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Is there an American Market in Transplant Organs: Allegations of Commodities, Proprietary Interests, and the Mob?

by Gregory W. Rutecki, MD

What do the international task forces that met in Bellagio (1997) and Rotterdam (2007) and the World Health Organization have in common? In the specific context of organ transplantation they all agree that an illegal and unregulated international organ market has become a serious problem. In fact, *The Bulletin of the World Health Organization* recently stated "The growth and regularization of the international organ trade should be regarded as a global public health issue" (p. 959).[3] Apparently, these organ markets succeed by preying on the vulnerable to serve the wealthy or better off.

Although the sale of organs in the U.S.A. is explicitly proscribed, with punishments including 5 years in prison and up to $50,000 in fines, Americans are not immune to their own variations on a nefarious theme. One American citizen received a liver graft in Shanghai, China after incurring a substantial, out-of-pocket cost there.[1] The donor was an executed prisoner and the American a "transplant tourist." Capital crimes in China may be as trivial as credit card fraud or stealing farm animals. The American, however, was not troubled upon learning of the fatal ramifications that his new liver had for the donor and his or her family. The American paid the suggested price and returned to his life in the U.S. As of now, there is no law in the U.S. to cover activities like this. This is just another example of "gaming" the system through a questionable international practice.

In a separate incident in November 2001, a plaque was placed at the entryway of U.C.L.A. Westwood Hospital's transplant section. It read, "In grateful recognition of the Goto Research Fund established through the generosity of Mr. Tadamasa Goto."[2] The donation was for $100,000. Additionally, it is presumed that Mr. Goto paid cash for a liver transplant he received at Westwood, estimated to be in the range of $500,000. This individual was recognized as having amassed his considerable fortune as a Japanese crime boss. Furthermore, at the time of his transplant he happened to be in the U.S. under FBI supervision, previously prohibited from entering this country. Later, in 2002, another $100,000 "donation" was received by the same center from another associate of the same Japanese crime family.[2] The transplant surgeon for these procedures has responded that the selection process utilized in these two instances was both legal and just. Meanwhile, concern persisted and, ultimately, led to allegations appearing in the *Los Angeles Times*. Has the integrity and credibility of transplantation been stretched to a breaking point? Although the center in question and its staff are innocent until proven guilty, a serious investigation should occur and should be conducted in a completely transparent manner.

What are the critical ethical issues involved here? There are at least four. First, were the two foreign individuals objectively chosen, especially when compared to others on the waiting list? Liver transplantation utilizes the "MELD" score which is an empirically proven formula that ensures the sickest get the first available organ, not the "first come" or otherwise positioned (e.g., financially). Is there proof that this objective standard was honored?

Next, what about the fact that both recipients were non-resident aliens and the majority population on the waiting list was comprised of American citizens? U.N.O.S (United Network for Organ Sharing) policy states "no consideration in organ allocation is given to gender, race, citizenship, or social factors such as wealth." As a result, 5% of organs available in the US are allocated to non-resident aliens. Whether or not the program in question exceeded this "cap" should be ascertained.

Thirdly, the specific criterion "or social factors such as wealth" from the UNOS policy must be dissected during the requisite investigation. The two recipients not only paid for the costs of transplantation, but in addition, made a sizeable donation assumedly procured from questionable sources. If similar potential recipients were "jumped over" based on financial considerations, there is a big problem.

Finally, given that donors and their families are gracious citizens, the court of public opinion should be considered. Any media suspicion of wrongdoing must be addressed to the public's satisfaction. Lack of trust in the system by donors could have adverse effects on the availability of organs. Responses to the article in the *Los Angeles Times* already suggest irreparable damage to a public trust—but only if the allegations are substantiated.

Transparency is essential when allegations of this nature arise, particularly in the context of organ transplants. A "blind eye" cast towards the specifics of the situations at this particular center may add to the already fifteen-plus people who die each day without a donated organ.

1.) Hua, V. "Patients Seeking Transplants Turn to China." *San Francisco Chronicle* April 17, 2006. http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2006/04/17/MNGHAIA5B51.DTL&hw=patients+seeking+transplants&sn=002&sc=848, accessed June 2, 2008.

