the most important. More recently, Margaret Edson's play *Wit* was turned into an HBO movie. It is a powerful embodiment of some of the difficulties of being a terminally ill person dealing with the health care system, and being at the same time a patient and a research subject. In fact, we are going to be using this film with second-year students this year. I have also been revisiting James Agee's book *A Death in the Family*, which is one of the most moving and powerful psychological studies about the impact of death. In recent years in particular, we've seen a lot of attention focused on specific disease entities; Lucy Grealy's *Autobiography of a Face*, the account of Grealy's childhood battle with Ewing's sarcoma that left her face permanently disfigured, comes immediately to mind. In the last ten to fifteen years there have been a large number of works in which particular illness episodes, or courses of illnesses, have been dramatized in some way. I don't know if this phenomenon was prevalent in the past, but it seems to me that it wasn't, and this has done a lot for the broad cultural understanding about what people experience. And sometimes these productions become catalyzing agents for advocacy groups. AIDS is easily the most recognizable, but there are others as well. The cystic fibrosis group, for example, is a powerful organization of people who have a shared body of experience. It's not high art, but there are paradigmatic stories that get passed through these communities that become catalytic for political and social action, and they influence the ways in which research dollars are allocated. It's very interesting and it's fabulous teaching material.

RAMSEY: The representation of illness in the arts—whether in the high arts or in popular culture—is extremely important in shaping perceptions of disease and of those

who suffer from them. In the case of AIDS in particular, the role of the arts has been extremely important in conveying suffering that goes beyond what could be expressed in a simple prose statement. To some extent the arts have helped to normalize patient groups that have been marginalized for various reasons. AIDS patients are a particularly good example of a much larger group of disease sufferers who have been rejected because of prejudice and fear.

I don't know if SARS has been around long enough for us to have a clear sense of the social response to its victims, but there was a very interesting article recently in the *New York Times* entitled "Behind the Mask: The Fear of SARS," which focused on a group of volunteers from America who had been recruited to go to Canada to relieve medical personnel in the infectious disease wards who had been working countless hours under very difficult conditions. The conversations that were reported were timeless in a sense because they recalled the responses to other threatening contagious illnesses in the past—leprosy in the Middle Ages, the plague in the early modern period. Families asked themselves whether a parent should leave the children behind for a period to go to Canada and risk contracting a lethal disease. There were discussions about obligation—the human obligation to the patients and the professional obligation to colleagues who had given their all and had no more to give. There were descriptions of the terror that spread through hospitals in Toronto and a few other places in Canada—accounts of doctors, for example, who at a meeting would always stay on the other side of the room from colleagues who had cared for SARS patients. This article succeeded in conveying the human reality of a disease experience that for most people has been a set of statistics and a list of cities to avoid. If SARS returns this winter, as it may, and spreads, I think we'll start to see a response that goes beyond these immediate news reports, and may ultimately find a place in the arts. Artistic expression may help to mediate the experience of the disease to a larger public in ways that simple reportage cannot.

Medicine, Health, and Society: 2003/2004 Fellows Program

LARRY R. CHURCHILL, Ann Geddes Stahlman Professor of Medical Ethics, is Spence and Rebecca Webb Wilson Fellow and co-director of the Fellows Program. He is known for his work on the social and cultural dimensions of health care and health policy, and has published on many topics in medical ethics, medicine and literature, and medicine and philosophy. He is the co-author (with H. L. Smith) of *Professional Ethics and Primary Care Medicine: Beyond Dilemmas and Decorum* (Duke University Press, 1986); *Rationing Health Care in America: Perceptions and Principles of Justice* (University of Notre Dame Press, 1987); co-editor (with N. M. P. King and A. W. Cross) of *The Physician as Captain of the Ship: A Critical Reappraisal* (D. Reidel Publishing Company, 1988); *Self-Interest and Universal Health Care: Why Well-Insured Americans Should Support Coverage for Everyone* (Harvard University Press, 1994); co-editor (with G. Henderon, N. Strauss, and R. Estroff) of *The Social Medicine Reader* (Duke University Press, 1997); *Ethical Dimensions of Health Policy* (Oxford University Press, 2002) co-edited with Marion Danis and Carolyn Clancy; and most recently, series editor (with Allan M. Brandt) of *Ethical Dimensions of Studies in Social Medicine* (forthcoming from University of North Carolina Press). His current research interests include access to health care and the ethical dimensions of health policy.

