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Preface

Contributing Authors

David Augustin Hodge, Sr., Ph.D., D.Min., M.Ed., M.T.S., is Associate Director of Education at the National Center for Bioethics in Research and Healthcare at Tuskegee University. From undergraduate to graduate school David's primary work was in Christian theology, Christian ethics, and Christian education. He taught in this genre for over two decades, primarily in South Florida. Additionally, for several years he was a primary writer for the adult Sunday School lessons and one of the Townsend Press, commentary authors for the National Baptist Convention, U.S.A., Sunday School Publishing Board. He published three books, primarily for women, God of Our Silent Tears: Women of the Bible Healing Women of Today, God of Our Silent Tears: A Five Week Journey, and In the Midst of My Tears: The Bible Speaks to Abandonment, Betrayal, Rejection and Loss. Developing a strong desire to pursue more complex questions in ethics and philosophical theology, he pursued a second doctorate degree, earning a (secular) Ph.D in Philosophy supervised by virtue and care ethicist Michael Slote. His dissertation topic: Jesus the Virtue Ethicist: A Metaethical Anticipation of Moral Sentimentalism, Empathy and Care.

Robin Risling-DeJong, MHS, PA-C. is a member of the Hoopa Valley Tribe, in Northern California. She comes from a long line of tribal family members serving as regalia makers, dance leaders, medicine men/women, traditional educators, tribal leaders, and leaders for American Indian sovereignty issues. Robin currently serves as full time faculty at the University of South Alabama Physician Assistant Studies. She maintains clinical practice in Family Medicine. She has strong history of working with underserved populations and is dedicated to improving access to care by helping to eliminate barriers.

Otis B. Head, PhD, MDiv. earned is B.A. from Fisk University in Nashville, Tenn., earned his Master of Divinity from the Interdenominational Theological Center in Atlanta, Georgia and his Doctor of Philosophy in Christian Counseling from the Restoration Theological Seminary in Atlanta, Georgia. His professional career includes service as a social worker, director of community and detention juvenile centers, warden of adult correctional facility, program director of a juvenile detention center, director of a non-profit family ministry and director of counseling ministry of a mega church. Presently he is a Visiting Scholar at the National Center for Bioethics in Research and Healthcare at Tuskegee University and serves as Project Director of the Tuskegee University & Macon County Bridge Builders Program. He is the former President of the Macon County Minister’s Council. His work is dedicated to the community of Macon County and their sacred & secular development. He is a Public Theologian.

Jo A. Valentine, MSW is the Associate Director for Health Equity in the Division of Sexually Transmitted Disease Prevention, Centers for Disease Control and Prevention (CDC). A social worker by academic training and personal vocation, she began her Public Health career in 1986 as an AIDS Prevention community educator and outreach worker. In September 1991 she joined CDC. During her CDC tenure she has held a number of positions. Currently her primary responsibilities include: 1) reducing STD disparities in the United States and
promoting health equity, 2) overseeing the Tuskegee Health Benefits Program, and 3) managing the Tuskegee University Bioethics Center Public Health Ethics Program. She leads multi-disciplinary teams and workgroups, and provides technical assistance for intervention development and program implementation with a focus on advancing community-engagement in public health work across CDC and other federal agencies, as well as across state and local health departments, non-governmental organizations, and academic institutions. She received her Bachelor’s Degree in Social Work from the University of Texas at Austin in 1982, and her Master’s Degree in Social Work in 1995 from the Clark Atlanta University School of Social Work.

Christina Williams, DNP, APRN, FNP-BC. is a Family Nurse Practitioner and Educator. Christina began her nursing career in 2007 as a Registered Nurse on a pediatric unit. She completed her Masters of Science in Nursing from Mississippi University for Women in 2010. She obtained her Family Nurse Practitioner certification through The American Nursing Credentialing Center (ANCC). She began practicing as a Nurse Practitioner at an Urgent Care clinic, where she continues to practice today. In 2017, she completed her Doctorate of Nursing Practice from Mississippi University for Women. Along with caring for the health of patients, Christina invests in the future of other nurses. She is a member of the Evaluator team for the Nursing Leadership and Management track at Western Governors University. Outside of work, Christina enjoys making memories with her husband and two children. She also enjoys researching and sharing the benefits of alternative therapies such as essential oils.

Moni McIntyre Ph.D., M.Div., M.A., M.A. is assistant professor in the Sociology Department at Duquesne University in Pittsburgh, Pennsylvania. She is an ordained Episcopal priest and former rector of The Church of the Holy Cross, the only predominantly African American parish in the Episcopal Diocese of Pittsburgh. Moni is also a retired U.S. Navy Captain (0-6). One of her duties during her 28 years as a line officer included a two year tour as Ethics Consultant to the Navy Surgeon General. She currently teaches medical ethics to Navy officers in the Advanced Medical Department Officer Course at the Walter Reed National Military Medical Center in Bethesda, Maryland. Moni has written one book, co-edited two others and solo-authored numerous refereed articles published in a wide variety of venues. She is a life member of the NAACP. A particular honor for her has been to accept invitations to speak at Tuskegee University.
The 2017 Public Health Ethics Intensive Course

Untold Stories of Healing for Social Justice

Course Description

The purpose of the Public Health Ethics Intensive Course is to provide an academically and professionally rigorous course for physicians, dentists, nurses, other healthcare professionals and medical residents, social workers, graduate students, undergraduate students, university faculty and other leaders including health educators, healthcare administrators, and community advocates. The course will build competency in the theory and practice of various spheres of ethics, including public health ethics, healthcare ethics, bioethics and research ethics, focusing specifically on their influence on race/ethnicity/sex/gender and class. Through various presentations and interactive discussions, the course will explore the relationship of these spheres of ethics to social justice and the needs of individuals, groups and communities locally, nationally and globally, especially vulnerable and susceptible populations. The explorations of these topics will give critical consideration to their expansive dimensions, including areas related to agro- and socio-economics, social structures, communications, human relations, health, healthcare and the humanities. The tensions that exist between these spheres of ethics and opportunities for collaborative work between them will also be discussed. These topics are explored utilizing keynote presentations, engaging responses, general discussions, and other learning venues.

Course Objectives

At the end of the course the participants will be able to:

1) Articulate how demographic constructs such as race/ethnicity/sex/gender and class play a role in bioethics, public health ethics and healthcare ethics by honing skillsets of ethical reasoning.

2) Discuss the ethical challenges and opportunities that influence human subject research, health care delivery, and public health policy and practice.

3) Identify and discuss the narratives of scientists, faith communities, educators, ethicists and other collaborators/partners that highlight the complexities inherent in untold stories of healing that result in social justice.

4) Define health as a total human experience, (for example, as understood in the concept of optimal health) and describe ethics and social justice as inherent to the health and wellness of individual persons, communities and institutions.

5) Identify contemporary social justice issues that continue to challenge the optimal health of persons and communities across the globe while describing the signature elements common to various contextual approaches that are seeking to rectify such issues.
Preface

National Center for Bioethics in Research and Health Care

Public Health Ethics Intensive Course
“Untold Stories of Healing for Social Justice”

and

Commemoration of the Presidential Apology for the
U.S. Public Health Service Syphilis Study

Schedule at a Glance

April 3-7, 2017
Tuskegee University
Kellogg Hotel and Conference Center

TUESDAY, APRIL 4, 2017

8:30 am – 4:00 pm  Registration and Continental Breakfast

9:15 am - 9:25 am  Welcome Provost Cesar Fermin, Ph.D.

9:25 am – 9:35 am  Mayor Lawrence F. Haygood, Jr., Tuskegee, Alabama

9:35 am – 9:45 am  Chairman Louis Maxwell, Macon County Commissioner

9:45 am – 10:00 am Overview
Rueben Warren, DDS, M.P.H., Dr. PH, M.Div.

10:00 am – 11:00 am Untold Stories of Healing Associated with Education that resulted in Social Justice
Darryl Scriven, Ph.D.
Michele G. Schedlin, Ph.D.

11:00 am – 12:30 pm  Group Session

12:30 pm – 1:30 pm  Lunch

1:30 pm – 2:30 pm  Untold Stories of Healing Associated with Science that resulted in Social Justice
David Baines, M.D.
Marcia Martinez, Ph.D.

2:30 pm – 4:00 pm  Group Session
4:00 pm – 4:45 pm  Refreshments
4:45 pm – 6:00 pm  Tour
Wednesday, April 5, 2017

7:00 am – 8:00 am  Continental Breakfast

8:00 am – 9:00 am  Untold Stories of Healing Associated with Environmental Justice that resulted in Social Justice

Gerald Durley, M.S., M. Div., Ed.D.
Robin Risling-De Jong, MHS, PA-C

9:00 am – 10:30 am  Group Session

10:30 am – 11:30 am  Untold Stories of Healing Associated with Faith that resulted in Social Justice

Bishop Barbara L. King, MSW, D. Min.
Former U.S. Ambassador Michael Battle, Ph.D.

11:30 am – 1:00 pm  Group Session

1:00 pm – 2:00 pm  Lunch

2:00 pm – 3:00 pm  Untold Stories of Healing Associated with Racism that resulted in Social Justice

Thomas LaViest, Ph.D.
Clyde Robertson, Ph.D.

3:00 pm – 4:30 pm  Group Session

4:30 pm – 6:30 pm  Tour

Thursday, April 6, 2017

7:00 am – 8:00 am  Continental Breakfast

8:00 am – 9:00 am  Untold Stories of Healing Associated with Ethics that resulted in Social Justice

Riggins Earl, Ph.D.
David A. Hodge, Sr., D.Min., Ph.D.

9:00 am – 10:30 am  Group Session

10:30 am – 12:00 pm  Untold Stories of Healing Associated with Collaborating and Cooperating resulting in Social Justice

Jo Valentine, MSW
Crystal James, JD, MPH

12:00 pm - 1:00 pm  Lunch

Commemoration Activities
Thursday, April 6, 2017

1:00 PM  Presenter

6:00 PM  Reception (By Invitation Only)

Friday, April 7, 2017

7:30 – 8:45 AM  Breakfast (Auditorium Foyer)

9:00 – 11:30 AM  Lecture & Panel Session (Auditorium)

Commemoration Keynote Speaker

12 Noon  David Satcher, M.D., Ph.D., FAAFP, FACPM, FACP
Luncheon (Ballroom)
Message from the Editor

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Two thousand seventeen was the 20th year that the National Center for Bioethics in Research and Health Care (NBC) hosted the Commemoration of the 1997 Presidential Apology for the U.S. Public Health Service Syphilis Study at Tuskegee. It also marked the 5th year of conducting the Public Health Ethics Intensive Course (PHEI) and 3 years of publishing selected articles from salient topics presented during the course. The theme of the 2017 Commemoration was, “Untold Stories of Healing for Social Justice.” Every year, the PHEI provides an academically and professionally rigorous course for public health officials, physicians, dentists, nurses, other health professionals, medical residents, social workers, graduates students, undergraduate students, university faculty and other leaders including health educators, health care executives, faith leaders, and community residents and advocates. The course, as does the journal, engages various spheres of ethics in order to improve the human condition. The 20th Anniversary of the Commemoration was particularly important to the descendant families and the University because it provided time to reflect and recall. David Satcher MD, PhD former Director of the Centers for Disease Control and Prevention (CDC) and 16th U.S. Surgeon General, attended this year’s Commemoration. Dr. Satcher actually requested the apology from President Bill Clinton. He provided the keynote address for the Annual Apology Luncheon and Banquet. Selected presenters from the PHEI transformed their presentations into publication format which were peer reviewed and published in this edition of the Journal of Healthcare, Science and the Humanities.

In this edition, Otis Head PhD, MDiv, writes a commentary about the Tuskegee University & Macon County Bridge Builders Program (MCBB). The Lilly Endowment Inc., through its Theology Institutes for High School Youth (TIHSY), funded the National Center for Bioethics in Research and Health Care (NBC) to encourage high school students to pursue vocations in theological leadership and religious life. Dr. Head starts his commentary with a quotation by the late Dr. James Cone, scholar and Black Liberation theologian, to make clear some of the challenges that Black people face. Dr. Head focuses his commentary on some of the challenges related to identity and agency. In the context of this commentary, identity refers to “the sense of who or what one is.” Agency is, “the capacity of a person or entity to act in a given environment.” The foundation that undergirds the MCBB Program, Head argues, is that all challenges and opportunities faced by Black people should be viewed from both a sacred and secular perspective. In the Deep South, particularly in Black Belt counties, religiosity and faith have powerful influences in all spheres of life. Dr. Head shares the objectives, strategies, challenges and successes of the MCBB Program and discusses the successes of the Bridge Builders students and the future of the program.
Preface

Jo Valentine MSW, is the Associate Director, Office of Health Equity, Division of STD Prevention, the NHHSTP, CDC and Project Officer for the cooperative agreement between the Centers for Disease Control and Prevention and the National Center for Bioethics in Research and Health Care. Ms. Valentine is doing an extraordinary job in managing the very important relationship between NBC and CDC. In her article, Ms. Valentine discusses the challenges and opportunities related to partnerships, particularly in population health. She describes the various types of partnerships, levels of collaboration and the importance of flexibility that sustainable partnerships must embrace. She further describes the reformation and evolution of the partnership between CDC and NBC. While she is programmatically based in the Division of STD Prevention, Ms. Valentine highlights that through the cooperative agreement, collaborative activities have occurred between her division, other units at CDC and other operative divisions in the U.S. Department of Health and Human Services, nongovernment agencies and universities. She writes about the importance of the Tuskegee Public Health Ethics Program and the value of enhancing the theory and practice of this relatively new sphere of ethics. Her peer reviewed article arguably is the first of its kind published in the scientific literature.

Robin Risling De-Jong, MS, PAC responded to the keynote address by Dr. Gerald Durley on environmental justice. Her article discusses the conflict, politics, and ethics of people and ecosystems by focusing on water rights of the Native Americans of the Pacific Northwest. The author suggests that a shift away from a Western dominant worldview to that of the indigenous pre-contact worldview creates a more powerful and concrete political site of active engagement between tribes and the United States government. This political paradigm shift is believed to help with decolonization, healing, health, and self-determination of indigenous peoples. De-Jong makes clear the importance of the harmony of all living things in the world of “interconnectedness” and all living things must rely on each other for survival and wellbeing. She raises empowering questions about Traditional Ecological Knowledge related to environment and native worldview and how colonialism and Western views that have violated Native American rights to manage their own lands. Her article provides much needed clarification about the original inhabitants of the land that we now call the United States.

Christina Williams, DNP, APRN, FNP-BC was a graduate student in the Department of Graduate Nursing, Mississippi University of Women, when she presented an exciting poster at the 2017 Public Health Ethics Symposium, cosponsored by the National Center for Bioethics in Research and Health Care and the Centers for Disease Control and Prevention. Her poster focused on patients being able to follow up once their treatment is completed and the patient is discharged. Dr. Williams used modern media modalities, such as videos, informatics as opposed to verbal instructions at the time of discharge. A brief survey was used to assess the benefits of the various teaching tools. Video-discharge teaching was the best method to improve patient outcomes. Her article challenges those who provide health care services to use evidence based strategies to assure patients know what to do when the leave the care setting.
Moni McIntyre, Ph.D., MDiv, writes on identity and argues that all human beings belong to one primary identity that she calls an earthling. She lists a series of demographics such as race/ethnicity, sex/gender, and class and describes the intersectionality of these demographic factors with the influence of religion. She discusses how religion is used positively and negatively to manipulate identity formation. Each of us can trace our primary identity to the Earth. Apart from any other factor, our basic beginning is as an earthling. If we ignore this fact, and focus on such derivative elements as religion, race/ethnicity, sex/gender, and class, at our peril, we may lose sight of our common identity and responsibility. Recognizing our primary common identity may propel us to relativize, but not discount the difference that other factors may introduce. A recognition of our most basic identity can ground us in relationships such that no other factor can destroy. The purpose of her article is to explore some of the contemporary facets of identity formation primarily as experienced in the United States, while also examining their relevance in the context of an Earth perspective.

David Augustin Hodge, Sr., Ph.D., D.Min, writes an interesting article entitled, “Ethics of Belief and Ethics of Ambiguity: Demystifying the Ethics of the USPHS Syphilis Study at Tuskegee.” He frames his article using the U.S. Public Health Service Syphilis Study at Tuskegee in ethical arguments to highlight the fact that Dr. Cutler and the other federal government scientists never acknowledged that what they did was wrong. Dr. Hodge makes it clear using philosophical and ethical theory that there was never any doubt in the minds of Public Health Service scientists that there was nothing wrong in what they were doing. They stressed that what they provided for the men in the Syphilis Study was something that the men did not have. He discusses, in detail, the ethics of belief and the ethics of ambiguity to provide a logical and rational argument to explain why there was never a defensible foundation to justify the USPHS Syphilis Study at Tuskegee.

The articles in this edition provide an excellent set of scholarly papers, which cross a multiplicity of disciplines with a common thread that connects all beings, human and otherwise, to the same universe. The theme of interdependence is a message that is well worth reflection and consideration. “Untold Stories of Healing for Social Justice,” continue to guide the direction of the National Center for Bioethics In Research and Health Care. Untold stories are many times captured in narrative ethics and provide guidance and direction for the reader of this edition of the Journal of Healthcare, Science and the Humanities. Enjoy!
ARTICLES
The Transformative Role of Authentic Partnership in the Tuskegee Public Health Ethics Program

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Abstract

Partnership is a much-venerated concept and is regularly applied to a broad range of human endeavors, as both a means to an end and the desired end itself. For example, to promote the public’s health many programs often rely on partnerships between institutions and communities to implement interventions. Yet despite their generally positive value, partnerships are not without challenges. Unfortunately there are times when a given partnership does not advance a common good, as illustrated by the U.S Public Health Service Syphilis Study at Tuskegee, Alabama (the Syphilis Study), which lasted forty years. However, despite this tragic history, by employing the principles of authentic partnership, the relationships between the federal government, Tuskegee University, and the affected communities are experiencing transformation. By collaboratively working together these partners are able to effectively promote and support ethical public health research and practice.

Keywords: partnership, U.S. Public Health Service syphilis study, Public Health Ethics

Introduction

Partnership is a much-venerated concept and is regularly applied to a broad range of human endeavors, as both a means to an end and the desired end itself. Partnerships are established for a variety of missions and objectives based on the needs or circumstances of individuals or organizations. In the field of public health, for example, partnerships are frequently formed to effectively address challenges to population health. Indeed when addressing many issues of social justice and equity, partnerships between institutions and communities are often seen as essential. To create partnerships, distinct parties who may posit different objectives, and even different methods, come together to work together to achieve common aims. However despite their positive value, partnerships are not without challenges. There are times when a given partnership does not advance a common good. The U.S Public Health Service Syphilis Study at Tuskegee, Alabama (the Syphilis Study), which would eventually
be deemed “ethically unjustified” by a federal investigatory panel,9 was in many respects an example of a kind of partnership. The study that involved the U.S Public Health Service (USPHS), Tuskegee Institute (now, Tuskegee University (TU), and even prominent members of the local community, exploited African American men, who were the unwitting subjects of the study, to further the partners own scientific inquiry. The study began in 1932 and ended in 1972, lasting 40 years. Based on sheer sustainability, the Syphilis Study arguably can be counted among the most remarkable of partnerships.

In 1974 the Syphilis Study’s subjects and their survivors won an out-of-court settlement from the federal government that included lifetime medical benefits and burial services.10 In 1975 the wives, widows, and offspring were added as beneficiaries to the settlement, and the program came to be known as the Tuskegee Health Benefits Program. In 1997, the federal government offered an official apology for the Syphilis Study to the study subjects and their families.11,12 This occasion ultimately led to the founding of the National Center for Bioethics in Research and Health Care at Tuskegee University (NBC), which seeks to actively address and prevent unethical treatment of persons in research and healthcare settings. Established in 1999, NBC is currently the only center dedicated to the study of public health ethics at a historically black college or university. The goals of the center are to: 1) conduct research, scholarship, and training in public health ethics and bioethics for underserved populations; 2) educate students, faculty, scholars, and the general public about public health ethics issues to improve public health services to under-served populations; 3) promote racial/ethnic and geographic diversity in the field of public health ethics and bioethics; and 4) facilitate effective, respectful, and mutually beneficial community partnerships to address inequities in health and health care and support health promotion for all Americans. Although the Tuskegee Health Benefits Program and the bioethics center are closely associated, it is important to note that the two programs are separate. The Centers for Disease Control and Prevention (CDC) through the Division of STD Prevention maintains ongoing support for both efforts.