2.) Ornstein, C., Glionna, J. M. "After Livers, Cash to UCLA." *Los Angeles Times* May 31, 2008. http://www.latimes.com/news/local/la-me-ucla31-2008may31,0,1503718.story, accessed June 2, 2008.

3.) Shimazono, Y. "The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information." *Bulletin of the World Health Organization* 85, no. 12 (December 2007): 955-962.

Director's Desk October 2008

by Michael J. Sleasman, PhD
Managing Director & Research Scholar

A long awaited greeting from The Center for Bioethics & Human Dignity. For those of you who have been involved with the Center for some time you are aware that this is a long delayed issue of *Dignitas*. The spring and summer were an exceptionally busy time around the Center with the completion of our first full-scale offsite conference, *Extending Life: Setting the Agenda for the Ethics of Aging, Death and Immortality,* held in March 2008, Phoenix, Arizona, as well as our 15th Annual Summer Conference, *Healthcare and the Common Good*. In lieu of our Spring and Summer editions, we offer you a combined issue with expanded content. Some of the pieces in this issue include highlights of both 2008 conference events, two essays by featured CBHD fellow, Gregory Rutecki, MD, updates on activities from CBHD staff members and fellows, as well as a focus on several key resources. We will resume our normal quarterly editions of *Dignitas* with the next issue (to arrive in early December), also in an expanded format, and finally unveil a new *Dignitas* design in the subsequent issue along with a highly anticipated logo redesign.

In addition to conferencing, the spring and summer brought a variety of other Center activities as well. We saw the release of J. Daryl Charles, *Retrieving Natural Law*, another volume in CBHD's *Critical Issues in Bioethics Series* with Eerdmans. The Center worked with several seminary students through internship and field education opportunities to produce early drafts of various bioethics and cultural engagement materials for the church. Through the generosity of a large gift, the Center initiated a multimedia conversion project that will create a digital archive of all the Center audio and video holdings, as well as the initiation of a complete redesign of www.cbhd.org to make the website more flexible, interactive, and user friendly. These projects should come to completion this winter.

These months also marked a point of sadness for the Center. In December 2007, our director, Dr. C. Ben Mitchell, announced that he would step down in July 2008 to refocus his energy teaching and writing. In his two years with the Center, Ben provided key leadership in a difficult time, serving as the architect of the merger of CBHD with Trinity International University. With the news of Ben's departure, the Center entered into the search process for a new executive director to provide strategic leadership and vision to the work of the Center for many years to come. Through the generosity of a large gift, the executive director's post of the Center has been expanded from a part time to a full time leadership position. Please keep us in your thoughts and prayers as the search process continues and we seek to fill this important position. We are confident that the Center is poised to continue engaging society in the area of bioethics in profound ways, and believe that with the right leadership we can expand the impact of the Center even more.

The past few months also have been busy in the world of bioethics. The march of scientific advances, as well as medical and technological innovation, continues to move forward at breakneck speed raising profound questions for what it means to be human and challenges to the fundamental notion of human dignity. Promising advances in alternatives to embryonic stem cells—from the developments with stem cells extracted from teeth, menstrual blood, and cord blood to the exciting research surrounding induced pluripotent stem cells derived from skin cells and the possibilities of direct reprogramming offer innovative approaches—to bypass some of the traditional ethical concerns surrounding embryo-destructive research. While some of these advances may themselves raise ethical concerns, they point to the importance of cutting edge bioethical news and commentary to foster awareness and critical reflection on the scientific and technological marvels of our day. Recent months have seen the developing storm surrounding right of conscience for physicians and pharmacists. Assaults on human dignity continue to abound with a news story reported in August of terminal patients in Oregon being offered "doctor-assisted suicide instead of medical care."[1] Internationally, animal-human hybrid protocols have been approved in the UK and a license granted for the cloning of human embryos in Australia.