CRAIG ANNE HEFLINGER, associate professor in the Department of Human and Organizational Development, has received numerous honors and awards for her research in child and family health services. She is co-editor of *Families and the Mental Health System for Children and Adolescents: Policy, Services, and Research* (Sage, 1996) and co-author (with L. Bickman, P. R. Guthrie, E. M. Foster, E. W. Lambert, W. T. Summerfelt, and C. Breda) of *Managed Care in Mental Health: The Fort Bragg Experiment* (Plenum Press, 1995). Heflinger's recent work involves using large data sets to examine health care access and service use patterns. She is currently focusing on personal and cultural perceptions of health, and factors influencing decisions to seek formal health care.

LEONARD M. HUMMEL, assistant professor of pastoral theology and counseling, is director of research for religion and spirituality at the Pain and Symptom Management Program of the Vanderbilt-Ingram Cancer Center. He is the author of *God on the Gallows: Consolation for Suffering in Luther's Theology and Lutheran Practice* (Fortress Press, 2002). He is currently collaborating with medical researchers on a proposal titled "Facing Death: Cancer and Spiritual Transformation." He is particularly interested in analyzing the religious and theological dimensions of spiritual

transformation among persons with cancer, as well as in the inter-related dimensions of culture, history, politics, and economics in the phenomenon of cancer.

SCOTT PEARSON is assistant professor of surgery at the Division of Surgical Oncology at the Medical Center. Pearson's research is primarily focused on racial disparity in the outcome of breast cancer. He is the author of numerous journal articles, book chapters, and abstracts on surgical oncology. He is currently developing an interdisciplinary training program in narrative medicine that teaches medical students to view their patients in a broader cultural context. The goal of this program is to teach physicians to include and address early in patient interaction the impact of issues of race, gender, socioeconomic status, culture, and spirituality on the patient's care.

STEPHEN D. RACHMAN, associate professor of English at Michigan State University, was awarded the William S. Vaughn Visiting Fellowship for the 2003/2004 Warren Center Fellows Program. He is the co-editor (with Shawn Rosenheim) of *The American Face of Edgar Allan Poe* (The Johns Hopkins University Press, 1995); *Cultural Pathology: Disease and Literature in Nineteenth Century America* (forthcoming from the Johns Hopkins University Press in 2004); and co-author (with Peter Vinten-Johansen, Howard Brody, Nigel Paneth, and Michael Rip) of *Cholera, Chloroform and the Science of Medicine: A Life of John Snow* (Oxford University Press, 2003); as well as numerous articles on nineteenth-century American literature and literature and medicine. While at the Warren Center, Rachman will continue work on a book project titled "Memento Morbi: Lam Qua's Paintings, Peter Parker's Patients," which is about the medical/aesthetic relationship between a leading American medical missionary in China, the Reverend Dr. Peter Parker, and the 19th-century Cantonese artist, Lam Qua, whose oil paintings depict Parker's patients.

MATTHEW RAMSEY, associate professor of history, is Jacque Voegeli Fellow and co-director of the Fellows Program. He is also the director of the Medicine, Health, and Society Center at Vanderbilt. His research interests concern the social and cultural history of late eighteenth- and nineteenth-century France. He is the author of *Professional and Popular Medicine in France, 1770-1830: The Social World of Medical Practice* (Cambridge University Press, History of Medicine series, 1988); a short monograph, *The Politics of Professional Monopoly in Nineteenth-Century Medicine: The French Model and Its Rivals in Professions and the French State, 1700-1900* (ed. Gerald L. Geison, University of Pennsylvania Press, 1984) as well as numerous articles

and book chapters on the history of medicine. He is currently at work on a book project entitled "The Development of Professional Monopoly in French Medicine," as well as a book on the therapeutic uses of the human body in eighteenth- and nineteenth-century France, which is based on a series of lectures that he delivered in France in the summer of 2003.

RUTH ROGASKI recently joined Vanderbilt as associate professor of history. Her research focuses on the intersection between corporeal experience and Chinese constructions of modernity. Her first book, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (forthcoming, University of California Press, 2003), explores China's engagements with imperialism and modernity through the lens of medical history, examining in particular how hygiene became both a major marker of Chinese deficiency and a cornerstone of imagined modernity. She is currently working on a second book on the role of the biological sciences in the construction of Asian empires.