The Partnership Continuum

Partnerships can be multi-sectorial and inter-sectorial,13,14 as is the case between the NBC and CDC. Partnerships can be equitable and self-governing, and at times they can be asymmetrical and bound by rules set by those completely external to the partnership itself, such as the federal laws and regulations that prescribe the use of federal funds. Although such characteristics can influence the reality of any given partnership, they do not necessarily need to fully determine it. The World Health Organization has defined partnership as a “voluntary agreement between two or more partners to work collaboratively toward a set of shared outcomes.”15 This is a straight-forward definition, and perhaps one that somewhat conceals the more complex and complicating aspects of partnership. Authentic partnership has been defined as a respectful alliance among all parties that values relationship-building, dialogue, and power-sharing.16 This understanding better gets at some of the challenging intricacies of partnership. For it is indeed the parties who enter into a partnership, how they interact with each other, how they work together towards a common aim, and how they share a vision that determines the nature and consequence of the partnership. It is what can make a partnership effort transformative.17,18
Partnerships are not static—they are dynamic, usually moving in one direction or another, growing in depth and efficacy or dying in stagnation and frustration, or worse. The Syphilis Study, for example, may have begun as well-intentioned but the study lost its way, moving from an outcome of searching for ways to save lives to studying the path to the end of life at the expense of the African American subjects.\textsuperscript{19} As the continuum developed by Riggs et al. (Table One) illustrates, the interactions among partners can change based on such things as commitment, the amount and type of change required, the levels of interdependence, power, trust and willingness to share a claimed topic area, territory or turf.\textsuperscript{20} Authentic partnerships often require extra infusions of resources, beyond money, such as time, and patience, and perhaps the most valuable resource of all—trust. The degree to which the partners are willing to collaborate with each other is fundamentally a function of how much the partners are willing to invest resources in a common enterprise. To be sure, sufficient funds to support a partnership's activities are necessary; however, money alone cannot ensure success. Despite the ongoing investment of funds and labor as the Syphilis Study continued, it became less and less clear what the common enterprise was. If elements such as commitment, trust, power-sharing, including shared decision-making, are in limited supply so too may be the lasting success of a partnership. However, if these elements are abundant among the partners, they can in effect compensate for funding shortages.

Table 1. Partnership Continuum (as developed by Riggs et al.)

<table>
<thead>
<tr>
<th>Continuum Based On:</th>
<th>Networking</th>
<th>Coordinating</th>
<th>Cooperating</th>
<th>Collaborating</th>
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<tr>
<td>Commitment</td>
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<td>Change Required</td>
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<td>Risk Involved</td>
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<td>Levels of Interdependence</td>
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<td>Coordinating</td>
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<td>Trust</td>
<td>Networking</td>
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<td>Collaborating</td>
</tr>
<tr>
<td>Willingness to Share Turf</td>
<td>Networking</td>
<td>Coordinating</td>
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</table>

In the current partnership between NBC and CDC, the Division of STD Prevention provides funds to the university through a cooperative agreement. The U.S. federal government generally funds external partners through three methods: a grant, a cooperative agreement, or a contract. A cooperative agreement is like a grant but with a very important difference: the significant involvement of the government in the execution of the funded project.\textsuperscript{21} In effect, the cooperative agreement mechanism mandates partnership by requiring that the funded recipient and the federal government work together, each with a substantial role in and responsibility for accomplishing the stated goals of the funded project. However, a funding mandate alone is not likely to guarantee an authentic partnership. Such an outcome is dependent upon the collaboration of the partners. In 2011, CDC and NBC entered into a new cooperative...
agreement and thus a new partnership. The shared vision and mission of the two entities were—and remains—the advancement of public health ethics in scholarship and practice, thereby building infrastructure that will prevent future exploitation of communities.

**Levels of Collaboration in Partnerships**

To be effective, partnerships must develop and support collaboration among the partners. In much the same way that a partnership itself can move along a continuum, so too can its levels of collaboration (Table 2).

A partnership grows—or dies—the vitality and utility of collaboration among its members can increase or decrease. Member capacity refers to individuals bringing their skills and knowledge to a collaborative effort. The initial collaboration seeds relationships among the partners. These relationships can be influenced by historical and societal context. From the more effective collaborations leaders can emerge. When these leaders are successful they can transform individual interests into a collective force. It is this collective force that ultimately leads to expanded and improved programmatic capacity, which then leads to positive outcomes for all involved.

**Table 2. Levels of Collaborative Capacity (as developed by Kendall et al.)**

<table>
<thead>
<tr>
<th>Member Capacity</th>
<th>Individuals employ a range of skills and knowledge during collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relational Capacity</td>
<td>Relationships are influenced by the history of interaction and broader social context</td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>Strong effective leadership with facilitation skills transforms individual interests into dynamic collective force</td>
</tr>
<tr>
<td>Programmatic Capacity</td>
<td>The ability to guide the design and implementation of program that have impact within the community</td>
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**The Tuskegee Public Health Ethics Program**

By 2008 federal programs had entered an era of increased accountability. The federal dollars that were at the time supporting Tuskegee University’s commemoration activities were at risk of being withdrawn. The center appeared to be drifting away from the original intent of addressing and preventing unethical treatment of persons in research and healthcare settings; and oversight, monitoring, and guidance was not sufficient to keep the project on track. By 2009 it was clear that a significant reformation of the partnership between CDC and NBC was needed, but there was resistance. As often happens, there was mutual doubt and suspicion. Allocation of resources were affected. Staff were threatened and concerned about their jobs. In the early days of the transition, the partnership, such that it was, was without a common vision or purpose. However, CDC and NBC were able to rebuild the program by adhering to the principles of authentic partnership.

*The Tuskegee Public Health Ethics Program* (TPHP) is the result of this programmatic restructuring. The new partnership between NBC and CDC, demonstrates both the components of the partnership continuum as well as the process of developing effective collaborations. Public Health Ethics has been defined as “a systematic process to clarify, prioritize, and justify possible courses of public health action based on ethical principles, values
and beliefs of stakeholders, and scientific and other information.”24 Public Health Ethics is a relatively new field as academic disciplines go, although it combines public health and ethics many of the core principles of Public Health Ethics are long-standing.25 Working collaboratively with CDC, NBC developed new goals for the project which now include: 1) providing public health ethics training and practice; 2) promoting partnerships with academic, government, and non-governmental institutions, private sector organizations, and community stakeholders to enhance and advance ethical public health practice; 3) engaging with under-served communities to develop public health services; and 4) advancing public health ethics scholarship in the scientific literature.

In 2010, in conjunction with the Syphilis Study subjects’ commemoration event, NBC began conducting an annual Public Health Ethics Intensive,26 an initiative funded by CDC. The intensive course focuses on ethical issues across a broad range of public health policies. The following year, NBC partnered closely with CDC’s Division of STD Prevention and the agency’s Office of Scientific Integrity to launch a Public Health Ethics training program for graduate and undergraduate students with the aim of better preparing these fellows and interns for future ethical professional public health practice. In April 2018, the Tuskegee Public Health Ethics Program will mark the 21st anniversary of the study subjects’ commemoration and the 7th anniversary of the Public Health Ethics Intensive.

June of 2018 will mark the seventh year of the Public Health Ethics fellowships and internships program. To date seventeen Tuskegee University students have participated in the internship component of the program, working with a variety of CDC mentors at the agency in Atlanta, Georgia to complete projects that allow the interns to put the principles of Public Health Ethics into practice. Twelve graduate fellows have successfully completed Public Health projects in some of the most underserved communities in the United States, giving them important opportunities to ethically perform public health work and improve health equity.

Moreover, the thriving partnership between CDC and NBC has expanded to include CDC’s Office of Minority Health and Health Equity, leading to stronger collaboration capacities at both the organizational and programmatic levels. Beginning with the centennial anniversary of National Negro Health Week, CDC and NBC launched a Public Health Ethics Forum series. The forums have focused on minority health and women’s health; and in 2018 the annual forum will focus on healthy aging. Both the Public Health Ethics Intensive and the Public Health Ethics Forum series have been featured in the double-blind, peer-reviewed journal, The Journal of HealthCare, Science and The Humanities.

Yet among the most important and transformative expansions of the NBC-CDC partnership has been the committed inclusion of the Syphilis Study subjects’ family members in the partnership. No longer limited to merely audience participation, subjects’ family members now have an active planning and implementation role in the commemoration activities. Additionally, with technical assistance and support from NBC and CDC, in 2014 the family members organized under the name Voices for Our Fathers Legacy Foundation. Their unique mission is “to uplift the legacy of the USPHS Study in Macon County by honoring the men in the study and convening their families as a means to preserve history and enrich education in clinical and public health research.”27 The foundation recently began awarding academic scholarships and the family members are currently publishing a newsletter entitled, Voices for Our Fathers.
Conclusion

Through the years the *U.S. Public Health Service Syphilis Study at Tuskegee* has been used to explain everything from community distrust to intervention ineffectiveness. African American communities, in particular, have frequently been described, sometimes unfairly and inaccurately, as unaccepting and even afraid of various health and social service programs because of what happened to the men who were the subjects of the Syphilis Study. In some instances one has but to say the word *Tuskegee* and public health practitioners cringe, perhaps even retreat. Yet there are valuable lessons to be learned from the now infamous and ethically unjustified study, but those lessons are only accessible to us if individuals are willing to study them and apply them. To enshrine the Syphilis Study in the dusty tombs of shame and regret, or of betrayal and anger, denies the opportunity to use the lessons for transformation.

The successful implementation of the *Tuskegee Public Health Ethics Program* has required committed collaboration among partners who share the mission of advancing ethical public health practice. The past relationships between the parties: Tuskegee University (and NBC), CDC, and the study subjects, their families and their communities, have undoubtedly had their challenges. Terrible mistakes have been made. Grave injustices have been done. Nevertheless, there can be positive change. There can be healing and progress. By “joining-up” the Tuskegee University National Center for Bioethics in Research and Health Care, the CDC, and the families and affected communities have been able to forge an authentic partnership; and together they continue to learn from the instructive lessons of the past and move forward. Working together these partners have been able to more effectively promote Public Health Ethics in research and practice, thereby building a lasting and transformative tribute to the men who were the subjects of the notorious *U.S Public Health Service Syphilis Study at Tuskegee, Alabama*. 
References


Articles


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The Ecology of Healing: The Meaning of Salmon

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This narrative is an expanded version of the response given to the keynote’s address of Untold Stories of Healing Associated with Environmental Justice that Resulted in Social Justice. The keynote address was delivered by Dr. Gerald Durley at the National Center for Bioethics in Research and Health Care’s Public Health Ethics Intensive Course at Tuskegee University, on the 20th Commemorative Anniversary of the 1997 U.S. Presidential National Apology for the United States Public Health Services Syphilis Study at Tuskegee.

Abstract
This article elucidates the conflict, politics, and ethics of people and ecosystems by focusing on water rights of the tribes of the Pacific Northwest. The author suggests that a shift away from a Western dominant worldview to that of the indigenous pre-contact worldview perspective creates a more powerful and concrete political site of active engagement between tribes and outside government. This political paradigm shift is believed to help with decolonization, healing, health, and self-determination of indigenous peoples.

Keywords: traditional ecological knowledge, fish pluralities, water rights, sovereignty, American Indian

Introduction
With the colonization of the United States came a worldview and concept of time foreign to the indigenous inhabitants. The Euro-Christian worldview and concept of time was linear in nature and based on the value of progress and prosperity. Humans were believed to be the dominant species on earth, and the only living creature with a soul. This view imparts a sense of disconnect between man and nature (Thong, 2016). In this sense, earth and all its natural resources served to help humans progress and prosper in a linear fashion. In the “Linear Time” concept, the arrow of time flows forward in one direction. There is a past, present and future. Progress and prosperity can be measured on this timeline by comparing past to present. Future can be used to predict and guide humankind’s actions toward value driven goal attainments (Blowers, Boersema, & Martin, 2006; Purser, Park, & Montuori, 1995).
In general, the indigenous inhabitants of North America possessed a different worldview. Time was viewed as cyclical, following the cycle of the seasons. Seasons brought predictable patterns, allowing for stability and adaptation. In addition, maintaining harmony and balance was a primary motivator and value among the indigenous people (Limb & Hodge, 2008). Humans were viewed as just one of all living species who shared the world in an equal way with plants and animals. Inanimate objects were also viewed as “living” in the sense that all earthly things, living and nonliving, embodied a spirit. In a world of interconnectedness, all inhabitants were interdependent, relying on each other for survival and wellbeing (Hill, 2006). Disruption of any one component could upset the balance everywhere, producing struggle and chaos. Keeping harmony and balance in the world was considered a natural and necessary component for living a good life. War, drought, floods and illness were all challenges to this balance (Nelson & Bayer, 1978).

Water Rights and the California Indian

During the colonization of North America, consistent contact with the California Indians did not take place until the establishment of the Spanish missions in the late 18th century. The goal of these missions were to Hispanicize the Indians in culture, language, dress, and theology (Rawls, 1992). Some of the recorded writings of this time reveal the clash of these two worldviews and two concepts of time between the missionaries and American Indians. They also reveal the beginnings of stereotyping and the rationale for the subjugation of the American Indian inhabitants as viewed from the Euro-Christian perspective. According to Jean Francois de la Perouse, a visitor to the Monterey mission in 1786, the following depiction of mission life is expressed (Olson-Raymer, 2014):

[Everything] brought to our recollection a plantation at Santo Domingo or any other West Indian Island ... We observed with concern that the resemblance is so perfect that we have seen both men and women in irons, and others in the stocks. Lastly, the noise of the whip might have struck our ears, this punishment also being administered, though with little severity. ... The day consists in general of seven hours labor and two hours prayer ... Corporal punishment is inflicted on the Indians of both sexes who neglect the exercises of piety, and many sins, which in Europe are left to Divine justice, are here punished by irons and the stocks ... The missionaries, persuaded from their prejudices and perhaps from their experience that the reason of these men is scarcely ever developed, consider this a just motive for treating them like children, and admit only a very small number to the communion ... The plan pursued by these missionaries is little calculated to remove this state of ignorance, in which everything is directed to the recompense of another life ... This government is a true theocracy for the Indians, who believe that their superiors have immediate and continual communication with God ... by virtue of this opinion, the holy fathers live in the midst of the villages with the greatest security. Their doors are not shut, even in the night. (p. 2)

Among the several coastal and mountain tribes of Northern California is one called the Hoopa Valley Tribe. Members of the Hoopa Valley Tribe are more often referred to as Hupa. Hoopa or Hupa is not the name that the tribe has given itself. Rather, it is a name that the neighboring Yurok Indians used to describe their territories (Rural & Grant, 2016). The
Hupa have lived thousands of years, tucked away in a valley surrounded by rough, mountainous terrain. The remoteness and geographical landscape spared these inhabitants from settlers until the Gold Rush and mining era of the 1850’s. In 1864, the United States government designated a reservation for the Hupa people (Goddard, P. 1903). Unlike many tribes in the Eastern part of the United States who were removed from their original lands, the Hoopa Indian Reservation was carved out of its homeland. This enabled the Hupa Indians to continue their spiritual beliefs and practices at their original sites (Nelson & Bayer, 1978).

The Hupa Indians believed that its people were created in the valley where the Trinity River flows plentiful with fish. Balance and harmony with other tribes, nature, and the earth were prominent values. Ceremonies of song and dance were the Hupa way of praying and thanking the creators for abundance and harmony. Through ceremonial prayer, order and balance could be restored (Nelson & Bayer, 1978). To this day the Hupa people carry out these traditional ceremonies despite colonization changes to their sociopolitical structure and affiliation with the United States Government.

The Hoopa Valley Tribe, like all federally recognized tribes, has a political relationship with the US government. The political status of the American Indian and the US government stems from years of negotiations wherein political exchanges and concessions took place in the form of treaties. The recognition of the ability to engage in negotiation through a political process of sovereignty with the United States government is fundamental to self-determination, i.e., the governance of tribes by its people (Biolsi, 2005). The inherent right to protected water through some of the roughest drought seasons in the history of California has been challenging. Conflicting interests over water issues has led to ongoing debates between the Hupa Indians and outside stakeholders (Chaffin, Garmestani, Gosnell & Craig, 2016).

Water drought has become an ecological nightmare in many areas of the world. It is one of the most relevant of all natural disasters, leaving in its wake persistent consequences of social, economic, and environmental impact (Ababsa, 2015). In the United States, California has experienced significant water shortages leading to major environmental, social and agricultural crises. The latest California drought took place between 2012 and 2014 and has gone on record as the worst California drought of the last 1,200 years (Brow & Kasser, 2005). In areas of California that are heavily populated, water supply in the best of times is taxing. Water must be imported from other locations to support people, land, agricultural, and biodiverse ecosystems. (Scauzillo, 2014).

Ecology and Worldview

Understanding the complexity of California’s water issues requires a knowledge of ecology. Ecology is the science of living organisms and their environment. It examines interrelationships, distribution and abundance of living organisms. Ecosystems are groupings of complex biotic and abiotic components occupying an environment. An ecosystem relies on the relationships of all existing entities to each other in the shared environment. Population ecology considers the roles that a single species plays with respect to other species and ecosystems (Parkes & Horwitz, 2016).

Contemporary temporal Western attitudes of humans and ecology view human beings as disconnected from and in control of the natural world. Such an attitude has led to
human exploitation of nature for gain (Pierotti, & Wildcat, 2000). It has also led to court cases wherein indigenous inherent rights to self-manage land and resources were overruled in favor of claims made by outside stakeholders (Gingrich, 2003). Inherent rights to manage land and ecosystems stems from the indigenous worldview that has existed for thousands of years. Regarding humankind and the environment, these inherent rights are literally and symbolically interconnected with the natural world. From this spatially oriented perspective emerges a construct called Traditional Ecological Knowledge (Pierotti, & Wildcat, 2000).

Traditional Ecological Knowledge (TEK) is the cumulative and adaptive ecological understanding and know-how used by one population of species in cohabitation throughout the ages with ecological systems. Indigenous beliefs, practice, and knowledge of ecology are handed down to generations through a process called cultural transmission (Marin, Coon, & Fraser, 2017). An example of TEK can be seen through the traditional First Salmon Ceremony of the Hupa people. This ceremony took place when the first salmon started up the river. The salmon ceremony incorporated three main components. The first salmon was caught and ritually eaten by the medicine man. This medicine man prayed, fasted, and sweated days before catching and eating the first salmon. Secondly, it was taboo to eat salmon before these rituals took place, doing so could incur negative consequences such as illness and/or death. Lastly, after days of the medicine man collecting salmon, a feast of salmon was held. From this point forward salmon fishing was open to all (Swezey & Heizer, 1977).

Salmon has always been a huge part of the sustenance of the Hupa people. For thousands of years the Hupa built a sacred dam for catching salmon. Only enough salmon was caught to feed the people. The rest of the salmon were set free. The building of the dam was a religious ceremony. The leader gathered the materials for construction and carried out the sacred rituals (Nelson & Bayer, 1978). Swezey and Heizer (1977) offered the following: “The formulist [sic] walked across it and back carrying a basket of water in his right hand, supported by the fingers as a waiter supports a serving tray. In his left hand he carried pebbles, which he scattered in the river, saying ‘May as many fish jump’” (p. 7).

From a ritualistic and ceremonial perspective, the salmon was an extensively managed and ecologically manipulated food resource for the Hupa Indians. The cultural practices served as a functional mechanism for the adaptation of the fishing economies of the natives (Swezey & Heizer, 1977). This ties into how Pierotti and Wildcat (2000) describe TEK. TEK intrinsically links the human and non-human, serving as an indigenous basis for concepts such as nature, politics, and ethics. These aspects of TEK can be used to help settle conflicts between a host of stakeholders and interests groups over the use of natural resources, animal rights, and conservation.

The central role that salmon plays for the Hupa people is at the heart of the water rights conflict. Hupa Indians have engaged in a relationship with salmon for time immemorial. Salmon is part of the rich ecosystem occupying the Hoopa Reservation. Salmon serves as a literal as well as a symbolic entity. In a literal sense, salmon has been used for sustenance and nutrition. Symbolically, salmon represents an immortal cultural hero who was ritually honored by the Hupa people (Swezey & Heizer, 1977). The tribe’s dependence on this resource is economically, culturally, and spiritually based. However, they have been subjugated to outside regulations affecting the river running through their homeland. The Dam of 1963 served to redirect the water to farmlands in need of this valuable resource. Since then, more dams have been built to redirect water away from its natural channel through the Hoopa Valley. Logging
and mining have contaminated the water. Overfishing in the oceans have depleted spawning in the rivers. This has negatively impacted the ecosystem and the quantity and quality of salmon (Hartridge, 1999).