These emerging issues are only the tip of the iceberg. We invite you to join us in our work to engage these pressing bioethical challenges. Throughout the pages of this issue we offer a variety of ways to get involved with the Center and to utilize our resources, and we hope that you will take full advantage of them.

1). Springer, Dan. "Oregon Offers Terminal Patients Doctor-Assisted Suicide Instead of Medical Care" *Fox News July 28, 2008*. http://www.foxnews.com/story//0,2933,392962,00.html, accessed on October 6, 2008.

Have Pharmaceutical Marketing, Patients, and Medical Practice Developed too Cozy of an Alliance?

by Gregory W. Rutecki, MD.

No doubt many have seen frequent television advertising touting the benefits of ezetimibe--a drug that inhibits the intestinal absorption of cholesterol. Its use confers an approximate 20% lowering of LDL cholesterol with an acceptable side effect profile.[1] Although ezetimibe does lower LDL cholesterol, when it was marketed and initially prescribed (alone or in combination with a "statin") there were no clinical studies addressing its efficacy in regard to "hard" endpoints related to atherosclerosis (protection against ischemic events, risk of death, or progression of disease). In 2007, $200 million were spent on direct to consumer marketing of ezetimibe and total sales of the drug hit $5 billion.[2] In early 2008, however, a prospective study was published demonstrating that the addition of ezetimibe to the "gold standard," a statin, did not slow the progression of atherosclerosis despite a predicted reduction in LDL cholesterol.[3] It was clear before that statins have pleiotropic effects, that is, they do other things than lower cholesterol (e.g., decrease inflammation) that add to their therapeutic effects. This, however, is not the whole story. The hype and marketing of ezetimibe, as well as its prescribing patterns, prior to the ultimately negative data on atherosclerosis end points are what warrant "further review."

Canada, unlike the U.S., does not permit direct to consumer advertising. From 2002 through 2006, the proportion of prescriptions for ezetimibe rose in Canada from 0.2% to 3.4%, compared to the growth from 0.1% to 15.2% in the U.S.![2] Furthermore the ratio of prescription statins (again, the "gold standard" for not only lowering cholesterol, but also preventing the critical morbidity/mortality outcomes) to ezetimibe in Canada was 26:1 versus 5:1 in the U.S.[2] Even though it was demonstrated that ezetimibe may not yield optimum "bang for its buck," expenditures for its use in the U.S. exceeded those in Canada by a ratio of approximately 4:1.[2] It appears that prescribing practices changed inappropriately before the critical data was in, and most likely, as a result of advertising. Patients and doctors seemed to respond to the call of the commercials. The bottom line is that ezetimibe cost consumers and insurance companies (including the U.S. government through Medicare and ultimately taxpayers) a lot of money and the important therapeutic outcome was not achieved. So is there a moral to this story?

Healthcare reform is complicated. It is not just merely about the sum total of healthcare financing. Reform does, however, have a certain "reducible complexity." The ezetimibe story highlights one costly aspect of financing that includes patients as consumers, physicians as prescribers and the pharmaceutical industry as the marketer. These complex relationships inhabiting the marketplace have to be addressed in policy. Recently, the American Medical Student Association (AMSA) published a "Scorecard" grading medical schools for their policies concerning potential conflicts of interest.[4] It focused on the "cozy relationship" of medicine with an industry that entices through many guises: gifts, monetary relationships, consulting and speaking fees, appropriate disclosure, "free" drug samples (totaling $18 billion per year), formulary composition, access to prescribers, and impact on continuing medical education as examples. No one component of the cost generating triad—patients, physicians, and industry—is inherently evil, but it is time to take stock about reasonable efforts to regulate conflicts of interest that may impact efficacy, safety, and costs. The admonition applies not only to academic medical centers, but is a call that should echo throughout the entire medical enterprise. There are portions of the healthcare reform debate that can be placed squarely in our lap, that is, healthcare professionals and patients. The ezetimibe story is one example that carries broader ethical implications.

1.) Bruckert, E., Giral, P., Tellier, P. "Perspectives in Cholesterol-Lowering Therapy: The Role of Ezetimibe, a New Selective Inhibitor of Intestinal Cholesterol Absorption." *Circulation* 107 (July 2003): 3124-3128.