PEGGY A. THOITS, professor of sociology, specializes in the sociology of mental health; social psychology; the sociology of emotion; self and identity; and stress, coping, and support processes, and is the

author of many articles on these subjects. She is currently engaged in studying stress from a social psychological perspective and plans to use her fellowship to bring two aspects of her research (on coping with identity-threatening events and effective forms of social support) into one pilot project. She recently co-edited (with Peter J. Burke, Timothy J. Owens, and Richard Serpe) *Advances in Identity Theory and Research*, (Kluwer Academic/Plenum, 2003). Thoits is currently collaborating with a colleague at Tokyo Metropolitan University on a cross-cultural comparison of depression in Japan and the U.S.

ARLEEN M. TUCHMAN, associate professor of history, is the author of *Science, Medicine and the State in Germany: The Case of Baden, 1815-1871* (Oxford University Press, 1993). She is completing a biography of Marie Elizabeth Zakrzewska (1829-1902), one of the most prominent female doctors in post-Civil War America and founder of the New England Hospital for Women and Children, an institution that catered both to the care of the poor and the education of female physicians. Upon completion of the biography, Tuchman will begin research for a book-length study on the history of diabetes in the United States, focusing on the history of the disease as well the history of health and health care disparities.

2004/2005 Fellowships

The 2004/2005 Fellows Program at the Warren Center, "Strategic Actions: Women, Power, and Gender Norms," will be co-directed by Vanderbilt University faculty members Holly McCammon (sociology) and Cecelia Tichi (English). The year-long seminar will bring together scholars from a variety of disciplines to explore the ways in which women have acted strategically to further women's interests and to reconstruct gender norms.

Women have been strategic in activism, literature, law, politics, religious institutions, families, the arts, the workplace, and the public dialogue. Their strategies are sometimes globally focused but at other times are focused at the national, community, or even personal level. Often the goals of these actions are combined with racial, ethnic, class, or regional agendas.

The Warren Center will sponsor a Visiting Fellow with expertise in the area of study, in addition to selected Vanderbilt faculty members. Information regarding the internal and external applications processes can be obtained from the Warren Center.

Stephen J. Pyne to Deliver 2003 Howard Lecture

Stephen J. Pyne, professor of biology and society at Arizona State University, will present the 2003 Harry C. Howard Jr. Lecture on Thursday, October 23rd at 4:10 p.m. in 126 Wilson Hall. Professor Pyne's lecture is entitled "American History, with Fire in its Eye." Pyne, acclaimed by *The New York Times Book Review* for his "major contribution to the literature of environmental studies," is the world's foremost historian of fire. He has published a series of environmental histories, *Cycle of Fire*, now being republished and expanded by the University of Washington Press. Books in the series, which have been translated into multiple languages, include *Fire: A Brief History* (University of Washington Press and British Museum, 2001); *Vestal Fire: An Environmental History, Told through Fire, of Europe and Europe's Encounter With the World* (University of Washington Press, 1997; paperback edition, University of Washington Press, 1997) and *Fire in America: A Cultural History of Wildland and Rural Fire* (Princeton: Princeton University Press, 1982; new preface for paperback edition, 1988; pa-

perback edition, University of Washington Press, 1997). Other recent books by Professor Pyne include *Smokechasing* (University of Arizona Press, 2003); *Year of the Fires: The Story of the Great Fires of 1910* (Viking, 2001; paperback, Penguin, 2002); and *Fire on the Rim: A Firefighter's Season at the Grand Canyon* (New York: Weidenfeld & Nicolson, 1989; Ballantine Books, paperback edition, 1990; University of Washington Press, paperback edition with new preface, 1995).

Professor Pyne has received numerous fellowships, including the MacArthur "Genius" Fellowship (1988), a Fulbright Fellowship, two NEH fellowships, and has twice held fellowships at the National Humanities Center. He is a Fellow of the American Association for the Advancement of Science, as well as the American Academy of Arts and Sciences. His works have garnered numerous literary awards. In 1995, he received the Robert Kirsch Award from the *Los Angeles Times* for a

"living author whose residence or focus has been in the West and whose career contributions merit body-of-work recognition."