Shifting from a Western world view of ecosystem management to the legitimacy of the Traditional Ecological Knowledge of land and resource management of native peoples is one way for indigenous people to claim a more persuasive political power (Pierotti, & Wildcat, 2000). Adding to this discussion the meaning of fish pluralities synergizes this concept. Fish pluralities are the multiple ways of defining and describing fish (Zoe, 2014). According to Zoe (2014) humans and animals are agents of political and colonial processes. In this framework a broader societal acknowledgement of complex and dynamic relationships between people, fish, and land is understood.

Understanding the dynamic connectedness proposes to change the symbolic interpretation of human-fish relationships to literal interpretations. Doing so puts human and non-human relationships in a political and legal engagement away from the Eurocentric toward a process of decolonization. Strengthening this perspective, the scientific community is realizing that the dominant geospatial ontology should include indigenous notions of cyclical time. Otherwise, there is a risk of having indigenous, sophisticated knowledge stripped of its significance in the mainstream (Reid & Sieber, 2016). These types of shifts from the predominant Western view could give an unprecedented potent political site of exchange to the inherent indigenous rights of ecological management.

**Conclusion**

Over the last few centuries colonialism and Western worldviews have served to oppress inherent American Indian sociopolitical rights to the self-governance of tribal ecological matters. Today, however, there are signs that the tide is turning. Traditional ecological knowledge, fish pluralities and the call for geospatial inclusiveness lend credence to the often times contended inherent rights of native peoples to manage their land and resources. They add fresh validity to the political claim for protecting indigenous interests where before their political power was hampered by anthropocentric worldviews. Reframing the perspective of land and resource management to include a lens endorsing the literal and symbolic meaning of the profound relationship between salmon and the Hupa Indians offers a step forward toward decolonization, healing, and wellbeing for people and fish.
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Articles


Religion, Ethnicity, and Identity: The Role of Race/Ethnicity, Sex/Gender and Class in Identity Formation

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Abstract
Each of us can trace our primary identity to the Earth. Apart from any other factor, our basic beginning is as an earthling. If we ignore this fact, and focus on such derivative elements as religion, race/ethnicity, sex/gender, and class, at our peril we may lose sight of our common identity and responsibility. Recognizing our primary common identity may propel us to relativize but not discount the difference that other factors may introduce. A recognition of our most basic identity can ground us in relationships such that no other factor can destroy. The purpose of this article is to explore some of the contemporary facets of identity formation primarily as experienced in the United States, while also examining their relevance in the context of an Earth perspective.

Keywords: Earth, race/ethnicity; sex/gender, class, religion, identity formation; whiteness

Introduction
The most fundamental identity of human beings is that of membership in the Earth community. Each of us share a common origin beyond any cultural factors. Our primary identity is the human species in the Earth community. Often, however, we tend to focus on our differences and sometimes use them to justify discrimination against others. For example, some individuals justify sexual assault that reveals latent and overt sexism while others justify racial policing and mass incarceration that reveal latent and overt racism, and still others deny existing structural poverty that reveals latent and overt classism. If we could reset ourselves in a broader context and realize that we share our very identity not only with all humans but with the whole Earth community, then perhaps we could reduce our micro-focus on what separates us and
envision a macro-focus on what unites us as planetary beings. Our differences matter, and they matter in ways that could help us to see ourselves as a beautiful mosaic rather than warring and disparate factions.

Social scientists have long discussed identity formation, and they now need to consider it more seriously from a cosmic perspective. As we drill down and emphasize our differences, it might be useful to see society as part of a cosmic reality. This is not to suggest that we wave aside the complexity of cultural and global factors; rather, it is to see that complexity through a new lens. In sum, the point is not to see past differences; the point is to see differences in a larger context.

This article is an exploration of some key facets of identity formation as seen through the primary identity of the human as a member of the earth community. These facets include religion, identity and identity formation, race/ethnicity, sex/gender, and class.

**The Importance of Religion in Identity Formation**

Religion points us in the direction of that which is beyond the human. Typically, we associate religion with a God or gods that exercise some control beyond what humans can do. That transcendent element of religion often leads individuals and groups to adopt a system of belief and worship. Too often this association turns people into fanatics who support their own prejudice based on a portion of their sacred texts. Religion also focuses on interiority. Meditation is a nearly universal aspect of religions around the world. One who meditates may become aware of that which is beyond the self, the vastness of the cosmos, the sameness of basic human longings, and the beauty of other humans who also long for peace and joy in their lives. Such awareness can open one to the merits of humility and the joys of sharing resources with others. Some who meditate may use their faculties to demonize “enemies” and search for new and more lethal means of destruction. Those aspects of religion that further reverence the whole Earth community have the capacity to foster deeper respect for human differences and encourage devotees to study and work toward peaceful means of coexistence. Those aspects of religion that encourage hatred and dissension need to be scrutinized and recognized as divisive and destructive elements.

Religion often helps to give people a reason for living in the face of difficulty. This healing power of religion can be very personal. The pain of living can be assuaged somewhat when one can pin one’s identity on the tenets of a religion, as is clear in the following African American spiritual entitled “Give Me Jesus.” The verses are simple:

1. In the morning when I rise, in the morning when I rise, in the morning when I rise, give me Jesus.

2. Dark midnight was my cry, dark midnight was my cry, dark midnight was my cry, give me Jesus.

3. And when I come to die, and when I come to die, and when I come to die, give me Jesus.

Religion, however, has a long history of repressing personality development, especially in sexual expression. Janet R. Jakobsen and Ann Pellegrini explore the downside of the way
religion has been used in the United States in their book, *Love the Sin: Sexual Regulation and the Limits of Religious Tolerance* (2003). The authors demonstrate how freedom of sexual expression has been seriously curtailed through laws and court decisions, especially those concerning homosexuality. Indeed, they cite conservative Christian views as carrying the day in public policy. Conflating American values and conservative Protestant interpretations of the Bible has proven to be a disservice to both. For example, E. Patrick Johnson (2014, p. 169) points out that the “don’t ask, don’t tell” tolerance toward gay people in the black church changed in 2004 when George W. Bush “was running for reelection and a lot of black churches, black leaders got on the band wagon with that administration and turned their backs on their black queer members in a really problematic way in terms of being openly hostile to black LGBTQ members.” In their effort to secure funds for their institutions from conservative political officials, some black religious leaders readily abandoned their LGBTQ members.

Not all religious communities have given up on their queer members, however. Johnson (2014) applauds the nurturing aspects of church membership. He reacts to those situations in which LGBTQ individuals who have found a home in a religious congregation are scorned by other LGBTQ persons who have left their religious communities:

It’s really frustrating to me when I hear people totally dismiss queers who’ve made the decision to stay in the church because they’ll suffer from internalized homophobia or whatever. It’s not as if you can automatically turn that off when you come into your consciousness around your sexuality, that you can just automatically and immediately leave behind this community that has up until this time, nurtured you despite its being homophobic. . . . (pp. 170-171)

Indeed, Johnson recalls that “[church] was a place where I got the most encouragement to be whatever I wanted to be” (p. 170). His ability to see beyond the limits of the institution and to appreciate the warm embrace of those who recognized the commonality among them speaks to the potential of all people to find and celebrate our common origin and the identity that we discover and claim.

If a broader approach to religion were employed, i.e., an Earth perspective, then each Earth creature, including human life, could be celebrated in its various manifestations. Indeed, in *The Body of God: An Ecological Theology* (1993), Sallie McFague urges us to consider the entire creation story, “an account of the universe as a whole or of the whole of reality” because it can lead us to “the radicalization of unity and difference” (p. 40). She develops the notion of “the world as God’s body” and concludes that this model of the world “encourages us to dare to love bodies and find them valuable and wonderful—just that and nothing more” (p. 211). She sees each Earth creature as a wonder.

If McFague’s perspective is adopted, then that which denigrates human freedom could at least be held with suspicion. In *A Black Theology of Liberation* (1990), James Cone underscores this point when he discusses incarnational theology in the Christian faith in a racial context:

The basic mistake of our white opponents is their failure to see that God did not become a universal human being but an oppressed Jew, thereby disclosing to us that both human nature and divine nature are inseparable from oppression and liberation.
To know who the human person is is to focus on the Oppressed One and what he does for an oppressed community as it liberates itself from slavery. (p. 85)

In the same volume, Delores S. Williams further points to the radical nature of the sacredness of all human beings when she quotes Cone as stating, “If we black male theologians do not take seriously the need to incorporate into our theology a critique of our sexist practices in the black community, then we have no right to complain when white theologians snub black theology” (p. 190). Christian theology must be a liberation theology for all human beings.

As distinguished Yale University research professor John F. Haught states, “We humans are latecomers in the cosmic story, and religion came along with us” (2017, p. 8). Embracing the implications of a recognition that the Earth predates organized religion and its sacred scriptures could be a first step toward human liberation. Such a move would require refreshingly new interpretations of the divine and divine texts based on a deeper understanding of what it means to be human as well as biblical anthropology, archeology and scholarship. A great deal of education and openness on the part of religious practitioners could lead to the appreciation of differences in the world, including the differences presented by the LGBTQ communities. This could be done without compromising their deeply held beliefs and violating their most sacred texts.

Identity and Identity Formation

Why is one’s identity important? As the spiritual “Give Me Jesus” indicates, one’s identity is the elusive ingredient that may give meaning in ordinary times, in stressful times, and, finally, when we come to die. As our identity forms, we learn who we are in relation to other persons, places, and things. We learn that we are formed from the Earth and, in McFague’s model of the Earth as God’s body, we realize that sin is “the refusal to be part of an ecological whole whose continued existence and success depend upon a recognition of the interdependence and interrelatedness of all species” (1987, p. 114). In another place, McFague notes that “the enemy—indifferent, selfish, shortsighted, xenophobic, anthropocentric, greedy human beings—calls at the very least for a renewed emphasis on sin as the cause of much of the planet’s woes” (1995, p. 332). I explain this concept further in “Sin, Evil and Death in the New Age” (1993). For our purposes here, it is sufficient to note that sin is a theological concept that in part describes the reality that keeps us not only from relating to God as our best selves, but also keeps us from becoming our best selves. We sin when we refuse to accept our primary identity, i.e., members of the Earth community.

Just as all things come together at the end of our lives, the ingredients of our identity work together as we reach that moment. Our quest for meaning is ongoing and must be addressed. The “I” who does the searching is made up, in part, of many social factors, including family, friends, employment, and religion. The “I” also includes the reality that, as we ponder who we are, we begin to consider the familiar words from Genesis 3:19c (NRSV): “you are dust and to dust will you return.” Both our substance and our final resting place is the Earth itself.

Identity formation is important because when we come to die, most of us want to have had a reason to live, i.e., we want our lives to have had meaning. As we ponder our impending death, we want to know that our time on earth has meant something to someone besides
ourselves and we will be remembered for contributing to the general welfare of those around us. Identity formation in our young lives is important because how we form our identity will lead to how we will feel about ourselves and others at the end of our lives. James W. Fowler (1981) notes that our quest for faith and meaning are part of our human development. He argues that “faith is a human universal. We are endowed at birth with nascent capacities for faith. How these capacities are activated and grow depends to a large extent on how we are welcomed into the world and what kinds of environments we grow in” (xiii). The faith offered to us in our birth family can provide a path to a meaningful reason to live and a way to die.

Imagine that you are on your death bed. You ponder what it took to get you there. Who is the you that is dying, and what will happen when your mortal body takes its last breath? Perhaps the persons whom you love have come to see you. Why are those persons there and not others? How is their you imagined and how will that you continue until their time comes to die? Questions such as these seem to come to all those who have the luxury to ponder them. Yet the answers vary somewhat depending upon the race/ethnicity, sex/gender, class, and organized religion, if any, of the person pondering them.

The composite picture of who we are, i.e., our identity, is formed by many elements, including such elements as race/ethnicity, sex/gender, class, and religion. Either alone or in combination, these categories cannot account for who we are entirely. Still, it is worthwhile to examine each element individually to determine, at least in a general way, what their impact is on each of us. Though the most profound questions and answers about human identity have most likely neither been asked nor answered, social scientists have arrived at some important conclusions about race/ethnicity, sex/gender, class, and religion. Geologists, i.e., Earth-centered cultural historians, have given identity and identity formation a broader context.

Côté and Levine (2002) remind us that “for most of human history, forming an adult identity was by all accounts a relatively straightforward process.” Indeed, they write that “humans have not been accustomed to living in societies where they are continually confronted with high levels of choice over fundamental matters of personal meaning” (p.1). During the thousands of years that make up premodern societies, much of one’s life was prescribed, and individuals were most often required to conform to cultural expectations. Young persons customarily accepted adult responsibilities in their mid-teens. As societies became more complex, however, the period known as “adolescence” developed and lengthened. Adulthood was put off until the early twenties. In families of some means today, adulthood may be delayed until the late twenties or even age 30 because of the many years of schooling required by various professions.

By the late modern period, identity issues began to occupy the thoughts of psychologists, especially “Erik Erickson, the ‘father’ of the identity concept” (Côté and Levine, 2002, p. xiii). Erikson (1902-1994) notes that the formation of one’s identity occurs during adolescence (Erikson, 1968). One’s identity is as inscrutable as it is inescapable, he observes. The formation of one’s identity is a process dependent upon the interior of the individual and the culture. As the culture changes, and the individual matures, new types of identity questions arise. Writing in the late sixties, for example, Erikson discussed the challenges to identity formation that were posed by the explosive changes in race relations as well as changing gender roles of the time. Throughout his professional life, Erikson approached the question of identity and identity formation from both theoretical and clinical perspectives. He explained that the
the young individual must learn to be most himself where he means most to others—those others, to be sure, who have come to mean most to him. The term identity expresses such a mutual relation in that it connotes both a persistent sameness within oneself (selfsameness) and a persistent sharing of some kind of essential character with others. (223-224)

As individuals enter adolescence and come to some point of comfort within themselves vis-à-vis others, Erikson observed that this process often involves an obvious identity crisis. He cautioned his readers about concluding that one’s identity could be formed fully before death: “identity formation neither begins nor ends with adolescence: it is a life-long development largely unconscious to the individual and to his society” (1956, p. 226). For social scientists, however, the primary age of study concerning identity is adolescence.

Aware that adolescents need to explore various alternative value systems before settling upon one set of strong allegiances across different life spheres, Becht, Branje, Vollebergh, Denissen, Nelemans, Koot, and Meeus (2016, p. 2010) note that “the process of identity formation represents a dynamic between certainty/synthesis and uncertainty/confusion.” Identity crises, then, are part of normal growth and development. We know that no two children are born into the same family, even if they have the same birth parents, because birth order is a strong determinative factor in how children experience family. Similarly, “the process of identity formation is not the same for all adolescents” (Becht et al., 2016, p. 2011). The addition (or subtraction) of a member changes the experience of everyone’s experience of family. No two individuals will experience adolescence (or anything else!) in quite the same way. Their identity formation will be influenced by multiple factors, including their birth order and the age, education, and abilities of their parent(s).

Flum and Lavi-Yudelevitch emphasize the relational facet of identity formation as opposed to the agentic (Cote and Levine, 2002, p. 9) and community aspects. Whereas the traditional approach focuses on the process of separation-individuation, Flum and Lavi-Yudelevitch analyze the self-talk and dialogue with others in which adolescents engage. The authors “probe the interpersonal experiences of adolescents who tend to carry out an internal dialogue with the self and those who report less capacity for or interest in such a dialogue” (Flum & Lavi-Yudelevitch, 2002, p. 158). They conclude that, as adolescents broaden and deepen their connections with others, their autonomy grows (p. 178).

Jensen, the originator of the “cultural developmental” theoretical approach to research in human psychology, observes that many young people today face issues that were unknown to their parents and grandparents because today’s youth are experiencing their adolescence in a multicultural world. Jensen writes, “due to the processes of globalization, adolescents increasingly have knowledge of and interactions with people from diverse cultures” (Jensen, 2003, p. 3). As a result, she concludes that young people frequently “face the task of integrating diverse cultural beliefs and behaviors conveyed to them by multiple agents of socialization—socialization agents that at times are at odds with one another, e.g., parents and TV” (Jensen, 2008, p. 14). This discord presents adolescents with many challenges as they integrate and form a coherent cultural identity. As youths encounter discordant elements in their lives,
they may develop new skills that enable them to manage and thrive in a multicultural world. Consequently, these individuals have more to contribute to their complex society. Along the way, however, racial discrimination and prejudice are among the most difficult obstacles that young people face. We now need to deepen our understanding of how we are fundamentally bound together as members of the whole Earth community and depend upon one another for our physical and psychic survival. Against the backdrop of our common identity as Earthlings, each of us must sort out and make sense of our differences that ultimately unite us in our common ancestry, and these include race and ethnicity.

**Race/Ethnicity**

No matter when children were born in the United States of America, their race/ethnicity play a significant role in their lives. Because of our despicable heritage that includes the genocide of indigenous peoples and the enslavement of Black bodies, as well as our inadequate attempts to right those wrongs ever since, their descendants have long endured prejudice and discrimination that affected them at the core of their being. Their identity, which they share with all members of the Earth community has, in many cases and for far too long, been viciously and deliberately negated. Similarly, descendants of European immigrants placed themselves on a hierarchy of being dictated by their proximity to England and the shade of their skin. Latinos and Asian Americans have developmental issues like but different from African Americans and those of European descent. Iwamoto and Caldwell (2006) explain the dynamic involved in developing one’s racial identity: “Racial identity development is a process of developing racial and ethnic self-consciousness; it also involves one’s progression in building self-concept and self-esteem” (p. 95). Each group and the individuals within the group experience race-based challenges to their self-understanding.

Warnke (2007) comments on significant issues for African Americans:

To the extent that being a black or African American in the United States is often more and other than being either the color black or from Africa, it might seem clear how being black and African American can be confusing identities to possess and identifications to make. (p. 3)

Warnke (2007) further points out that “we cannot be blacks and whites unless the identity and identification are available” (pp. 83-84). While we may choose to identify ourselves as Pittsburgh Steeler, Pirate, or Penguin fans, it is possible (however unlikely!) that these categories could change. Our identity as black or white or Asian or Hispanic is not similarly fluid: “We cannot become an ex-white in the same way that we can become an ex-patriot” (Warnke, 2007, p. 85). There is a permanence and enduring visual quality about one’s racial identity that other identities, e.g., sports fan, fail to have. Likewise, if one is Irish-American, then that identity is permanent, even if it may not be visible.

The visual quality of race is not necessarily convincing, however. To illustrate this point, McLaren (1999) relates this anecdote:

George Lipsitz tells the story of an African man who grew up believing that Pete Seeger was Black, because he knew Seeger was a civil rights activist, sang freedom
songs, and included Paul Robeson among his personal friends. After coming to the United States, the man got into an argument over Seeger’s ethnicity and was shown a picture of Seeger that showed him to be White. Yet still the man replied: "I know that Pete Seeger is Black . . . why should I change my mind just because I see his face” (1996, p. 409). (p. 54)

Beyond skin color is the notion of “whiteness” that stands in stark contrast to the notion of “blackness.” The prevailing view among many whites and some people of color is that the concept of whiteness conveys superiority, while the concept of blackness implies inferiority. The social construction of whiteness has been discussed at length by such scholars as George Yancy and David Roediger. Beliefs in the inherent superiority of white people, i.e., Europeans, can be traced to many whites in colonial times in America (McLaren, 1999) and their self-proclaimed right to enslave Africans to build the United States. Racist meanings of whiteness have, if anything, deepened, rather than abated since then. Bery (2016) recalls the famous quotation of W.E.B. DuBois (1868-1963) on whiteness from *Darkwater: Voices from within the veil*: “But what on earth is whiteness that one should so desire it? Then always, somehow, some way, silently but clearly, I am given to understand that whiteness is the ownership of the earth forever and ever. Amen!” (p. 152). Bery contends that “the ontology of whiteness exists only within and is constituted by the apparatus and practices of white supremacy” (p. 152). Insofar as virtually everyone in the western hemisphere is affected by these, the notions of whiteness and white supremacy impact one’s sense of identity at the core of one’s being. They can give a person a sense of great self-confidence or utter worthlessness, depending upon their culturally perceived racial identity. Today’s adolescents, therefore, realize that they take their color and its cultural appraisal wherever they go. To the extent that the feeble frame upon which the assumptions of whiteness and blackness hang goes unrecognized and unacknowledged, the identities and safety of young people and their elders may be threatened.