2.) Jackevicius, C. A., Tu, J. V., Ross, J. S., Ko, D. T., Krumholz, H. M. "Use of Ezetimibe in the United States and Canada." *New England Journal of Medicine* 358, no. 17 (2008): 1819-1828.

3.) Kastelein, J. J. P., Akdim, F., Stroes, E. S. G., Zwinderman, A. H., et al. "Simvistatin With or Without Ezetimibe in Familial Hypercholesterolemia." *New England Journal of Medicine* 358, no. 14 (April 2008): 1431-1443.

4.) American Medical Student Association. "AMSA PharmFree Scorecard 2008." http://www.amsascorecard.org, accessed July 23, 2008.

Dr. Rutecki, is the Director of Medical Education at Mount Carmel Health System, Columbus, Ohio and a Fellow of The Center for Bioethics & Human Dignity.

Extending Life – Setting the Agenda for the Ethics of Aging, Death, and Immortality

Under the sun of the Sonoran desert, conference and course attendees gathered in the first week of March for CBHD's first full-blown offsite conference. Conference course offerings challenged students to develop basic and advanced training on key bioethical issues as well as the biblical, theological, and philosophical underpinnings necessary to engage these issues. The exceptional line-up of speakers surveyed the gamut of end-of-life issues from the traditional questions surrounding death and dying, euthanasia and physician assisted suicide, and palliative care, to the emerging questions of radical life extension, longevity and immortality research, on to the rise of human replacement agendas such as transhumanism.

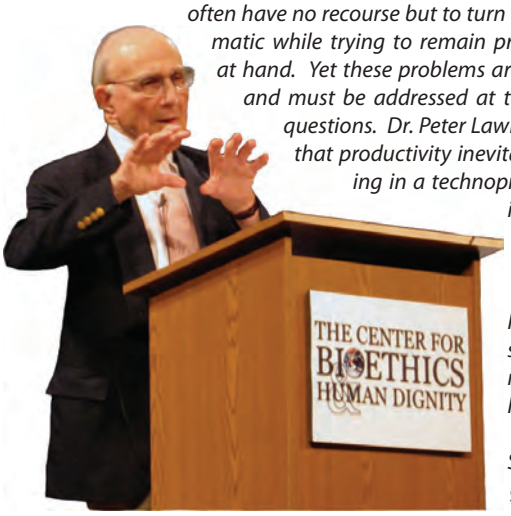
One highlight was the *Titans of Immortality Research* debate at the Arizona Science Center IMAX Theatre over the question "Do You Want to Live Forever." This lively dialogue featured Cambridge biomedical gerontologist Aubrey de Grey, PhD (Methuselah Foundation) and S. Jay Olshansky, PhD (University of Illinois). Another highlight was the keynote dinner address by Stephen Kiernan, journalist and author of *Last Rights*, on the importance of the palliative care movement as a means to relieve end of life suffering and as a necessary alternative to euthanasia and physician assisted suicide.

Healthcare and the Common Good

Emerging from an October 2007 consultation of the same title, *Healthcare and the Common Good* sought to reframe the domestic healthcare debates over access, finances, and coverage through a retrieval of the classic notion of the common good. This conference marked a significant milestone in bioethical engagement with our 15th annual summer conference. Led by the inaugural plenary by Edmund Pellegrino, MD, conference attendees were challenged to reexamine a Judeo-Christian notion of the common good and its relation to healthcare before delving into the various pressure points in the healthcare debate, including: economic concerns, ancillary care, professionalism in peril, medical education and the dilemma of the patient. The conference concluded with a Symposium of Solutions in which two current members of the President's Council on Bioethics (Edmund Pellegrino, MD and Peter Lawler, PhD), as well as a former member (Dean Clancy) offered various interpretations regarding constructive means of reframing the often-debated options in the context of the common good.