In conjunction with this year's Howard Lecture, the Warren Center will host a show of Vanderbilt University



Professor of Art Marilyn Murphy's series of fire paintings. Professor

Murphy is an artist whose oil paintings, drawings, and prints create curious situations from what appears to be everyday life, giving the impression of film noir. Her work has been shown in

more than 200 exhibitions in locations including the National Academy of Design, The Drawing Center in New York, and the Perc Tucker Regional Gallery in Australia. A recipient of numerous awards, she has curated more than thirty exhibitions and her work is included in many public and private

collections.

The Harry C. Howard Jr. Lecture Series was established in 1994 through the endowment of Mr. and Mrs. Thomas E. Nash, Jr., and Mr. and Mrs. George D. Renfro, all of Asheville, North Carolina. The lectureship honors Harry C. Howard, Jr. (B.A. 1951) and allows the Warren Center to bring an outstanding scholar to Vanderbilt annually to deliver a lecture on a significant topic in the humanities.



Robert Penn Warren Center Executive Director Mona Frederick (left) and Associate Professor of English Kate Daniels met with Senator Lamar Alexander (Vanderbilt '62) in Washington, D.C. to discuss issues related to the humanities in higher education.

2004 Warren Center Summer Graduate Student Fellows Program

The Warren Center will offer graduate students in the College of Arts and Science the opportunity to participate in a summer Graduate Student Fellows Program. Warren Center Graduate Student Fellows will receive a \$4,500 stipend and will meet weekly or twice-weekly for two hours, from mid-May through early June at the Warren Center to give presentations based on their research. Each Fellow will be expected to give one seminar presentation and will be required to attend all seminar meetings. Occasional social events will be a part of the program as well. After the four-week series of seminar meetings, the remaining portion of the summer fellowship will be service-free. The Warren Center grants are intended for graduate students in the humanities or qualitative social sciences who are at the advanced stages of writing their dissertations. Detailed application and fellowship information will be distributed during the fall semester.

The Warren Center hosted its inaugural Graduate Student Summer Fellows Program in the summer of 2003. Participants in the program were: Ivan Fernandez Pelaez, Department of Spanish and Portuguese; Elizabeth Festa, Department of English; Aisha X. L. Francis, Department of English; Jennifer Holt, Department of Philosophy; Karissa McCoy, Department of English; Matt O'Mansky, Department of Anthropology; and Carrie Lee Smith, Department of Sociology.

2002/2003 Warren Center Fellows Conference

The 2002/2003 Warren Center Fellows are planning a conference focusing on gender, sexuality, and activism. The conference will be held October 31 and November 1. Participants will include Alejandra Sarda, coordinator of the Program for Latin America and the Caribbean at the International Gay and Lesbian Human Rights Commission. Several local activists will participate in the conference as well, including Abby Rubinfeld (Human Rights Campaign and ACLU-TN), Becca Stevens (founder, Magdalene House), Dwayne Jenkins and Victor Anderson (Brothers United), and Pamela Degroff (Tennessee Vals). More detailed information about the program will be distributed shortly.

Race and Wealth Disparity in 21st-Century America

The Warren Center and the Vanderbilt Law School are cosponsoring a research circle entitled "Race and Wealth Disparity in 21st-Century America." The project is funded by the Ford Foundation and directed by Beverly Moran, professor of law and sociology at Vanderbilt University. Members of the research circle are working to bridge the gap between their separate disciplines by sharing each field's unique insights and methods with one another and with the general public, through a series of private workshops and public lectures, as well as the development of teaching materials for use in the classroom. Participants in the program include faculty members from five colleges within Vanderbilt University (College of Arts and Science, Law School, School of Medicine, Owen School of Management, and Peabody College), Fisk University, Meharry Medical Center, and Tennessee State University. Also participating in the program is the executive director of the Tennessee Network for Community Economic Development, a not-for-profit organization committed to increasing asset acquisition among the working poor. The lecture series, which began in the fall of 2002, will continue during the 2003/2004 year. Lecture dates and topics will soon be announced.

THE ROBERT PENN WARREN CENTER FOR THE HUMANITIES

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Statement of Purpose

Established under the sponsorship of the College of Arts and Science in 1987 and renamed the Robert Penn Warren Center for the Humanities in 1989, the Center promotes interdisciplinary research and study in the humanities, social sciences, and when appropriate, natural sciences. Members of the Vanderbilt community representing a wide

variety of specializations take part in the Warren Center's programs, which are designed to intensify and increase interdisciplinary discussion of academic, social, and cultural issues.

Vanderbilt University is committed to principles of equal opportunity and affirmative action.

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