Irizzary (2006) observes that limiting racial discourse to skin color and the black/white paradigm is restrictive and exclusive. He states, “this static and one-dimensional characterization of race can serve to alienate groups like Latinos who do not fit easily into this paradigm yet still grapple with being a racial minority in the United States” (p. 57). (Note that Latino/Hispanic is an *ethnic* group and not a *race*, although Hispanics are considered the largest minority in the United States when compared with various racial groups.) As a result, the voices of many minorities are marginalized. He concludes that “the traditional view of race within the Black/White binary are inadequate for classifying Latinos” (p. 66). Students need to be able to express their identities in other than static categories and Irizzary argues in favor of the blurring the color line when Latinos are included in the mix. Similar points are made by Asian Americans, “who represent the fastest-growing racial group in the United States” (Iwamoto and Caldwell, 2006, p. 91). Those of mixed heritage encounter still other problems in their identity formation and challenge the definition of racial identity (Kelley and Clark, 2006). The soaring popularity of Ancestry.com and the opportunity they provide to discover the mixed heritage evident in virtually everyone’s DNA makes the claim for racial purity increasingly difficult to sustain.

Furthermore, as noted by Kwame Anthony Appiah (2005), many of the labels, racial as well as others, that have been applied to groups of persons were employed to limit these groups: “Black, woman, gay, aboriginal—so many of the identity categories that are politically salient are precisely ones that have functioned as limits, the result of the attitudes and acts of hostile
or contemptuous others” (p. 112). Appiah highlights the cruel intentions inherent in many of these categories.

If we were to recognize our primary identity as earthlings, then it is possible that a claim of fundamental equality could prevail. Differences among us could be understood as derivative and, therefore, secondary. Such differences at the level of race, sex, class, age, etc. would be enhancements and not claims of ontological worth. It would be self-evident, then, that individuals should have the freedom to explore and claim their own identity. The splendor of the universe would set the tone for many ways to reckon human identity. That there is no “correct” identity would become obvious. Racism, sexism, heterosexism, classism, etc. would be recognized as the problem, not individuals claiming their own identity, however socially constructed it might be.

The Earth perspective, however, does not preclude social action against the racism that is rampant in our society. The “green perspective” implies and necessitates committed action for justice so that all God’s children may walk the earth in safety and with pride and dignity. Clearly, human beings have a long way to go before we effectively realize our common origin and meaning.

**Sex/Gender**

Nearly thirty years ago, Judith Butler (2006, [1990]) rocked the feminist scholarly world as she probed the viability of categories of sex and gender. Butler depicted these terms as socially constructed and was critical of their use even by feminists. Her aim was to break the connection between these terms so that gender and desire could be free of other factors. Since those early days, Butler has attempted to “undo gender” (2004) and engage in political activism on behalf of oppressed peoples worldwide. Her work has invited praise and criticism in academic communities.

Rogers and Meltzoff (2017) raise the question: Is gender more important and meaningful than race? In their study of black, white, and mixed-race children, they found that “children rate gender as a more important identity than race” (p. 323). The implications of this and their other conclusions for identity theory are remarkable. The authors link their findings to the increasingly diverse society in which children are being raised today. The number of mixed-race children is increasing as is the number of transgender and openly gay and bisexual individuals. The prevalence of people who transcend the bounds of traditional understandings of race and gender have necessitated increasingly complex and nuanced categories of sex/gender.

Hattersley (2004) wonders about a future in which being gay is irrelevant. He writes:

What would it mean to be gay in a world in which the fact that a friend, sibling, aunt, or uncle was gay was about as relevant as her hair color? What are the implications of a world in which GLBT people have become familiar features in the family, the media, literature, and the political scene? (p. 33)

What, then, is the goal of the LGBTQ movement? Is it for those individuals so identified to blend in with society or to be rebels? Clearly, it is different for different persons.
The attitude of the anti-LGBTQ movement, however, is now and has always been the problem for LGBTQ individuals, not the fact of their not being in the majority.

Identity confusion affects not only those young persons who are gay but also those who are attracted to more than one gender. Dyer, et. al. (2017) focus on the stress among bisexuals or “nonmonosexual individuals.” The authors prefer the latter term because it is “inclusive of all individuals who report attractions to more than one gender, regardless of the specific sexual identity label they use, (e.g., bisexual, pansexual, omnisexual, polysexual, and queer)” (p. 87). The authors note that sexual identity uncertainty often leads to poor mental health outcomes and is, therefore, an important construct and element of the discussion of sex/gender.

Erikson (1968) and others are aware of the importance of the adolescent’s task to form their identity. This process of identity formation is made more difficult when young persons discover themselves to be different from their peers regarding their sex and gender. Pinto and Moleiro (2015) explored the journey of transsexual people as they came to terms with their gender identities. The authors distinguished between the terms “transgender” and “transsexual.”

Transgender is an umbrella concept that describes different people who transcend society’s traditional gender roles or expressions, such as transsexual and intersex individuals, or cross-dressers and drag queens/kings. Within the transgender spectrum transsexual people are those whose gender identity is the opposite of the assigned sex at birth. (p. 12)

Transsexual individuals, then, do not believe that their birth bodies represent their true sex. Some transsexuals will seek sex reassignment surgery and some will not. The authors identified five development stages that the participants of their study experienced:

- Confusion and increasing sense of gender difference;
- Finding an explanation and a label: exploring identity;
- Deciding what to do and when: exploring options;
- Embracing gender identity: performing a new social identity and undergoing body modifications;
- Identity consolidation and invisibility. (p. 12)

Pinto and Moleiro acknowledged the complexity of the process and were clear that psychologists, psychiatrists, and other health care professionals who treat transsexuals need to have a thorough understanding of the situation. In sum, sex/gender identity is a wide-ranging category. Much research has been done and more needs to be done to know how to assist adolescents in their quest for self-understanding.

Not surprisingly, several fields of study may be included in discussions of sex, gender, and identity, including pornography. In her book, The Black Body in Ecstasy: Reading Race, Reading Pornography (2014), Jennifer Nash offers “a ‘loving critique’ of the field” of black feminist theory (p. 8). She is concerned with how the black female body is visually represented and focuses on racialized pornography. Nash’s work challenges those who reject pornography out of hand, believing that pornography is all the same and without value. She takes a scholarly view of the subject and joins others who provide theoretical tools for deconstructing a pro/anti porn stance that assumes that all porn is inherently racist and misogynist. Her carefully nuanced

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**Articles**

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inquiry into racialized pornography presents challenging implications for its possible inclusion in identity formation studies.

Just as emerging fields of sexual inquiry provide new avenues for the valuing of those genres that were previously assigned to the category of “other,” so the emerging awareness of the Earth as our common home is providing new avenues for valuing not just the human species but also the others with whom we share the Earth. As Thomas Berry has pointed out, “neither humans as a species, nor any of our activities, can be understood in any significant manner except in our role in the function of the earth and of the universe itself” (1987, p. 24). We must be open to understanding the “other” if we are to discover and cherish the gift of life found there. Rejecting anyone out of hand is, therefore, is perilous.

Class

The confluence of race/ethnicity, sex/gender, and class form an intersection regarding identity formation that is multifaceted and vastly complex. Sociologists regard class as one of the most important concepts in their discipline and it underlies the very basic notion upon which sociology rests, i.e., social structure. The notion of class has undergone some development. For example, Aage B. Sorenson (2001) notes that “in much of modern sociology, class has come to mean nothing more than a homogeneous categorical grouping of social positions in contrast to the gradation provided by socioeconomic status” (p. 291). The classic concepts of class, however, are generally traceable to Karl Marx (1818-1883), Max Weber (1864-1920), and, to some extent, Emile Durkheim (1858-1917).

Marxist or market notions of class capture the class differentials in terms of the ownership of the means of production. Writing during the Industrial Revolution, Marx investigated the exploitative relationship of those with power and authority and those who lacked them. As Sorenson notes, “It is the is the exploitative relationship that defines classes”; indeed, “capitalists exploit workers because the logic of capitalist production forces them to do so, not because they are evil or conservative or white males” (291). Thus, capitalism breeds classism and those who form their identity in a classist society will be led to understand their self-worth based upon their net income and holdings. The surplus produced by the proletariat is absorbed by the bourgeois as profit. It can then be reinvested in countries all over the world, as it is in today’s global market. Marx bemoaned the inability of the average worker to approximate the holdings of the owner class.

Despite the similarities between class and community, Max Weber (1946) warned against equating them. He noted, “a class does not in itself constitute a community. To treat ‘class’ conceptually as having the same value as ‘community’ leads to distortion” (135). Antagonism between and within various classes is to be expected, since Weber always had market interests in mind when he spoke of class. The identity of those who offer their labor for sale on the market is affected by many factors, including race, sex/gender, and religion, as noted above; class relationships complexify the puzzle of human identity since those who operate out of their own self-interest may go against members of their class, which may result in further economic hardship.

A third foundational thinker on the subject of class was Emile Durkheim, whose classic work, The Division of Labor in Society (1893), shaped much of early thinking on
class into the twentieth century. David B. Grusky and Jesper B. Sorensen (1998) noted that Durkheim optimistically predicted that there would be “an organizational counterbalance to the threat of class formation on one hand and state tyranny on the other” (190). Today’s young people of color who get involved with the police and the prison system would likely agree with those who believe that Durkheim missed the mark on this hoped-for counterbalance.

Contemporary sociologist William Julius Wilson considers the challenges of the marketplace through the lenses of poverty and race. Writing long after Marx, Weber, and Durkheim, Wilson describes the virtually jobless environment of those in the lowest socio-economic classes. His *When Work Disappears: The World of the New Urban Poor* (1996) describes the remnants of white flight and job loss in urban areas. The marketplace is virtually absent in a world in which there are no jobs and schools are underperforming. Those whose identities are forged in these conditions must struggle beyond what could have been imagined by pioneering sociologists.

Aries and Seider (2007) set out to discover how social class affects identity formation in college students. To minimize the intersectionality of the project, they interviewed only white students at two different colleges. The first of their three groups attended an unnamed prestigious liberal arts college and were affluent. The second group attended the same school and came from working class homes. The third group attended a state school and came from working class families. Most of the students from modest homes maintained that they would prefer to come from their working-class homes because of the values they learned there. Still, these same students were striving to do better economically than their parents. The authors interpreted this finding as an indication that the students’ desired to protect their achieved identity as working-class individuals. The authors concluded that “social class plays an important role both as an independent variable that shapes the formation of identity and as a domain of identity exploration” (p. 151). Their results exemplified the definition of a class system proffered by Macionis (2017): “social stratification based on both birth and individual achievement” (p. 209).

Lui, et al. (2006) reflect the intersectionality of class issues. They note that “for every dollar owned by the average white family in the United States, the average family of color has less than one dime” (p. 1). The authors trace this situation to centuries old laws, violence, and government programs that benefited white Americans. Since an even playing field was never either a reality or a possibility, the suffering and inequality experienced by people of color are both predictable and understandable. This awareness could imply that further study of class as its own reality is impossible.

Throughout our class struggles, we have simply forgotten who we are and our common origin. Those in power because of means, skin color, education, and gender have too often denied the humanity of those not like them. They have trampled on the Earth with their muddy shoes as if they owned it and had the right to destroy that which does not yield a profit. Forging an identity at the bottom of the social ladder is too often fraught with too few skills and too little work. Class relationships based on beliefs in intrinsic differences between and among individuals is at the heart of the classism that runs rampant in our world.
Conclusion

Forty-eight years after the creation of Earth Day on April 24, 1970, it is time that we took our collective identity seriously. We are of the Earth; we are not just on the Earth. Human beings, like the entire Earth community, are made of material that has been evolving for billions of years. The complexity of this universe has given birth to us, and we are related in profound and ancient ways. It is short-sighted to fail to recognize this interrelatedness. There are many lessons for us to learn as we contemplate our origins. We learn that cooperation, not war, is the ticket to success. We learn that race/ethnicity and sex/gender are manifestations of the universe’s largesse; they are not reasons for us to hurt and kill. Each human person, like each flower or tree, manifests a subjectivity that we can never fully comprehend. The diversity of our Earth community is a gift to be celebrated, not squelched.

While we may all have come from the Earth, we have not all had the same advantages and experiences. Greed, power, and control have ruined lives and threaten to end life as we know it. As we come to understand ourselves, then, we may yearn for the meta-narrative that will tie our differences and similarities together in a manageable and meaningful story. Various traditional religions offer such an overarching story. Within each of these stories, however, have emerged factions and variances on the narrative. The story of humankind is a story of competition and violence as well as love, cooperation, and possibility. To look beyond and appreciate our differences as we recognize our common origin is perhaps our only hope. That is, after all, the essence of those religions that would have us, finally, understand ourselves in relation to one another. We must first recognize that, in ways we can never fully comprehend, I am the other whom I love and despise.

A near-sighted approach to identity and identity formation is deadly. The security promised by affluence is fleeting, as too many stories of market failures have shown. Those who define their worth by their wealth may learn in the face of disaster how fragile their self-perception may be. Junger (2016) traces our human roots on Earth back to tribal days when people had to work together to survive. One may argue that discovering our foundational identity as people of the Earth may be how we finally come to know who we are and how we can get along together on this planet.
References


Utilizing Technology to Improve Patient Comprehension

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Abstract
Patient comprehension of discharge instructions is a cornerstone for successful health care. Patients in an acute care setting often have difficulty with recollection or comprehension of discharge instructions. Poor comprehension is likely to interfere with the patient’s ability to properly administer medication, follow treatment modalities, recognize complications, and adhere to follow up care. The purpose of the project was to increase patients’ comprehension of discharge instructions to promote optimal recovery from illness. The project was conducted in an urgent care setting and utilized informatics to aide in patient comprehension of discharge instructions. The researcher recorded videos explaining important instructions on prognosis and follow up care regarding Strep Throat, Mononucleosis, Upper Respiratory Infections, and Urinary Tract Infections, as well as Lacerations and Sprains. Once patients were diagnosed, they viewed the appropriate video via an electronic device in the office while waiting on discharge paperwork. A brief survey was provided to assess the benefits of the teaching tool. Of the 376 participants, 56% responded that they preferred video discharge instructions, while 36% prefer verbal discharge teaching. Ten percent of the participants wrote in that they had no preferences. Overall, video discharge instruction was determined to be beneficial to the patient’s comprehension of the information provided.

Keywords
The following terms were used to define key components of the implementation process. Each term is defined theoretically and operationally.

Discharge Instructions. Discharge instructions were defined theoretically as instructions given to patients on how to care for themselves after discharge. Operationally they were defined as information given to a patient about the diagnosis they are given. The instructions provide further instructions on prognosis and follow up care. Mode of transmission and means of transmission are also parts of the discharge instructions.
Urgent Care. Urgent care was defined theoretically as a place where individuals seek medical treatment or advice for acute illnesses. It was defined operationally as a setting in which individuals are examined and provided care through a physician, nurse practitioner, or physician assistant. It accommodates equipment, tools, and clinical staff members that facilitate the health care professionals in meeting the needs of the patients.

Streptococcal pharyngitis. ICD-10 diagnosis code J02.0. Streptococcal pharyngitis was defined theoretically as an acute respiratory illness marked by fever, tender lymphadenopathy, absence of cough, rash, and swelling, redness, and exudates of the tonsils or pharynx (Centers for Disease Control and Prevention, 2015). It was defined operationally as a bacterial illness that is spread by respiratory droplets through person to person transmission (Carrillo-Marquez, 2015).

Mononucleosis. ICD-10 diagnosis code B27.90. Mononucleosis was defined theoretically as an acute clinical syndrome consisting of fever, pharyngitis, fatigue, enlarged spleen, inflamed throat, and adenopathy (Cunha, 2015). It was defined operationally as an acute virus that is transmitted by intimate contact with body secretions, primarily saliva. The virus can also be transmitted by the uterine cervix and blood transfusion. Mononucleosis is one of the most common acute illnesses seen in urgent care settings (Centers for Disease Control and Prevention, 2015).

Urinary Tract Infection (UTI). ICD-10 diagnosis code N39.0. Urinary tract infection was defined theoretically as an acute illness that presents with symptoms of painful urination in uncomplicated infections. More serious infections can be associated with abdominal or back pain, fever, sepsis, and decreased kidney function. It was defined operationally as an infection of the urinary tract that is most commonly caused by *Escherichia coli*, acquired from fecal contamination (Centers for Disease Control and Prevention, 2015).

Upper Respiratory Infection (URI). ICD-10 diagnosis code J06.9. Upper respiratory infection was defined theoretically as an acute illness that is characterized by symptoms such as nasal mucosal erythema and edema, nasal discharge, fever, lymphadenopathy, foul breath, and possibly coughing. It was defined operationally as an illness that represents the most common acute illness evaluated in the outpatient setting. URIs can range from mild, self-limited nasopharyngitis, such as a common cold, to more serious illnesses such as epiglottitis (Meneghetti, 2015).

Sprain. ICD-10 diagnosis code T14.8. Sprain was defined theoretically as a musculoskeletal injury to a ligament as a result of abnormal forces applied to the joint. It was defined operationally as the results of an injury to a joint that results in pain and swelling with decreased range of motion.

Laceration. ICD-10 diagnosis code T14.8. Laceration was defined theoretically as a wound produced by the tearing of body tissue, like a cut or tear to the skin. It was defined operationally as the result of an injury that punctures the skin causing a tear or cut that requires medical attention.
Introduction

Patient comprehension of discharge instructions is a cornerstone for successful health care. If a healthy outcome is to be achieved, the patient needs to comprehend the discharge instructions that are given by the healthcare provider. Healthcare providers are required by the Joint Commission, which provides hospital standards and accreditation, to provide effective discharge instructions. In the clinic setting, meaningful use also has the same regulations. There are no standards for assessing patient comprehension for patient education (Alberti & Nannini, 2013).

Patients in an acute care setting have difficulty with recollection and overall comprehension of discharge instructions. In the urgent care setting, other factors may affect patient comprehension of patient education including illness of the patient, fast pace of surroundings, or acute trauma of patient or family member. There is a need for evaluation of the comprehension of education to make adjustments that could improve patient outcomes and self-care. With the rise of mobile devices and the Internet usage for health and patient education, an educational tool using informatics would be an ideal development. The efficacy of using a standardized video, related to the specific diagnosis, provided the patients with the proper discharge teaching needed. The videos could be accessed by the patient after discharge via the Internet as a reference teaching tool. The videos were shown to the patient in the clinic. A survey was given to the patients to assess comprehension of discharge teaching and assess further questions before the patient was discharged.

Comprehension of discharge instructions is required for patients to achieve better management of medical diagnoses, appropriate medication usage, adhere to follow-up guidance, which intends to protect patients from confusion and complications. Poor comprehension of instructions may interfere with the patient’s ability to properly administer medication, follow treatment modalities, recognize complications, and adhere to follow up care (Alberti & Nannini, 2013). In the emergency room or urgent care setting, the patient’s ability to comprehend information given may be decreased because of the scenario. The environment may seem chaotic to the patient because of patient flow and surrounding issues, so the patient may not be able to focus. Providers must rapidly develop an effective rapport with the patients, while managing distractions, interruptions, and time pressures within the acute care environment. The patients may feel anxious, without other access to the healthcare system, and are sometimes meeting the provider for the first time, all of which may impede the patient education process or comprehension (Alberti & Nannini, 2013).

Significance of Project

It is the responsibility of the provider to properly educate the patient to promote optimal recovery and comprehension of important information concerning the illness. For patients to recover fully from an acute illness, it is important that they understand treatments and the recovery process. With injuries or lacerations, it is important that patients understand self-care to prevent further injury or infection. In some cases, it is important to include the family in the education process, to aid in the wellbeing of the patient. Improving the outcome of the patient is the most important element to providing care as a patient advocate.
With evidence-based practice, the provider should strive to improve patient experience, care, and outcome. Using previously reviewed research, the researcher implemented a new learning tool using current technology to improve the comprehension of discharge teaching for the patient related to the specific diagnosis. The usefulness of the project was assessed based on patient response, as well as call backs and return visits.

With the fast paced surroundings in the uUrgent cCare setting, the use of standardized discharge teaching via videos shown to patients could prove very beneficial for patient outcomes and also benefit the facility. The use of video teaching would decrease the amount of time needed by the provider for discharging the patient and in turn, increase productivity of the facility. The use of informatics opens many new possibilities in the world of health care.

**Purpose**

If patients were properly educated on their diagnosis and prognosis, then the rate of repeat office visits for the same illness would likely decrease. This would in turn, decrease healthcare cost and days missed of school or work. The spread of communicable illnesses would also be decreased if patients understand the modes of transmission and the periods during which their illnesses might be contagious. The project implemented the use of informatics to aid in the teaching of discharge instructions to the patients. A brief survey was also provided to assess the benefits of the teaching tool. The researcher recorded videos explaining important teaching on specific illnesses chosen for the project. The illnesses that were discussed were strep throat, mononucleosis, URIs, and UTIs. Lacerations and sprains were also discussed. The purpose of the project was to further educate the patients to promote optimal recovery from illness and comprehension of teaching.

According to Carrillo-Marquez (2015), acute pharyngitis accounts for approximately 12 million annual acute care visits in the United States. It is ranked in the top 20 most common primary diagnosis groups. It is more prevalent in Winter and early Spring months. There are an estimated 616 million Group A Beta Hemolytic Strep cases annually worldwide. It is rated as one of the top ten worldwide pathogens. *Streptococcus pyogenes* (“Strep”) is the most common cause of pharyngitis and Strep is most commonly seen in patients aged 5 to 15, but can affect men and women of all ages. Children often experience symptoms for 4 to 5 days. Strep is transmitted from person to person. Its growth can be facilitated on toothbrushes, orthodontic appliances, and even pets. An infected family member has a 40% chance of transmitting Strep to another family member (Centers for Disease Control and Prevention, 2015).

*Ebstein Barr mononucleosis* (“Mono”) is mostly commonly seen in patients who experience fatigue, lymphadenopathy, fever, nausea, and headache. In the United States, approximately 50% of the population seroconverts before age 5, with the remaining population seroconverting in adolescence or young adulthood. Approximately 12% of college-aged young adults convert each year, with half of them developing acute infectious Mono. Mono is transmitted through saliva droplets and other body secretions (Cunha, 2015).

Upper Respiratory Infections are the most common infectious illnesses in the general population, are the leading causes of missed school and work days, and URI is the most frequent acute diagnosis in the office setting. Children under the age of 5 have a higher incidence of
URI. Children have about 3 to 8 viral respiratory illnesses per year, adults and adolescents have approximately 2 to 4 a year, and adults over the age of 60 have fewer than 1 per year. There are more than 200 viruses that are known to cause URIs, which involve direct invasion of the mucosa lining the upper airway. Exposure to smoke can cause this lining to be more susceptible to infection. URIs are spread from person to person (Centers for Disease Control and Prevention, 2015). Inoculation of bacteria or viruses occurs when a person’s hand comes in contact with pathogens and the person then touches the mouth or nose. Inoculation with URIs also occurs when the person directly inhales respiratory droplets from an infected person who is sneezing or coughing (Meneghetti, 2015).

According to the Centers for Disease Control and Prevention (2015), UTIs account for about 4 million ambulatory-care visits each year, representing about 1% of all outpatient visits. It is most commonly caused by *Escherichia coli*, but can also be caused by other pathogens. This is commonly due to poor hygiene. The UTIs are most commonly diagnosed in sexually active females but can be seen in all populations.

**PICOT Question and Expected Outcomes**

With the implementation of a standardized teaching tool, such as the video addressed in the project, the provider could be sure that every patient was told all the correct and pertinent information related to their diagnosis. By allowing the patient to ask questions after viewing the video, the patient would be allowed to have further discussion if needed. This, in turn, would improve patient outcome by improving knowledge and comprehension of what was taught. If the patient forgot something that was discussed, he/she could access the video via the Internet and re-watch if needed. This would provide a way for the patient to get answers to their questions without having to call back to the clinic, if it was related to the information given at discharge. This would also help decrease the number of call backs and time spent by the nursing staff returning phone calls. If the patient fully understands expectations for wellness before they leave the clinic, they would not need to call back questioning the staff. The video teaching also provides more time for the provider to be working on discharge paperwork, or assessing a new patient. This implementation would require less time for the provider to spend with the patient, but still allow the patient to feel the connection with the provider by seeing the provider on the video.

The expected outcome of this project and implementation was to improve the experience for the patient and to provide a better outcome for the acute illness of the patient. Patient outcome is always the most important aspect in healthcare.

**Literature Appraisal**

A search was completed on the following databases: Academic Search Complete, CINAHL Complete, Health Source: Nursing/Academic Edition, MEDLINE, Psychology and Behavioral Sciences Collection, MEDLINE Complete. The following are keywords that were used: Patient teaching, patient comprehension, discharge teaching, informatics, recall, evaluation, recollection, evaluation, video teaching, and Acute Care. The search included surveys, questionnaires, review of literature, and a comprehensive evaluation of teaching methods. Articles that were related to the teaching of healthcare providers instead of patients
Articles

were discarded. Some articles that pertained more to chronic care settings or illnesses were also discarded. The studies were narrowed by adding more specific search terms. Studies were discarded based on relevance to the project.

Alberti and Nannini (2013) conducted a literature review with a goal to identify interventions that were used to provide discharge instructions, examine the methods used to assess patient comprehension, and determine the most effective strategies for assuring patient comprehension of discharge instructions. Their focus was on the Emergency Department and Urgent Care settings. Alberti & Nannini (2013) discovered that simplification of material is paramount in achieving patient comprehension of discharge instructions.

Chappuy et al. (2012) conducted a study to evaluate the extent to which parents understood four crucial points of discharge information from emergency departments: the reasons for their child’s hospitalization, the diagnosis, prognosis and treatment. Chappuy et al. (2012) found that parents had a poor overall understanding of the information provided when their children were admitted to short stay units. Less than half of the parents understood the emergency department physician’s discussion of the reason for admission. Previous studies showed that parents of sick children had a better recollection and comprehension of discharge than when the adult was the patient. This may be because the adult was not sick at the time of the instruction. It was also noted in this study that parental understanding was affected by the perception that the child was in pain. It may have been more difficult for the parent to receive and understand information from the physicians because of the concern about the suffering of their child. Increasing the time spent educating the parents did not seem to reflect on the comprehended knowledge. In this study, only 19% of parents understood all the information provided by the doctor at the time of their child’s admission to the emergency department. One factor that did improve the parents’ understanding was the nurse giving additional information according to Chappuy et al. (2012).

According to McBride and Andrews (2013), implementing effective teaching at the time of discharge can lead to a decrease in the rate of hospital readmissions and mortality for patients after discharge. McBride and Andrews (2013) conducted a study to identify and examine models and concepts relevant to improving discharge education in an acute care setting. In acute care settings, it was estimated that 40% to 80% of what was taught to patients was forgotten immediately following teaching, and that 50% of the information that patients did remember was recalled incorrectly (McBride & Andrews, 2013). This could be due to factors such as stress of an acute illness, an overload of new information, or patients’ education and literacy levels.

The use of mobile applications in health care is becoming more prevalent daily. MobileSmith (2014) showed the rise of mobile application use and the impact it could make on the health care society. A tremendous increase in the use of healthcare apps has occurred in the past few years. Almost 100 million Americans use mobile Health (mHealth) technology and 38% of smartphone users deem their mobile device as an essential for finding health and medical information.

A survey of physicians in 2013 found that 93% of the physicians believe mHealth apps could improve patient outcomes, and 89% are likely to recommend a mHealth app to a
patient. The downside to this is that the physicians believed that the majority of the apps that were available were limited in scope, functionality, and efficiency. Physicians were not willing to recommend an app to their patient without evidence of approval and success. MobileSmith also looked at how mobile apps could effectively reduce healthcare costs for providers, payers, and patients. Twenty percent of patients who used a mobile app to record their blood pressure and weight daily were readmitted to the hospital within three months compared to 60% of the patients who did not use the mobile device. The use of mobile apps could also prove to decrease healthcare costs. Mobile devices could also be helpful to remind chronically ill patients to take medications daily.

The use of the Internet as a source for health information by patients and providers has rapidly increased over the past several years and continues to do so. Physicians were reluctant at first to turn to the Internet for health information to improve patient interpersonal communication and education (Siegel et al., 2006). The physicians expressed concerns about the anticipated time demands of emails from patients, lost time in patient visits to discuss information from unknown or dubious sources, and the unreliability of much of the health-related information posted on the Internet (Siegel et al., 2006).

The American Medical Association and the Joint Commission on Accreditations of Healthcare Organizations have standards and obligations that physicians must follow when dealing with patient education. Because of these regulations, more emphasis is placed on patient-physician communications. With the development of new educational tools including websites and mobile applications, patients have more opportunities to learn and be self-efficient. Siegel et al. (2006) conducted a study to determine if the use of the Internet, and potentially mobile applications, are very beneficial to the education and comprehension of patients concerning specific illnesses. The use of these databases also allowed patients to take responsibility and play a larger part in their own care.

Lewis (1999) conducted a literature review that focused on computerized education for patients. Computerized education provided a private learning environment and immediate reinforcement of the learning that had occurred. Lewis reported that computer-based learning programs were popular and effective in delivering information and that patients were generally able to use them without complications. In eight studies, an improvement in knowledge scores was noted when computer-based patient education was compared to traditional instructions. Computer-based education could reach all ages across the spectrum. Patients with low socioeconomic status responded well to computer-based interventions. The use of computer-based education had a positive impact on clinical outcomes, knowledge acquisition, self-care management, and skill development. In 17 of 21 research reports, patients who participated in computer-based patient education experienced significant improvements in the desired outcomes.

Blank and Smithline (2002) created a patient teaching program that included an education video and written instructions to educate patients to reduce pre-hospital delays in patients with chest pain. A group of patients received standard discharge instructions and another group received video teaching and written instruction. In this study there was no significant difference between the two groups.

Albert, Buchsbaum, and Li (2007) conducted a study to evaluate the short-term impact of video education in addition to standard education on heart failure patients. The
authors evaluated self-care behaviors at a three month follow up visit. One group was given standard discharge teaching and the other given video teaching along with the standard teaching. The group of patients that received the video education had a higher mean self-care adherence score to reflect greater self-care. The study found that video education was a useful tool in education.

**Literary Discovery**

*Description of Theory and Framework*

When discussing the comprehension of discharge instructions by adults, the Theory of Adult Learning must be understood. The patients must be properly taught if expected to improve outcome. Malcolm Knowles developed his theory to discuss the process of learning as it is different for a child compared to an adult. The adult process of learning must be used to ensure that proper comprehension discharge instructions is achieved.

Pedagogy is the art and science of teaching, especially the teaching of children. This was developed in Europe at the close of the 12th century. The pedagogical assumptions about learning and learners were based initially on observations by the monks in teaching very young children relatively simple skills, originally mostly reading and writing. When adult education began to organize, the teachers noticed that the plans that they had been following were not working for the adults. The adults seemed to get bored and drop-out rates were high. The transmittal of knowledge and skills that had been effective for children previously, were not appropriate for adult learning (Knowles, 1970).

Andragogy, the art and science of helping adults learn, was developed in the 1960s. Malcolm Knowles viewed andragogy not to be specific to just adults. He noticed from reports of teachers that the concepts of andragogy were beneficial to youth age as well. He then redefined andragogy as another model of assumptions about learners to be used alongside the pedagogical model of assumptions, thereby providing two alternative models for testing out the assumptions based on the fit with the particular situation (Knowles, 1970).

**Utilization of Model in Project**

The concept of adult learning was used when assessing the comprehension of what adult patients were taught about their discharge instructions. The development of a teaching application or program that could also be used to evaluate the method and comprehension would focus on the needs of the adult learner.

Specifically looking at the urgent care setting, there are ways to implement the theory into the practice to improve the learning experiences for patients. The first way is to take into consideration the learning climate. An environment that is conducive to adult learning is desirable. The environment should make the adult feel at ease, comfortable, informal, and have proper lighting and sound. It should make the adult feel accepted, respected, and supported. An environment where the patient has the freedom to express without fear of punishment is desired. The attitude of the teacher reflects the openness of an adult learning.
As a tool to learning, the development of an education tool by video was implemented during this project. The patient was shown the video while in the office, while waiting for discharge paperwork. The video was specific to the patient’s diagnosis. The patient was then asked to participate in a survey that evaluated the discharge teaching experience. The patient was questioned about the preference of the teaching tool. Based on the knowledge gained from this theory, the videos were directed to the learning of an adult to meet their needs.

**Methodology**

This project was used to implement the use of informatics to assist in the teaching of discharge instructions to the patients. The researcher evaluated the recommended discharge instructions from the Centers for Disease Control and Prevention on the following illnesses: strep throat, mononucleosis, URIs, and UTIs. Teaching for sprains and lacerations was also provided. From the information gathered, the researcher developed short videos to be shown to the patient at discharge. The videos were of the researcher discussing the recommended discharge instructions. The purpose of the project was to further educate the patients to promote optimal recovery from illness and comprehension of discharge instructions.

The participants were patients seeking medical treatment at an urgent care clinic. The patients were assessed and diagnosed per routine at the facility. If the patient was diagnosed with strep throat, mononucleosis, URIs, UTIs or had a laceration or sprain, they were chosen for the study. The first 100 patients with each given diagnosis were used in the study.

Once the patient was diagnosed, the patient was shown the video in the office while waiting on discharge paperwork. The patient watched the teaching tool on a provided electronic device, or was directed to the website via the patient’s own electronic device, such as a cell phone or tablet. After the teaching was complete, a brief survey was also provided to assess the benefits of the teaching tool and to obtain suggestions or further questions from the patient. The results were given to the project conductor. The patient was given instructions on how to access the website containing the discharge teaching videos for further reference if needed later.

Two days after the visit, a third-party program was used to contact participants via text message who had provided a cell phone number during registration. The participant was sent a reminder related to their diagnosis along with the link to the discharge teaching video they had watched in the clinic. This provided the patient the link to access the teaching video at their convenience.

Before the intervention, there were no specific ways of tracking patient call backs. Once the intervention was initiated, a message was placed in the chart of each participant. The message was used to notify staff that the patient was involved in the study. If the patient called back, the nurse would see the message and send the researcher an e-mail notifying her of the call back. If the patient returned to the clinic for the same complaint or diagnosis, the provider would see the message and notify the researcher.
Population

The clinic where the project was implemented is an Urgent Care clinic in Corinth, Mississippi. Corinth has a population of approximately 15,000. The ethical break down of Corinth is about 70% Caucasian, 23% African American, 5% Hispanic, .1% Asian, 0.1% American Indian, and approximately 2% reported being two or more races (City-Data.com, n.d.). The Urgent Care clinic treats patients for acute illnesses. A full lab and x-ray are available at the facility. The clinic sees workman's compensation patients for several of the surrounding factories and other businesses. Chronic illnesses are not treated at this urgent care clinic. The clinic also provides travel consultations regarding vaccination and preventative medications for overseas travel.

When discussing comprehension of discharge instruction by the patients, educational levels play a factor in how well patients understand what they are taught, or able to read teaching material. For the population of Corinth, 80.2% have a high school education or higher, 22.7% have a bachelor’s degree or higher, and 8.8% have a Graduate or professional degree (City-Data.com, n.d.).

Since these illnesses are all acute illnesses, the urgent care setting was an adequate place to implement this project. Another benefit to the implementation was that the time usually spent by the provider during discharge teaching could be used to see another patient, or complete other tasks due to the standardization of the video discharge teaching. Fast pace and decreased patient visit times are key factors in urgent care. This implementation aided in both areas.

Results

Three-hundred seventy-six patients were chosen to participate based on the diagnosis they were given. Only one patient declined to participate in the study during the time of implementation. Of the participants, 26.3% (100) were diagnosed with strep, 3% (12) with lacerations, 5% (17) with a sprain, 13% (47) with UTIs, 26.3% (100) with mononucleosis, and 26.3% (100) with URIs. (Figure 1)

Of the 376 participants, 54% (205) responded that they preferred video discharge teaching over verbal teaching, while 36% (134) prefer verbal discharge teaching. Ten percent (37) of the participants wrote in that they had no preference. Participants were given a copy of the web address where the teaching video specific to their diagnosis could be accessed. When participants were questioned on whether they would access the link if they developed questions about their diagnosis after discharge, 77% (289) of them responded yes, and 23% (87) responded no. All participants responded that they felt well informed about their diagnosis from the teaching that was received.

There were 100 participants with the diagnosis of strep of whom, 54% (54) preferred video discharge teaching over the conventional verbal teaching. Thirty-eight percent (38) of the patients preferred to continue with verbal discharge teaching. Of the patients diagnosed with strep, 8% (8) wrote in that they had no preference of teaching style. The patients were provided with the web link to access the teaching video after discharge. Of the patients with this diagnosis, 80% (80) responded that they would access the teaching video after being discharged.
via the internet address provided, while 20% (20) responded that they would not access the link. All of the participating patients answered that they had been fully informed of their diagnosis.

Looking at the participants with lacerations, 58% (7) of the 12 participants preferred the video discharge instructions more than traditional verbal teaching. Thirty-three percent (4) of patients treated for lacerations preferred the verbal teaching, while one patient had no preference. When asked if they would access the video if needed after being discharged, 83% (10) responded yes, while 17% (2) responded no. All the participants with lacerations responded that they felt well informed on how to care for their wound and felt well-informed of the discharge information.

Of the 376 participants, 17 of them were diagnosed with a sprain. Of the patients diagnosed with a sprain, 47% (8) preferred video discharge teaching over verbal teaching. However, 47% (8) responded that they preferred verbal teaching. Six percent (1) of the participants with sprains wrote in that they had no teaching preference. Seventy-six (13) of the patients with sprains responded that they would reference the video via the web link provided, while 24% (4) responded that they would not. All 17 patients answered that they felt well informed about their diagnosis before leaving the clinic.

There were 100 participants with the diagnosis of mononucleosis. Of the patients diagnosed with mono, 62% (62) preferred video discharge teaching over the conventional verbal teaching. Thirty percent (30) of the patients preferred to continue with verbal discharge teaching. Of the patients diagnosed with mono, 8% (8) wrote in that they had no preference of teaching style. Eighty-one percent (81) of the patients with this diagnosis responded that they would access the teaching video after being discharged via the internet address provided, while 19% (19) responded that they would not access the link. All the patients reported that they felt they had been fully informed of their diagnosis.
Participants with UTIs represented 13% (47) of the total participants. When asked whether they preferred video teaching over verbal teaching, 59% (28) responded yes, while 32% (15) responded no. Nine percent (4) of the participants wrote in that they had no preference. When asked if they would access the video via the address provided, 74% (35) responded yes and 26% (12) responded no. All 47 participants indicated that they felt well informed about their diagnosis from the teaching.

Upper respiratory infections represented 26% of the overall participants with a total number of 100 participants diagnosed with URIs. Of the 100 participants, 46% (46) of them responded that they preferred video discharge teaching compared to the 39% (39) who responded they did not prefer video teaching. As with the other diagnosis, 15% (15) of participant had no preference. When asked if they would access the video after discharge if needed, 70% (70) responded yes while 30% (30) responded no. All of the participants diagnosed with URIs felt well informed about their diagnosis before leaving the facility. (Tables 1-3)

Table 1. Patient preferences for video vs. verbal discharge instructions.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Yes</th>
<th>No</th>
<th>Either</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strep</td>
<td>54%</td>
<td>38%</td>
<td>8%</td>
</tr>
<tr>
<td>Laceration</td>
<td>58%</td>
<td>33%</td>
<td>8%</td>
</tr>
<tr>
<td>Sprain</td>
<td>47%</td>
<td>47%</td>
<td>6%</td>
</tr>
<tr>
<td>UTI</td>
<td>59%</td>
<td>32%</td>
<td>9%</td>
</tr>
<tr>
<td>Mono</td>
<td>62%</td>
<td>30%</td>
<td>8%</td>
</tr>
<tr>
<td>URI</td>
<td>46%</td>
<td>39%</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>54%</td>
<td>36%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 2. Preference of accessing video instructions after leaving facility.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strep</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Laceration</td>
<td>83%</td>
<td>17%</td>
</tr>
<tr>
<td>Sprain</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>UTI</td>
<td>74%</td>
<td>26%</td>
</tr>
<tr>
<td>Mono</td>
<td>81%</td>
<td>19%</td>
</tr>
<tr>
<td>URI</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Total</td>
<td>77%</td>
<td>23%</td>
</tr>
</tbody>
</table>
Three participants called back to the clinic out of 376 who participated in the study. These callbacks were all related to the medications the participants were prescribed. One was for a child who had been prescribed pills and could not swallow them and the caller requested the medications to be changed to liquid forms. The other two calls were from participants who could not tolerate the medications prescribed and desired for the medications to be changed. There were two return visits. The patients who returned did so for the same illness as originally diagnosed, URI. These participants returned because they desired to receive another injection to shorten the recovery period from their illness.

There were no call backs related to misunderstandings of the information given about the diagnosis. There were no return visits related to patients mis-interpreting the information given at discharge.

**Limitations**

A limitation to the study was the inability to know the number of callbacks or return visits before the implementation to compare to callbacks and return visits after the implementation of the teaching tool. There was no system to track callbacks or return visits for the same diagnosis. Because of the implementation of the teaching tool and text follow-up with the patient, the number of return visits could increase because the patient may feel well pleased with the experience at the clinic and with the provider, so he/she may want to return to the same facility. Because of this, Thus, evaluating patient returns was an imperfect measure.

Another limitation of the study was a language barrier. There were several Hispanic families that sought care at the Urgent Care clinic. Some of these families did not speak English very well. This was a limitation in that the videos were recorded in English. The patients usually had an interpreter with them, so that may have resolved any language barrier issues.

The teaching of deaf patients could also have been a limitation. The videos were recorded and if the patient was unable to hear the recording, teaching might have been impeded.
Conclusion

Mostly positive feedback was received about the implementation of discharge teaching videos in the urgent care setting. The video discharge teaching tools could be used solely, or in conjunction with verbal teaching to ensure that patients are properly educated on their diagnosis. This would ensure optimal recovery for patients, as well as decrease the spread of illnesses. The use of the tool would also be beneficial for urgent care facilities by decreasing the time the provider spends with the patients to improve productivity in the fast pace of the urgent care setting.

Table 4 displays some of the responses of the patients when asked to give their opinions. The table is formatted as direct quotes of the patients’ written responses.

In the future, the use of video teaching tools could be used or adapted for the chronic care setting. Patients with chronic illness such as diabetes, hypertension, hyperlipidemia, etc., may find the added teaching beneficial to their understanding of and adherence to medical treatment and advice as did the acutely ill patients in this study. The accessibility of the tool after the initial clinic visit may be more beneficial for the chronic care setting. The patients may access the video from home to become more knowledgeable of the disease, or more compliant with their treatment regimen.
Table 4. Written responses from patients.

<table>
<thead>
<tr>
<th>Written Responses From Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The video is more detailed, but I don’t feel like I can ask questions as easily.</td>
</tr>
<tr>
<td>• Using the video would expedite the office visit.</td>
</tr>
<tr>
<td>• Prefer information from a person at the clinic so I can ask questions. Making it available on the net afterward would be helpful.</td>
</tr>
<tr>
<td>• Verbal is better for the parents, but video is better for the younger clients in today’s technology age.</td>
</tr>
<tr>
<td>• I liked the video in conjunction with the verbal follow-up. It reinforces the discharge instructions.</td>
</tr>
<tr>
<td>• I feel more informed about what is going on.</td>
</tr>
<tr>
<td>• Much more detailed and better communicated.</td>
</tr>
<tr>
<td>• It covered everything that I needed to know about my diagnosis versus verbal, something could have been left out.</td>
</tr>
<tr>
<td>• I prefer face to face so questions could be voiced right away. In so many cases now we are taking the personal aspect of our health care away and moving to an electronic provider.</td>
</tr>
<tr>
<td>• Sometimes we may not catch it the first time being said, so this does help me to better understand. Thank you!</td>
</tr>
<tr>
<td>• Video was great. Teaching by video was very helpful. Usually when verbal discharge instructions are given I personally try to listen but get side tracked with my sick child. Caring for them in the office prevents me from fully hearing and remembering 100% of the verbal instructions. Visually seeing the video allowed concentration and personally I will remember better by visual presentation.</td>
</tr>
<tr>
<td>• I was more in tuned to what was being said by watching the video.</td>
</tr>
<tr>
<td>• I learned a lot more about things I need to do and not to do to keep from spreading it and what it could possibly turn in to.</td>
</tr>
<tr>
<td>• I learned more about the causes.</td>
</tr>
<tr>
<td>• The video was very specific about symptoms, prognosis, causes, and precautionary measures.</td>
</tr>
<tr>
<td>• It answered questions I didn’t know to ask.</td>
</tr>
<tr>
<td>• I love information about diagnosis and treatment. That way I am not googling and possibly getting wrong info.</td>
</tr>
</tbody>
</table>


Ethics of Belief and Ethics of Ambiguity: Demystifying the Ethics of the USPHS Syphilis Study at Tuskegee

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A young boy and his mother stood viewing a museum art piece depicting a man slaying a lion. Looking incredulous, the boy argued, “Mama, everyone knows that a man can't beat a lion.” The mother prudentially responded, “Yes, but remember son, it was a man who painted the picture.”

– anonymous source

...there can be mutual reinforcement between an explanation and what it explains. Not only does a supposed truth gain credibility if we can think of something that would explain it, but also conversely: an explanation gains credibility if it accounts for something we suppose to be true.

– Quine and Ullian The Web of Belief

Abstract

One of the lead physicians defending the “United States Public Health Service Study at Tuskegee of Untreated Syphilis in the Negro Male” was Dr. John C. Cutler. His defense of the study was (roughly) on the grounds that the benefits to society in general, and the black community in particular, far outweighed any corresponding risks or harms. His moral judgement controverted the voluminous number of thoughtful essayists decrying the Study as a straightforwardly and racist dehumanizing of men, women and families. In this essay I seek to show two things. First, I seek to show how an action or event done at a particular time may lack the objectivity that comes with distanciation, thus a (malicious) systemic distortion may be ambiguously reducible to an historical error, especially if there is no critical theory borne from critical reflection to hold the action or event morally accountable. Second, I show how two things should be apparent with disambiguation of the historical narrative and with critical reflection: 1) an ethic of ambiguity (and the integrity thereof) should demand that moral propositions be critically assessed at the time of an action or event from more than one angle to ensure the protection of all humans, especially historically marginalized individuals and groups; 2) an ethic of belief, given its Intentionality and intentions, should understand its inherent vulnerabilities and accentuate the import of evidence in moral epistemology.

Keywords: ethics of belief, ethics of ambiguity, Intentionality, moral epistemology, Syphilis Study, Tuskegee, USPHS, public health ethics and bioethics
Introduction

There is a uniquely discursive and unexpected feature of the notorious United States Public Health Service Study on the effect of Untreated Syphilis on the Negro Male at Tuskegee (the Study), one that points to either a weakness in the structure of ethical arguments or the propensity of agents to put forth invalid ethical arguments due to an accentuation of fallacious propositions, maniacal beliefs, or justifiable ambiguities. This paper shows that an in-principle attempt to justify the treatment (or non-treatment, as it were) of 623 Negro men (and their families) survives no credible moral epistemology or justification, cannot rely on an ethic of ambiguity to demonstrate its veracity, and cannot avoid its inherent racism. We are almost five decades since the Study, and almost nine decades since its inception. Given this near half-century of critical reflection, analysis, and moral inferences, I take a look at the force of predominant ethical theories to see whether or not an ethic of ambiguity is a sustainable defense for the Study’s protagonists. In this essay I use Dr. John Cutler as a symbol of the primary protagonists. Born in 1915, Dr. John Cutler, finished Western Reserve University Medical School in 1941 at the age of 26, and one year later, ten years after the Study began, started his career at the United States Public Health Service—the government organization that authorized the Study. His participation in the Study as one of the primary doctors, his furtherance of a similar study in Guatemala, and his unswerving commitment and defense of the Study decades after its public revelation, are all indicative of why he surmounts several others as the Study’s protagonist. There’s a prima facie sense in which his words can be perceived as genuine empathy: “The Tuskegee Study has been grossly misunderstood and misrepresented this way. And the fact was it was [our] concern for the black community, trying to set the stage for the best public health approach possible and the best therapy, that led to the Study being carried out” (Deadly Deception. 3:31). Defensive terms like “grossly misunderstood,” “misrepresented,” “concern for,” “best...approach,” and “best therapy” suggest the deep lack of empathy and care that the United States Public Health Service visited upon the families of Macon County, Alabama between 1932 and 1972. If Dr. Cutler is correct, that ambivalence surrounding the Study was only a gross “misunderstanding” and that there was nothing duplicitous about it, then the last half-century of critical analysis amounts to nothing more than the subjective misinterpretation that is (potentially) commonplace to all historical events. The “historical events” to which I refer are those events that come into being—that occur—due to actions caused by Intentional mental states (beliefs) and intentional (deliberate) actions. In this regard, I am not referring to anything environmental, for example; rather, I am referring to a particular narrative that was imposed upon one group of humans by another group of humans. Historical events of this ilk, such that they are the consequence of human actions, are themselves narratives—they occurred because of (1) particular Intentional mental states, attitudes, beliefs, etc. (2) and intentional, planned out/ premeditated actions. Thus, the historical event of my present concern is the USPHS Syphilis study at Tuskegee.


2 Such as hurricanes. In 2017 Hurricane Irma and Maria devastated the Caribbean, but there were no underlying mental states. Though we tend to use generic language like “acts of God” to contextualize a certain kind of phenomenon, hurricanes and other kinds of environmental events are natural historical events having no import for my present concerns.
Undergirding many mental states (beliefs, desires, etc.) is the property of *Intentionality*. All beliefs are mental states having certain properties: 1) beliefs (because they have Intentionality) have aboutness or directedness. “If I have a belief, it must be a belief that such and such is the case” (Searle, 1983, pg. 1). Not all mental states have aboutness. I may have an attack of nervousness, for example, that is not about anything in particular. Beliefs, on the other hand, is not of that kind. It is a mental state that is about something. This notion that my beliefs have aboutness (or directedness), i.e., that my beliefs are always traveling towards something is philosophical jargon for inferring that my beliefs have Intentionality. Also, beliefs have 2) intentions. In this regard, I am referring to intentional in the classical, non-philosophical sense of having goals, objectives or purposes. Intentions of this sort cannot exist independent of background mental states. To speak of Intentionality, then, is to speak in a discursive and reflective way on a necessary property of belief. One can’t speak of the ethics of belief without acknowledging the belief’s Intentionality, i.e., “what is it about?” If I say I have a certain belief, the very next question would (or should) be “what is your belief about?”

The Study didn’t just happen, as say, an accident of history, void of an Intentional human narrative. The Study was a non-natural act, the result of intentional mental state, attitudes and belief. Such states need a (mind-to-world) *direction of fit*. This direction of fit disqualifies interpretations that are inconsistent with an agent’s belief. On this account there are two kinds of beliefs worthy of mention: *de dicto* and *de re*. A *de dicto* belief is essentially a “belief,” i.e., it is a mental state with content and Intentionality. I am not going into the richness of this discussion, which would take me too far afield of my present concern, except to say, very roughly, that a *de dicto* belief is an *a priori* belief, the kind of belief that can be had (arguably) by a brain in a vat, independent of experience. Thus, there is a redundancy in uttering a term like “*de dicto* belief” (Searle, 1983, pg. 209). On the other hand, a *de re* belief is far more fundamental to my present concern. A *de re* belief is a belief that denotes something existential—or external. One can say that a *de dicto* and a *de re* belief have the same starting point. They have the same initial properties for sure. But *de re* beliefs interacts with the actual, real world. Commonly these distinctions are of no major consequence beyond the philosophy of mind and the philosophy of language, but given my showing of how contextual beliefs can function to marginalize fellow humans, this distinction helps in clarifying the ethics of belief. Thus, we will start with a clarification of belief, namely, what it means to have an ethical belief and how an unethical belief can yield ambiguous concern and render harm to others and self. With respect to the Study, unethical beliefs began as *de dicto* mental states and ended with the (*de re*) marginalization of 623 black men in Macon County, Alabama, then extended to their families.

### The Ethics of Belief

Historical events, caused by intentional actions, happened because human minds made them happen. Beliefs about the historical narrative, if they are untrue, don’t count for anything ethical. If the trajectory of their beliefs is *to do good*, then the truth value of their beneficent proposition is ethical. If, on the other hand, the trajectory of their belief is *to do harm*, then their actions are maleficent and unethical. I. L. Humberstone (1992) surmises, “Beliefs aim at being true, and their being true is their fitting the world; falsity is a decisive failing in a belief, and false beliefs should be discarded; beliefs should be changed to fit with the world, not vice versa.” Facts

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**Footnote:** The “I” is capitalized to differentiate between “Intentionality” as a function of mind in which mental states are very often about something and “intentions” or to “intend.”
about the world (e.g., grass is green, snow is white, Nigeria is in Africa, and water is wet) should always be prioritized over individual opinions about the world, both epistemically and ethically. If the beliefs we have aren’t fortified by facts and good evidence (or valid arguments in defense of facts and evidence) we should set them aside. First person authority of one’s beliefs—the fact that I have access to my beliefs in a way that no one else are able—tends to render a superiority (or perhaps even an arrogance) that is not necessarily justifiable (Davidson, 2001). It is a special positioning, with special access, but it isn’t totally sacrosanct or devoid of error. A person, for good or for ill, may feel fully justified in believing her beliefs—and that makes perfect sense (unless one knows oneself to be delusional)—but if that belief is taken to be perfect, free from error, hubris may prevail. Donald Davidson (2001) reminds us that “Error is possible.” Error, mistakes and miscalculations are always possible, “Though there is first person authority with respect to beliefs and other propositional attitudes, error is possible; this follows from the fact that the attitudes are dispositions that manifest themselves in various ways, and over a span of time” (pg. 4). Thus beliefs (both de dicto and de re) are vulnerable to error and doubt, “For first person attributions are not based on better evidence but often on no evidence at all” (pg. 6). Fashioning one’s actions based upon uncritical beliefs, therefore, is hubris. It is the beginning of personal folly, bigotry and unethical behavior. It seems rather difficult for the protagonists in the Study to discount the word-evidence of the credible, namely, one of the primary participants in the Study and the one who brought the law suit, Charlie Pollard when he said, “And when this first started up, I didn’t know nothing—just a country boy, as they say. And when they got down here in Alabama, they found what they wanted—they just went to doctoring on us. And said they gon treat us. They just said ‘bad blood.’” It is clear that Pollard’s words, once juxtaposed with the goal and title of the Study, “the effects of syphilis in the Untreated Negro male,” successfully refute Dr. Cutler and the other protagonists’ intentions. So long as their de dicto beliefs were only beliefs, there was no ethical issue. The moment their beliefs became de re (actual), i.e., they came to Macon County, Alabama and fulfilled their beliefs, they were officially involved in unethical behavior. It’s time now to distinguish the two types of beliefs more clearly.

If we have a de dicto belief there is no moral consequence. This is simply because I cannot be held morally responsible for thinking an act that I don’t commit. My beliefs are of no moral consequence unless they are de re beliefs—i.e., my beliefs are of no consequence unless they are beliefs that are imposed upon real external objects—in this case 623 black men and their families. Such that Cutler and other protagonists of the Study opined privately—like a brain in a vat—nothing ethically hung on their beliefs (or the content thereof). But the moment their beliefs were imposed upon men, causing unjustifiable harm, their beliefs in correspondence with their actions became unethical (Slote, 2001). Beliefs remaining in one’s head may be metaethical moorings—analogue attempts at resolving puzzles, for instance. Philosophers ponder counter-intuitions and counter-factuals or expedient analogies on a regular basis, everything from pedophilia to murder to genocide are considered, and none of these beliefs (or moorings) are considered unethical as such. They are simply thoughts, and some may even rise to the level of beliefs. But if their beliefs move from private to public, impacting real humans (or non-human animals) in the real world, their beliefs, and their corresponding actions, are susceptible to (normative) moral judgement. Let’s say for example, that a certain man (Paul) dislikes his father-in-law (Sam), which is not abnormal. Paul so dislikes Sam that he regularly ponders murdering him. He envisages a myriad of scenarios about how to kill Sam, and he even practices shooting at an effigy of Sam pinned to a tree stump in the woods. But because
Paul's ponderings are *de dicto*—words and thoughts only—he committed no ethical wrong. If he actually murders his father-in-law through premeditation, he has committed a moral and a legal *de re* wrong. But is there a possibility of ambiguity here? Perhaps. Imagine that Paul is so angry that with Sam that he goes to the woods and continues his vitriolic target practice with Sam's effigy attached to a tree stump. As Paul takes aim at the effigy, unbeknownst to him Sam is taking a walk in the woods and crosses Paul's line of fire precisely as Paul pulls the trigger. Sam is killed immediately. This is a homicide, but is it murder? Certainly there is a great likelihood that Paul may be convicted, especially after the jury hears how much he despised Sam, wanted him dead, and often premediated his murder even to the point of practicing it. The truth of the matter is that this is a case of accidental death because there is no causal relationship with the Paul's *de dicto* beliefs and Sam's death. The *de re* direction of fit is absent in Paul's mind. In short, *de re* beliefs are subject to ethical judgement due to their interaction with the real world in ways that *de dicto* beliefs do not. Cutler's (et al.) beliefs moved from *de dicto* to *de re* and as such, their uncritical analysis of their actions made them susceptible to the prevailing evidence against the Study and made them susceptible to moral judgement. Paul can legitimately plead ignorance of his father-in-law's presence when the homicide/death took place. Cutler, however, fully believes that his beliefs were justified and his actions were of no negative consequence. But he is wrong—again. He was wrong with his participation in the Study and he is wrong in the way he frames and delivers his reflections. The evidence is against him. Let me say why.

W. K. Clifford (2008) poignantly claimed in the 19th century,

He had no right to believe on such evidence as was before him. He had acquired his beliefs not by honestly earning it in patient investigation, but by stifling his doubts. And although in the end he may have felt so sure about it that he could not think otherwise, yet inasmuch as he had knowingly and willingly worked himself in that frame of mind, he must be held responsible for it. (pg. 10)

The most compelling function of the ethics of belief is an epistemic one: one is never justified in making assertions in the absence of evidence. Evidence is sacrosanct. And justification for believing is intimately connected to evidence. Certainly “whether or to what degree a person is justified in believing something may vary with time” (Haack, p. 73). The protagonists, when faced with mounting evidence, over a 40 year period of time, chose to believe corrupted beliefs and false truths rather than good evidence. Once again Clifford makes excellent ethical sense, “However convinced you were of the justice of your cause and the truth of your convictions, you ought not to have made a public attack upon any man’s character until you had examined the evidence on both sides with the utmost patience and care” (Clifford, p. 12). There was never an intent to treat these men, as a matter of fact, when a penicillin was discovered as a treatment for syphilis they were never administered this potentially curative antidote. And as an aside, in 1932, the same time the Study began, notorious gangster Al Capone was incarcerated in the Atlanta U.S. Penitentiary with syphilis and gonorrhea. When

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There are some ethical theories, like Christian ethics, for example, “For as he thinks in his heart, so is he” (Proverbs 23:7) and other words spoken by Jesus on his Sermon on the Mount, that take motives and other *de dicto* beliefs to be on the same level of committing the action. But this doesn’t work rationally. It is hard to envision an argument that would put thinking about pedophilia as being equivalent to actual pedophilia. Doing an act requires far more commitment than thinking an act. Either way, Christian ethics would also decry the Study even to a greater extent than other non-cognitivist and cognitivist approaches.
penicillin was found to be curative for syphilis, the ruthless, alleged murderer gangster and convicted income tax evader, was offered the medication though he refused it thinking it was poisonous (Chicago Sunday Tribune, January 26, 1947. p. 1). Then hard working black men in Macon County, some of whom were share-croppers, were given less consideration than an acrimonious gangster. Speaking with respect to his honest feelings about the Study, Pollard quietly said, “It did make me, you know, I might have said some curse words—when I was by myself—but they ought to have been ashamed of themselves. I wouldn’t have done them like that” (46:00). Experimenting on humans without letting them know, and without their consent, is unethical. The men thought they were patients. The protagonists knew they were objectifying these human subjects. If the Study had any integrity they would have told them the truth; they would have asked for their consent. Whether we like it or not, beliefs, if they are to be regarded as ethical, have social constraints. Clifford offers the following refrain, “And no one man’s belief is in any case a private matter which concerns him alone. Our lives are guided by that general conception of the course of things which were created by society for social purposes” (p. 13). Social justice should never be seen as a privilege—it is an ethical responsibility that begins with doing the good.

The Ethics of Ambiguity

Beliefs are said to be ambiguous or false if they are derived from an interpretation of a historical event in which the mind-to-world direction of fit is somehow fuzzy or unclear. Ambiguity takes place in the mind. It is a confusion of beliefs—justifiably or without justification—based upon evidence and the interpretation of evidence derived from a historical event. As a result, the ethics of ambiguity boils down to what a person believes to be ethical truths based upon his or her interpretation (assuming there are no guiding moral absolutes). If there are no moral absolutes or if there is no objective moral truth, any person seems fully justified in his or her beliefs, even if said beliefs lead to moral relativism, moral skepticism, or even more extremely, moral nihilism—and ethical ambiguity has room to thrive. Facing this quirk in the complexity of moral philosophy, Fyodor Dostoyevsky’s (The Brothers Karamazov) way of inveighing against such views is to couch his own beliefs as a religious ethic, “Without God everything is permitted.” This relativistic view, which is also found in the Hebrew Bible, “In those days there was no king in Israel; every man did what was right in his own eyes” (Judges 17:6), was refuted by Plato in the Euthyphro over two millennia ago. On Plato’s account, the rightness or wrongness of an action is not contingent upon a Divine Commander who makes an action right because it is “loved by the Gods.” An action tends to be right or wrong for other (more human) reasons (e.g., reason, consequences, sentiments, virtues or caring relations). Nevertheless, there is something that the relativists and the universalists have in common: they are both necessarily conjoined by the fact that there is no way to construct an argument independent of beliefs. Belief (or having a belief) is a necessary (but not sufficient) condition for having knowledge. If I say I know any particular thing I must also believe it. It makes no sense to say “I know that my mother’s name is Alice, but I don’t believe it.” With respect to moral epistemology (i.e., moral knowledge), the same rule applies. I can’t say, for example, “I know that murder is wrong, but I don’t believe it is wrong.” The challenge question in making such a moral inference, particularly with respect to analytic philosophy, is do I have a supporting argument in defense of my belief and my moral knowledge? So, a justifiable question for John*

* As well as, to what degree am I justified in believing my beliefs? It does make good sense to believe my beliefs—even if they are ambiguous, but I am justified to a lesser degree—because if I don’t believe my beliefs, I would believe nothing at all, unless I find that my beliefs are delusional or fail to correspond to the “experts” or facts about the real world.
Cutler and others of his ilk could be, “How did you understand the nature of your beliefs and the nature of your ethics during and after the Study? And in the face of moral outrage, law suits, personal objections and a demand for social justice, why did you hold fast to your beliefs?”

Something is said to be ambiguous if its’ significance is such that more than one interpretation can be offered. Immediately it is clear that ambiguity has something to do with mind and language—mind in the sense that it is here that interpretations are done, and language in the sense that this is the medium through which interpretations are played out both in the mind and in conveyance to others. These terminologies are governed through both cognitive meanings and emotive meanings. From a logical point of view, and in order to get to the particular ends of which I see in this essay, I am more concerned with the cognitive meaning than the emotive one. Cognitive meanings demand evidence to determine the truth-value of particular statements/propositions, but emotive meanings tend to allow emotions and feelings that are vulnerable to biases in a way that facts aren’t. An act or an event is never ambiguous—they are facts. They occurred. The motivations that brought about a particular event may need unpacking, but the act or the event can be independently verified. Acts or events take place in the presence of certain irreversible contingent properties; therefore, “with regard to the past, no further action is possible” (Simone de Beauvoir, 1948, pg. 77). Interpretations of the actions or events are certainly all we have—interpretations. Interpretations such can be correct or incorrect, wrong or right—They can be ambiguous based upon several human factors. But the action itself, or the event, is a fact. It occurred. It represents a historical reality—it is not ambiguous—our interpretations are.

Thus, since an action or event lacks the property of ambiguity, and are, as such, factual or evidentiary, the true focus of our investigation lies in the nature of interpretation—for it is here that the ethics of ambiguity truly finds itself. The nature of interpretation must begin, in logical form, with the truth value of propositions. Such that a proposition is true, it has sustainability in valid and sound logical arguments. There is no ambiguity here. Susan Haack pointedly articulates what propositions can and can’t be if they are to have unequivocal truth-value as premises in a valid argument: “For it is valid if it couldn’t have, not just doesn’t have, true premises and false conclusions” (Haack, 1978, pg. 23). So the proposition, “The men in the Syphilis study were inhumanely violated,” is true if and only if this proposition can be shown to be true. It is false otherwise—so says the Law of Non-Contradiction. And if this conclusion is true, and if the major and minor premises are constructed with truthful propositions, then the logical dictum—there is no conclusion that is false if all of the premises are true—remains. Every argument such is valid and sound, having true premises (none of which are false) and a true conclusion. This is quite straightforward and an irrefutable philosophical yardstick, especially in analytic philosophy, from Aristotle to today. The strength of any successful refutation would have to show a compromise (or weakness) in any of the propositions (either in the premises or the conclusion) such that either one is less formidable making the premises indeterminable, the argument (potentially) unsound, and is thus ambiguous.

Propositions, then, must be of such disambiguation that they are inaccessible to falsification or pliability. To this end Scott Soames says the following about propositions, “The key constraint shaping the account is that real propositions are not things we, or other cognitive agents, interpret; they are not instruments we or they use to carry information; they are not entities we or they endow with Intentionality. Rather, propositions are inherently representational entities that are capable of being true or false, independent of any actual use to which we or
other agents put them” (2015, pg. 15). The key to Soames benchmark definition is “real propositions”—i.e., as opposed to, say, unreal, artificial, fake, or illusory propositions. The latter has cognitive meaning buttressed by unequivocal evidence, the latter is suspect—suspicious even—a fantasy of sort that seems to render an historical event ambiguous, if it were able—more open to (subjective) interpretation. But again, with respect to the ethics of ambiguity, de Beauvoir says, “With respect to the past, no further action is possible. There have been war, plague, scandal, and treason, and there is no way of our preventing their having taken place; the executioner became and executioner and the victim underwent his fate as a victim without us; all that we can do is to reveal it, to integrate it in the human heritage…” (pg. 77). The only way, it seems to me, to reveal the facts of human history, especially those facts that rise to heinous acts against others, given human tendency toward tribal revisionism, is to disambiguate the propositions of those promoting dehumanization as a matter of course,

I need to be clear: Cutler didn’t commence the Study, neither is he its only defender, he is more of a metaphor for its advocates. As historian Susan Reverby avers, there were some, even blacks, who saw “nothing wrong with what was done” (2000, pg. 4). But the preponderance of evidence suggests a malicious complicity. The researcher/playwright David Feldshuh (Tuskegee’s Truths, 2000, pg. 5) of Miss. Ever’s Boys, the fictionalized account of the Study, usefully argues, “Here’s this reprehensible study that very caring people partook in that made me wonder what guidelines would you follow...If our intention are good, how are we to be certain that we’re not engaged in something that will in the future prove to be morally reprehensible or at least morally questionable.” Ambivalence of this sort, often moves hurriedly to a kind of consequentialism—a utilitarian defense that would concede moral rightness if a reprehensible (or sacrificial) act is such that it produces a greater good, yay, a greater happiness overall. On this account, there is no moral uncertainty; there is no ethical ambiguity. An action is right—not intrinsically, but consequentially—if it tends to promote a better state of affairs overall. Cutler, then, is not at all ambivalent about the Syphilis Study. He quite clearly states, “We were dealing with a very important study that was going to have the long term results of which was to actually improve the quality of care for the black community—so that these individuals were actually contributing to the work towards the improvement of health toward the black community, rather than simply serving as merely guinea pigs for the Study. And, of course, I was bitterly opposed to cutting off the Study for obvious reasons” [italics mine] (Deadly Deception, 42:10).

The amount of rational, learned professionals, mostly employed by the Centers for Disease Control (CDC) or other parts of the USPHS, who were deeply lacking in human empathy, is so astounding that one may ask why choose Cutler as the metaphor for the Study? His words, as I’ve already shown, in the wake of an escalating moral epistemology decrying the Study, seems heartless—“It was important that they were supposedly untreated, and it would be undesirable to go ahead and use large amounts of penicillin to treat the disease, because you’d interfere with the study.” His willingness to make these claims on camera for the Nova documentary Deadly Deception is instructive, and his responses to the views of others in the USPHS is confirming. Sidney Olansky, Chief of the Division of Veneral Disease Research Laboratory, wrote to Cutler, “Dear John...We agree wholeheartedly with your premises for the validity of the study, your arguments for the importance of this follow-up, and your recommendations for the clinical examination” (Tuskegee’s Truths 2000: 99).
Cutler’s argument that it would be “undesirable” to use “large amounts of penicillin to treat the disease” is in itself a violation of the Hippocratic Oath as a physician he vowed to uphold, particularly the stanza, “I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free.” Do no harm is the common phrasing. But in the minds of Cutler et al., were they committing harm? Not according to their interpretation of their actions or the event. On their account, “the validity of the study” (i.e., the argument that the Study should be prioritized over all other interpretations) or the economy of the Study was sacrosanct—it was an investment in something noble, regardless of other interpretations. Olansky (2000, pg. 100) continues in 1951, one year shy of two decades into the Study, “We have an investment of almost 20 years of Division interest, funds and personnel; a responsibility to the survivors both their care and really to prove their willingness to serve, even at the risk of shortening life, as experimental subjects. And finally, a responsibility to add what further we can to the natural history of Syphilis” (pg. 100).

The protagonists of the Study were very clear: the Study was a noble act; there was no ambiguity with respect to their interpretation, even when it meant the direct infliction of pain for no curative end, which is fully in view with Olansky’s words to Cutler, “Careful studies of spinal fluid and neuromuscular system are advised.” The trauma associated with this kind of invasive medical procedure was not only extremely painful, it was also dangerous during its early 20th Century usage, which was only a few decades in use prior to the Study’s conception. As a matter of fact, Charlie Pollard’s testimony clearly and heroically states, even during the associated agony of the spinal tap, “It was pretty bad—that spinal tap—course, I did along pretty well with it, but uh… I stayed in the bed a week or two” (Deadly Deception: 19:20). These men were told that the spinal tap was a “special free treatment.” It is clear that the men saw themselves as patients receiving special care from the United States Public Health Service and the scientist who conducted Syphilis Study at Tuskegee saw the men as “experimental subjects” (and falsely) with a “willingness to serve.” Any willingness they may have had was based upon deception.

The key words in Olansky’s letter to Cutler, which served to affirm and congratulate him, were all given in the best interest, not of the men, but of the Study. Terms like “investment,” “Division interest, funds and personnel,” as well as the paternalistic ambience of their tone, “their willingness to serve,” “at the risk of shortening [their] life,” and “experimental subjects” are omniscient language in which they offered no unadulterated evidence. Their “willingness to serve” begs the question, did they know they were serving some grand humanitarian end? And if they did know, did they know they were “experimental subjects” and that their lives (and their families’ lives) were at risk? The omniscient, omnipresent and omnipotent languages of these doctors bespeak their God-complex in the lives of an extremely vulnerable population of Negro men in Macon County, Alabama. One year after Olansky’s letter, Eleanor N. Walker, writing to Cutler, continues to encourage him to keep the course: “It seems to me that after 20 years we have too much at stake in this study to let it slide now for the sake of a few dollars.” And, as for those “lost” men who were able to slip through the idiomatic cracks, “In the case of those residing in Alabama it should be simple enough to have them located and examined.” Once again it is clear: the administrators of the Syphilis Study wanted nothing to do with its ceasing, even after two decades of watching misery and death. Their empathy for this population of black had either eroded or never existed. And their urgency didn’t recede—it abounded as we see in Walker’s search for options to ensure the Study’s continuance, “Would it be possible to think about tying in more closely with the [Tuskegee] Institute staff in some way. Certainly
something should be done right now to put the study on a firmer foundation if it is determined it should be continued.” Apparently, the firmer foundation was solidified since the Study continued for another two decades.

The Ethics of the Study

With the help of Simone de Bouveur et al., I’ve tried to show how that the Syphilis Study wasn’t at all ambiguous—it was a straightforward historical event. Any potential ambiguity would have to hang on a misinterpretation of the Study—a misinterpretation that I take to be wholly unjustified given the level of deception and harm. If the doctors in the Study desired moral salvation, it would have had to be because they thought they weren’t doing something morally prohibited. In their minds, their interpretation of the Study was the correct one. There was no moral or ethical ambiguity in their imagination. I believe that Cutler’s beliefs were morally groundless and unjustifiable, but what of his/their actions? Cutler says, “The fact was it was a concern for the black community.” The morality of the Study rests on the truth-value of this proposition. I think I’ve shown this proposition to be false. And I’ve also showed how Clifford’s scourge against false beliefs, especially when used as propositions in the construction of an argument, is also embraced by Bertrand Russell (1941), “It is undesirable to believe a proposition when there is no ground whatever for supposing it true.”

The USPHS Syphilis Study at Tuskegee was an experiment with (objectified) human subjects, but for these black men in rural Alabama it was an unconscionable disrespect of their freedom and bodies by none other than their government—the United States of America, the “land of the free.” Their basic human liberty was denied and for four decades empathy was an irrelevance. This “study” was anti-black racism. There can be no gainsaying the fact that the USPHS Study on Untreated Syphilis in the Negro Male at Tuskegee was an intentionally racist study; it wasn’t simply a human rights violation. It was an antiblack racist act. None of the men in the Study were white. It was titled as a study on Negro males. An argument could be made that the Study would not have been done with black slave men, because during slavery commodified black bodies had value. But free black men of the Deep South were disposable (this is clear from the post-slavery lynchings), thus the nomenclature of “anti-black racism” of which I give Lewis Gordon’s reflection a generous quote.

In this explicit foregrounding of the self, Gordon’s focus is on the ontology (not the psychology) of everyday black and white egos, the interactive dynamics between these ontologies, and their relations to the origins and maintenance of antiblack racism. The interactive dynamics between these ontologies have trapped black and white ego formation in classic imperial battles for ontological space. By ontological space, I mean space to be, to posit oneself and realize that self-positing. The imperial nature of this battle derives from the fact that Europeans and Euro-Americans have defined the ontological space of white ego genesis in a way that requires the evading of the humanity of Africans. This evasion is effected through the racial redefining of Africans as blacks, Negroes, or more pejoratively as “niggers.” The result is an imperial ontology that restricts the space of black ego genesis and appropriates its ego-formative resources in the interest of white self-formation. (italics mine, Henry, pg. 149).

Black men in 1932 Alabama lacked the power and the resources to defend themselves against the imperial threat of a United States government sanctioned, white supremacist
ideology. They had nothing with which they could resist the invasion of whiteness—they knew that many of their family members were sick with “bad blood” so they trusted their bodies (and their ontology) to those whose interest was self-centered. The men deserved an ethic of empathy and care. Instead they were the recipient of an ethical egoism—the USPHS did what was right in their own rational self-interest, regardless of the collateral damage in the form of devalued black bodies (and later, Guatemalan brown bodies).

The underlying conceptual scheme facilitating the Study was a white supremacist, anti-black racism that envisioned black lives and black bodies as non-free property, void of any significance or import that whites were duty bound to respect. Truly antiblack racism envisaged black bodies as non-free regardless of time or space. Consider for a moment the case of Dred Scott, the black slave who accompanied his master, Army officer Dr. John Emerson, to various northern Free states, where it was decided in 1852 by Chief Justice Roger Taney that

...a negro, whose ancestors were imported into the [United States of America], and sold as slaves...had for more than a century before been regarded as beings of an inferior order, and altogether unfit to associate with the white race, either in social or political relations; and so far inferior, that they had no rights which the white man was bound to respect; and that the negro might justly and lawfully be reduced to slavery for his benefit. He was bought and sold, and treated as an ordinary article of merchandise and traffic, whenever a profit could be made by it. This opinion was at that time fixed and universal in the civilized portion of the white race. It was regarded as an axiom in morals as well as in politics, which no one thought of disputing, or supposed to be open to dispute; and men in every grade and position in society daily and habitually acted upon it in their private pursuits, as well as in matters of public concern, without doubting for a moment the correctness of this opinion. (Scott v. Sanford, 60 U.S. (19 How.) 393 (1857))

The Dred Scott decision, among other things, set the stage for the white supremacist arrogance that would eventually enable hideous actions like the Syphilis Study. Chief Justice Taney’s conceptual scheme was not based upon a parochial decision—it was the overarching decision with only two members of the Court dissenting. The Civil War may have put an end to physical (body) enslavement, but the white supremacist conceptual scheme promoting black inferiority through a pervasive anti-black racism was institutionalized in many white minds through their beliefs, creating the kind of patriarchal white supremacist culture that would make the Syphilis Study a possibility among enlightened, rational people who lived in the United States. The correlation of Scott and the men of the Study accentuates the absence of two values in the overarching conceptual scheme: freedom and empathy.

**Conclusion**

In conclusion, Simone de Beauvoir, writing on what it means to be free, says, “But if man is free to define for himself the conditions of a life which is valid in his own eyes, can he not choose whatever he likes and act however he likes?” (1948, pg. 15). I am not binding myself to the French existentialism Beauvoir is defending here, but as a definition of freedom, I find much purchase. In other words, 1932 Macon County, Alabama had an unusually high rate of syphilis, roughly one-third of the men tested had the sexually transmitted disease. This “fact” caught the attention of the USPHS, whereupon they commenced a study—and experiment—of what
would happen if these black men were untreated. To our present knowledge, the USPHS didn’t give the men the syphilis virus, neither through injection nor any other form (though we can’t discount this possibility that they may have, given the nefarious action was done a few years later in Guatemala by some of the same scientists, including Dr. Cutler), but what they did was of such deceitfulness that it interrupted history. The force of history is such that, in the words of theologian David Tracy, “[i]t is not only contingent; history is interruptive” (1985, pg. 66). The historical interruption seems clear enough:

The men thought that they were patients of a joint federal and local medical and nursing program at the Tuskegee Institute and the Macon County health department for their “bad blood,” a local idiom that encompassed syphilis as well as anemias. They did not consider themselves subjects since they did not know the study existed. The PHS followed the men for forty years (from 1932 to 1972), actively keeping them from many forms of treatment (including penicillin when it became available in the 1940s), never giving them a clear diagnosis, but providing them with the watchful eyes of a nurse as well as exams (including a diagnostic spinal tap), placebos, tonics, aspirins and free lunches. Burial insurance became an additional inducement for their participation. In exchange, the men or their families agreed to allow for autopsies without knowing that the researchers needed to confirm the ravages of syphilis on the men’s organs and tissues. (Reverby 2000, pg. 2).

Among the many evidences of what seems rather sadistic, or apathetic, is the organizational structure derived from the conceptual scheme. There is no happenstance in this socio-scientific-medical construction. Rather, we see the properties of what injustice demands: an abuse of power by those who were in structurally powerful positions to halt the freedom of the powerless. The ethical violations, the human rights violations and the racism that hovered over this successful effort to constrain the vulnerable is clarified further by Tracy’s critique, “To be an American is to live with pride by participating in a noble experiment of freedom and plurality. But to be a white American is also to belong to a history that encompasses the near destruction of one people (the North American Indian, the true native Americans) and the enslavement of another people (the blacks) (1987, pg. 68). In contrast to Dred Scott, a slave, the syphilitic (as well as the controlled group) men of Macon County were not slaves, but they were deceived just the same. They thought the actions of the doctors were noble. Herman Shaw, one of the men in the Study, said, “The way I heard about it was through a rumor that the people, and this came out of Macon County, said that you can get free medicine for yourself, and things of that kind. And therefore, I went. On that Saturday afternoon when we went over there, they said we would get free medicine, that wouldn’t cost us anything and the doctor... We will get free doctoring” (Deadly Deception) They went to become patients of medical doctors. They were made interruptions of history as objectified experimental subjects. There is no way that a deception of this kind can be morally prudential.
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Deadly Deception: https://www.youtube.com/watch?v=qNa8CnC4sSU

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Tuskegee University and Macon County Bridge Builders Program

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To be free is to be black – that is, identified with the victims of humiliation in human society and a participant in the liberation of oppressed humanity. The free person in America is one who does not tolerate whiteness but fights against it, knowing that it is the source of human misery. But refusing to behave according to its expectations.

–James Cone, In Black Theology 2010, p. 108

The preceding quotation by James Cone, scholar and Black Liberation Theologian, describes the challenges of identity and agency facing Black people in the United States. For the purpose of this commentary, identity refers to “the sense of who or what one is.” In the context of sociological and philosophical thought, human agency “is the capacity of a person or entity to act in a given environment.” The Tuskegee University & Macon County Bridge Builders Program is a University based program designed to improve the well-being of young people in a small rural city, in a small rural county in Alabama. The Program focuses on engaging high school students in ethical conversations about sacred and secular strategies to address the life circumstances that a select group of African American students face as they navigate through their high school years. The Program is based at Tuskegee University, which is located in the city of Tuskegee, in Macon County, Alabama. The county is 85% African American, which is a disproportionately low income, and many of the adults have limited formal education. Young people have little to do in rural towns and cities like Tuskegee; therefore, they are vulnerable to many of the challenges that plague young people around the country. The National Center for Bioethics in Research and Health Care at Tuskegee University (National Bioethics Center) continues its vision of assuring social justice by working with high school students who live in Macon County. In 2015, the National Bioethics Center was funded by the High School Youth Theology Institutes, Lilly Endowment Inc., to implement a three-year community engagement program entitled, Tuskegee University & Macon County Bridge Builders Program. The Program focuses on theological exploration and religious leadership.

The historic legacy of Tuskegee University (aka. Tuskegee Institute) is grounded in the extraordinary work of its founding president, Booker T. Washington, the scientific genius of Dr. George Washington Carver, and the Tuskegee Airmen. Unfortunately, however, the city of Tuskegee and Macon County were also the site of the U.S. Public Health Service Syphilis Study at Tuskegee (aka the Tuskegee Syphilis Study). While the Syphilis Study actually began in Macon County, the scientific and resource leadership for the Syphilis Study was the Public Health Service, U.S. Department of Health and Human Services. From 1932-1972, 623 Black men were intentionally not treated for syphilis, even after penicillin was discovered in the late
1940s. The Syphilis Study was exposed and ended in 1972. Subsequently, Fred Gray, Sr, an African American attorney from Tuskegee, sued the federal government on behalf of the men in the Syphilis Study. A legal settlement was reached between the men and the federal government, which provided some financial compensation and medical insurance for the men and their direct family members. In 1997 President William Jefferson Clinton, at a White House Ceremony, apologized to the men, their families, other African Americans and the Nation for the unethical study conducted by the federal government.

Much has occurred in Macon County since those days, but the county remains predominately African American; many of the residents are still low income, undereducated, and unemployed. The city is a food desert with very limited access to health care. Young people in Macon County have little to do beyond finding ways to leave the city and the county as soon as they are legally able to do so. The historic accomplishments of Tuskegee University, and the longstanding challenges faced by the residents of Macon County, undergird the rationale for developing the Tuskegee University & Macon County Bridge Builders Program (MCBB). The focus of this program, and its design, is to empower Macon County high school students to improve themselves and their community.

The faculty and staff at the National Bioethics Center were challenged to design a transformational program to restore the historic legacy of Tuskegee University, while at the same time, the Program addressed some of the current challenges that threaten the well-being of the young people living in Macon County. The Tuskegee University & Macon County Bridge Builders Program is specifically implementing a program to enhance theological vocation and religious leadership among selected high school students in Macon County. The Program interfaces with Tuskegee University, Macon County residents, the Macon County Public School System, and selected historic Black colleges and universities throughout the country, especially targeting colleges and universities with seminary affiliation. The Program focuses on matriculating through high school, decision making when faced with life challenges, enrolling in a college or university immediately after graduation and developing additional life skills to address the challenges faced during and after high school.

The Program started with a collaborative summer program with community agencies, designed as a pre-test pilot project to assess the perspectives of 17 youth from Macon County. A three-day discussion session on the “Ten Most Challenging Issues facing Youth in Macon County” was conducted with a youth group on the campus of Tuskegee University. The data collected from several focus group sessions highlighted the needs, as expressed by the youth. Interventions were recommended by the group in 10 specific areas of their lives. The most significant challenges centered around three areas:

- Identity
- Decision Making Process
- Agency

Based on the data collected from the expressed concerns for the youth in Macon County, Tuskegee University students, faculty and staff, residents of the City of Tuskegee and Macon County, and the National Bioethics Center, a competitive proposal was submitted to Lilly Endowment, Inc. The Lilly Endowment’s High School Youth Theology Institute
Commentary

(HSYTI). The HSYTI seeks to encourage young people to explore theological traditions, ask questions about the moral dimensions of contemporary issues and examine how their faith calls them to lives of service. In 2016, the National Bioethics Center was funded and implemented the Program. The Program Team includes a Program Director, External and Internal Project Directors, and an Administrative Assistant.

Program Aims and Purposes

The aims of the Tuskegee University & Macon County Bridge Builders Program (MCBB) are:

1) To assess the perception of high school students about the relevance of religion, spirituality and theology in their lives and their future;

2) To engage 50 Macon County high school students in guided sacred and secular, synergistic and seamless activities;

3) To facilitate the matriculation of high school students through high school, college and selected seminaries;

4) To design social support systems to assure and reinforce theological and praxis experiences during high school and continuing through college and seminary;

5) To document the “lessons learned” related to the barriers and opportunities associated with spiritual formation and future engagement in theological leadership for African American youth living in Macon County and similar rural counties throughout the Alabama Black Belt.

Structural and accountability measures were developed for the MCBB Program which include several documents: Mission Statement, Code of Ethics, Behavior Contract Exclusion Contract, session schedule and evaluation tools, and pre and post tests for each session. These documents provide the guidelines for the MCBB faculty, staff and students. The Program Team developed the eligibility criteria for the Program, assessed logistical needs, developed a strategic plan for the Program and operational plans for each session which includes discussions on best practices and evaluation strategies. The Program Team agreed to approach each session from the perspectives of the sacred and the secular, so the youth would have at least two ways of assessing the topics discussed. Outside speakers are invited in to address specific subject matters. Sessions are held each month on a Saturday, then on the Sunday of the same weekend the youth, together with their parents, visit a local faith institution (different church denominations church, mosque, etc.). The Pastor/Faith Leader is asked to preach/teach on the topic discussed the previous Saturday. And in order to solicit input from the community, the External Project Coordinator informs community stakeholders through weekly emails on the proposed topics. Numerous presentations were done by the Project Director to promote the Program at the two high schools in Macon County, the Macon County Board of Education, City & County Governments, local housing authorities and businesses. Announcements were made through local newspapers and radio stations, and through the Tuskegee University and the National Bioethics Center websites.
Recruitment efforts began in May 2016, targeting July 2016 as the Program’s startup month. The Program began with 50 high school students, but based on each student’s lack of commitment to abide by the requirements of The Program, some of the students either left The Program or were dismissed. Nonetheless, The Program has a consistent enrollment of 46 students. The admission goal was to match the youth participant/parent/guardian with the Program aims and goals. The Program is not an “enforcement” or a judgmental agency; rather, it is a program that offers students an opportunity to express, discuss, and consider alternative ways of thinking and/or decision-making. The expectation is for each Bridge Builder student to become a critical thinker.

The student admittance process included an application, a short narrative on why the applicant wanted to join the Program, a record of their grades and a letter of recommendation. Before a student was admitted, they had to commit to the following ethical framework:

“I commit my energy and efforts to...

1. Making decisions that allow me to be my best self.
2. Behaving at all times to assure my family and community are proud, not allowing myself to behave in a way that is viewed negatively or as an embarrassment.
3. Behaving in a manner which reflects positively on the Bridge Builders Program.
4. Honesty and integrity characterizing my behavior at all times.
5. Always use social media thoughtfully and in ways to reflect positively on the Bridge Builders Program and my character.
6. Ensure that my character is my greatest asset.
7. Respecting the person and personality of all human beings regardless of race/ethnicity, sex/gender, sexuality and economic status.
8. Choose non-violence over violence, including “bullying.”
9. Honor and respect parents/guardians and other persons in authority.
10. Learn and abide by the principles of Optimal Health.

By committing to this ethical framework, I will continually strive towards personhood through mature reflection and steady motivation; I will be able to carve out a reasonably ample livelihood for myself, ‘family,’ and a potentially wide group of kin-de-pendants while also making substantial contributions to the well-being of the larger community.”

A reflection on the first year of Program operations was conducted in July 2016 in preparation for the second year’s beginning. This review included those students who fully participated. There were discussions about the two college/university and seminary tours. The first was a visit to the Atlanta University Center schools: Clark-Atlanta University, Morehouse College, Spelman College, Morehouse School of Medicine and the Interdenominational
Theological Center. Thirty-five Bridge Builder students participated. The second tour was to Nashville, Tennessee to visit Fisk University, Tennessee State University, Meharry Medical College and the American Baptist College. An intensive summer session was held on the campus of Tuskegee University in the Bioethics Living and Learning Center, which provided an opportunity for the students to experience college life, along with an opportunity to visit another set of HBCUs including, Alabama State University, Selma University, Alabama A&M University, Oakwood University, Miles College, Stillman College and Tuskegee University.

All Bridge Builders participants were exposed to various speakers with different leadership styles, participated in several group discussions and were requested to select the HBCU of their choice. They then completed a research assignment about their selected HBCU.

The mission of “walking with them” through their high school years is to assure their performance is exemplary. The HBCU tours were to enhance their exposure, interest and possible admission to an HBCU or to another university of their choice. Increasing enrollment at an HBCU was discussed at length because it is a goal of the National Bioethics Center. There are nine Bridge Builders seniors who are graduating from high school in May 2018. Seven of the nine have been admitted to multiple colleges/universities. The two who were not accepted did not fully participate in the Program. Twenty five Bridge Builders students will be seniors and are expected to graduate in May 2019.

Additional Program Activities

- visit to the Tuskegee History Museum,
- participation in the MLK Celebration and Service Day-on in January 2018,
- participation in the Youth Conference for Men at a local church,
- participation in dual enrollment classes at Alabama State & Tuskegee University by Bridge Builders students,
- Participated in several service projects in the Macon County Community, such as the building of a playground and the maintenance of a park.

The involvement of the community partners enhanced exposure and an increase in applicants’ interest and involvement. The Program initially reviewed from 60 to 65 applicants before identifying 50 participants in the core group of participants. During the second year, we evaluated the core participants and were able to add an additional 10 new participants, keeping our core group at 50.

Reflections

From the pilot to the present MCBB Program, the Bridge Builder’s students expressed extraordinary insight. The students have firm beliefs and they are willing to share them if safe and non-judgmental venues are provided. The Bridge Builders reflect their culture, their community and their home life, which is not surprising. Yet, unless the context of culture, community and home life are understood, their behaviors may be misunderstood or misinterpreted and they may become more vulnerable to anti-social behaviors. The high school students are often accused of being disrespectful, but that was seldom the case with Bridge Builders. They are accused of being
nonchalant and/or uncaring, but the Bridge Builders exhibited very different behaviors. The willingness of the Program Team to listen to students and to interpret what they say from a sacred and secular perspective requires empathic listening, which develops trustworthy relationships between Bridge Builder’s students, program faculty and staff.

The Bridge Builders are responding to new opportunities, new suggestions of handling conflict or disagreements, knowledge of subjects they assumed were bad or not correct (i.e., religious beliefs, authority, gender selection, etc.). Equally important, the Bridge Builders provide opportunities for reflections and for the Program Team to reevaluate our thinking. The tours allowed the Program faculty and staff to develop trustworthy relationships with the students outside of the school setting. The Program made possible for Bridge Builders to imagine going to college and/or university and to experience life beyond Macon County. The Program also exposed the students to how they can assist Macon County return to its historical greatness.

The ultimate reflection on how this goal can be accomplished through a theological education similar to that offered by the MCBB Program is beyond explanation. The personal reflections of the Program Team and all associated with the MCBB Program are reflected in expressions of excitement, surprise and appreciation. Once we started the MCBB Program, and even as we work to continue discussing the concepts and precepts of the sacred and secular, few of us fully appreciate the long term impact of the MCBB Program. There have been requests from community residents for us to offer something with youth at even earlier ages. This request resulted in our commencing the Jr. Bridge Builder Program in the one middle school in Macon County for students in the 7th & 8th grades, funded by the Morehouse School of Medicine in Atlanta, Georgia.

**Next Steps**

Our plan is continuing on the work by providing monthly sessions for the participants throughout the academic year and summer. These sessions began in January of 2017 and will continue through December of 2018. In March 2018, 30 Bridge Builders toured Washington D.C. and visited Howard University, the University of the District of Columbia along with other historical sites in the D.C. area. The Program is working continuously on the sustainability plan after the funding period ends in December 2018. We see a need to continue our “walking with them” mission during their initial year of college and their professional careers. The Program continues to look for grant opportunities to enhance and sustain the MCBB Program. Our plan is to expand our operations through the use of our 24/7 operations with our social media tools and expanding our email contacts with other HSYTI programs with whom affiliate over the year.

The colleges and universities where the students were accepted include those visited by the MCBB Program. Because many of the students are the first generation in their family to attend college or university, the MCBB Project Director has offered parents an opportunity to visit the college/university where their child will attend to assist then with transitioning from home and college life to college and university life. This process will allow the “bridge building” to continue. The MCBB Program continues to theological education by engaging the sacred and the secular because we believe they are one and the same. We are also very thankful to Lilly Endowment High School Youth Theological Institute for its support and encouragement.
I. General Information

The Journal of Healthcare, Science and the Humanities (JHSH) publishes a wide variety of articles intended to enrich and advance the knowledge of health and health care, science and the humanities, as well as the art and science of health care delivery and the health professions.

Program or project summaries/exemplars, formal case studies, or case scenarios are acceptable, but must be carefully constructed to avoid any subtle commercialization or politicization. Authors are free to submit academic manuscripts that present differing or alternative views to current issues and debates. The Editor will make final decisions regarding these issues after consultation with the members of the Journal Executive Leadership, including Intellectual Property Counsel if so required.

JHSH will not consider manuscripts that are being submitted or considered elsewhere simultaneously. If an author wishes to have a work rescinded from JHSH consideration for submission to another publication, the author must request in writing and be granted an official written notification regarding the same from the Editor or Senior Associate Editor.

Unless there is clear justification, and only with the written permission of the previous publisher, JHSH will not accept manuscripts published elsewhere, or that will be published prior to appearing in JHSH. Authors must inform the Editor of such matters at the time their manuscript is submitted; review by Intellectual Property Counsel may be required. Such matters must be acknowledged in the Author Note.

II. Representative Manuscript Categories

JHSH encourages authors to choose from a wide range of subject matter categories. Authors may explore various categories and possibilities with the Senior Associate Editor, who will subsequently discuss with the Editor. The Editor has responsibility for final decisions in this area. The following are representative categories.

a. Research papers, theoretical investigations.

b. Scholarly critiques and commentaries on various topics.

c. Formal case studies and program/project reports.

d. Reaction papers and editorials.

e. Book, film, media, law, education or other reviews.

f. Other academic or professional articles related to the JHSH interdisciplinary mission.

g. Creative work, including poetry and short fiction relevant to the JHSH mission.
Author Requirements

III. Submission Review Processes

Submissions undergo a four-stage process of rigorous review, discernment, evaluation, and approval. The Editor may adapt these processes to meet specific circumstances.

Stage 1:

Authors submit full manuscripts or manuscript concept proposals to both the Editor and Senior Associate Editor. The Editor, Senior Associate Editor, and Associate Editors will conduct a preliminary assessment for relevance to the JHSH mission. The Senior Associate Editor will provide guidance to the corresponding author about shaping the manuscript for JHSH readers. All manuscripts, including all figures and graphics, must be formatted correctly and comply with JHSH Author Requirements before manuscripts will be allowed by the Editor to progress to Stage 2. Compliance with this requirement is mandatory. Exceptions will not be granted.

Stage 2:

After the Senior Associate Editor determines that all Stage 1 requirements are met and that all manuscript and graphics/figures formatting is in compliance, the Senior Associate Editor forwards the manuscript to the Chairs of the Academic Review Committee (ARC) for rigorous peer review. Also, at the time of Stage 2 submission, all authors must submit their completed Author Agreements and Copyright Release Forms. No article can be published unless this requirement is met by all authors. All journal peer reviewers have executed non-disclosure agreements and conflict of interest declarations to protect an author’s rights and academic property. Peer review routinely results in manuscript revision. The first author and the ARC Chairs work together to address matters stemming from peer review and to ensure that the manuscript is revised accordingly.

Stage 3:

After successful peer review and revision, the ARC Chairs send the revised manuscript to the Chairs of the Manuscript Editorial Committee (MEC) for rigorous editorial and formatting review, revision, and critique of actual content and language. This also includes careful review of all figures, graphics, and other related elements for compliance with requirements. The MEC also reviews, critiques and recommends minor formatting needs. The author and the MEC Chairs process and finalize the manuscript. When this process is completed, the MEC Chairs send the final manuscript back to the Senior Associate Editor as certified ready for final review.

Stage 4:

Upon receipt from the MEC Chairs, the Senior Associate Editor sends the final edition of the manuscript to the Journal Associate Editors for a final qualitative review. Any additional changes required are completed between the author and the Senior Associate Editor. Upon successful final qualitative review by the Associate Editors, the Senior Associate Editor sends the final edition to the Editor for final review and approval. If all items are in order, the Editor formally approves and accepts the manuscript for a future edition of JHSH. The Editor notifies the author of final acceptance.

Note: The Editor may make further determinations regarding requirements or revisions to manuscripts. In the event of circumstances, the Editor may disapprove a final edition.
IV. Style Requirements


APA Style Web Resources: The URL links below provide additional information and assistance for APA style requirements.

http://owl.english.purdue.edu/owl/resource/560/01/
http://www.apastyle.org/elecref.html
http://www.psychwww.com/resource/apacrib.htm

Formatting Specifics:

In addition to meeting APA style requirements, articles must be organized according to the format below. All papers must be divided into appropriate, titled sections and subsections based on subject matter.

a. Introductory Material. Each manuscript must begin with the title, name of author(s) with current title(s) and institutional affiliation(s). With the exception of creative essays pre-approved by the Editor, manuscript titles shall be consistent with the scholarly and professional nature of the Journal. Informality, a casual tone and colloquialisms must be avoided. When using degrees after an author’s name, periods are omitted. (e.g., PhD, not Ph.D). Contact information for the corresponding author is to be included, either in the introductory material or as part of the Author Note. Authors are to provide complete, precise information for themselves and each co-author, to include street address, phone, fax and e-mail address (see example below):

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b. Author Note. Immediately following the title and author information, each manuscript must include a brief, un-indented paragraph containing important preliminary and/or disclaimer information. This paragraph, called an Author Note, will state the source of the subject material (e.g., preliminary presentation or doctoral dissertation). If the work was supported by a grant, contract, or similar instrument, proper credit must be given. In the Author Note it is required to place the information about IRB and IACUC review and approval with relevant protocol identification numbers and dates of approval or determination. The Author Note should include any required institutional disclaimers. The author/authors must declare any and all financial conflicts of interest (or lack thereof) in the Author Note. The Author Note shall include information regarding contributors.
Author Requirements

See Section VII below concerning requirements for designating authorship as opposed to contributors. Acknowledgments are placed in the Author Note.

c. **Abstract**. Immediately following the Author’s Note and without any page break, all articles will have an abstract of approximately 200 words. The abstract is a single, unindented paragraph of plain text without bullets or subsections. The abstract must use key information from the text to provide a clear, concise and unbiased summary. Review Articles or Creative Writing submissions do not have an abstract.

d. **Keywords**. Immediately following the abstract and without any page break, list at least three key words to facilitate electronic searches of the manuscript. The choice of key words will depend on the subject matter. Review Articles or Creative Writing submissions do not include key words.

e. **Introduction**. Immediately following the Keywords and without any page break, the text must begin with a section entitled “Introduction.” In the Introduction the author should preview what is about to be presented, and may chronicle the past history of the subject under discussion with appropriate use of references from the literature. Both the content and length of the introduction will vary according to subject matter. Review Articles and Creative Writing must include an introduction explaining the intent and providing important background to what follows.

f. **Middle Sections**. Based upon subject matter and methodology, the middle portion of the manuscript is to be divided into appropriate sections and subsections, each of which must be appropriately titled. See Section V for the formatting of section and subsection headings.

g. **Conclusion**. This section provides a concise summary of the materials previously presented, and points toward future or practical implications and/or implementation. Review Articles and Creative Writing should include a conclusion that points out the benefit of what has been presented to the reader and to the JHSH mission.

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Author Requirements

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Bullets are not permitted within the text. Numbered or lettered lists are acceptable.

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All manuscripts are to be submitted to the Editor and the Senior Associate Editor as an e-mail attachment. All manuscripts must be submitted in MS Word format for MacOS and/or Windows (.doc or .docx format). Do not send manuscripts using the pdf or webarchive format. Such will be returned. See Section VI regarding graphics. Authors may wish to review examples of previously published articles as guides. These can be made available upon request.

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Each manuscript must be subdivided into relevant sections as discussed above. Sections may be further subdivided to enhance the discussion or for other editorial reasons. Major sections should use Level 1 headings. Subsections should use headings for Levels 2 through 4. Directions for formatting Headings follow:

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Book (author):
Hewlett, L.S. (1967). Title of work. Location: Publisher.

Book (editor):

Chapter in an Edited Book:

Journal Article (print):

Journal Article, more than seven authors

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VI. Special Manuscript Preparations

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XI. Contact Information

Manuscripts and/or concept proposals for articles are to be sent directly to dhodge@tuskegee.edu.

If needed, call the Tuskegee University National Center for Bioethics in Research and Health Care at (334) 724-4554.
The 2019 Public Health Ethics Intensive at Tuskegee University will be held April 8th through 13th.