An excerpt from the closing remarks of the conference follows:

> *A few days ago, we joined in a much more intentional way in a conversation that has been percolating in the Center for over a year. Not many of us would question that there is a dilemma facing us in the domestic healthcare agenda. Distance and increasingly untrustworthy relationships between the patient, physician, and as Dr. Gene Rudd pointed out the professional third party mistresses, have complicated the practice and care of medicine. Rising prices and the population of the uninsured are the source of an ever-tightening belt of difficult financial decisions. The perfect storm of medical education and a professionalism in peril mark a significant departure from the tradition of care and character that has served as a moral compass and guide of practice through the Hippocratic tradition and oath.*
>
> *We have seen a cultural drift where the practice of medical care, like our culture at large, has substituted the financial transaction and the promise of a technological society, replacing our traditional notions of the value and dignity of human life, such that our common humanity has become reduced to merely "my personal benefit" and any obligations to serve and care are replaced by whatever is most convenient to "my schedule."*
>
> *The loss of touch with the rise of assembly line medicine, the creation of a healthcare aristocracy through boutique medicine. With all of these pressures and problems, the prospect of Healthcare and the Common Good in our country looks dim. As we are well aware, there is not a short supply of prophets crying out the near collapse of a failing system. Surely with all these pressures and problems we need practical solutions and ideas that take care of the most egregious injustices. Our intention from the outset was not to disregard these types of second-order questions.*
>
> *Policy and economic reform are important contributions to a comprehensive reform program. It is also true that in the tyranny of the expedient we often have no recourse but to turn to that which is pragmatic while trying to remain principled for the crisis at hand. Yet these problems are more deeply rooted and must be addressed at the level of first order questions. Dr. Peter Lawler rightly pointed out that productivity inevitably replaces caregiving in a technopragmatic society. This is the nature of first order reflection. As was just pointed out by Dr. Edmund Pellegrino, a discussion of healthcare is more than just about how do you pay for it.*



> *Surely we have a greater responsibility than this. Failure to pause to address the first order questions lay at the heart of the issues, manifesting themselves in these pressures and problems that we have examined these past few days. The issues are more systemic and entrenched. This is what drew the Center to reflect on the notion of the Common Good as a framework for discussing healthcare in the first place. . . .*
>
> *We must discern some narrative of the common good to guide our obligation to our fellow humanity by understanding healthcare in a way fitting for our views of the value and dignity of human life. We must reject any suggestion that human persons can be reduced to fiscal statistics, case numbers, or commodities for enhancing efficiency and productivity. . . .*
>
> *Despite the problems, I am not without hope. We begin to make a difference first by practicing what we believe about the value and dignity of human beings. We represent spheres of impact that reverberate in so many unanticipated ways. . . . Let us always remember and demonstrate that healthcare is an encounter with our fellow humanity. . . . Whatever ways in which we determine to engage these challenges, let it be guarded by a first order understanding that it cannot be said of us that we contributed to the collapse of healthcare, but rather that we contributed to a vision of healthcare and the common good.*

Beyond Perfectionism

by Michael J. Sleasman, PhD

With the Olympics soundly behind us and the rhythms of the fall launch of new television episodes well established, several reflections come to mind. An interesting thread below all of the accomplishments of the elite athletes during the Beijing Olympics were concerns over doping of various sorts. Artificial enhancements, steroids, hormones. These are not new issues surrounding the elite athletic competitions of our day, but they increasingly are becoming difficult to evaluate. For the first time during these Olympic events the world was introduced to the next generation of the pursuit of perfection through gene doping and stem cell injections. The irony to the events surrounding the Olympics were the artificial enhancements discovered by the news media of the various proceedings from digitally enhanced fireworks displays to lip-syncing children. In the age of Photoshopping we have become obsessed with perfection of the whole package. Or, to put it in the words of one Chicago Tribune author "we live in the Age of Fake." In the realm of biology, our obsession with perfection has led us to an unprecedented desire to pursue making things bigger, better, and faster.

It really is no wonder that the pursuit of perfection has become an obsession of humanity. Whether it be for the sake of national pride or for personal gain, the average and the normal have been tossed to the wayside as humanity seeks to push the limits on achievement and advancement. We see this in the rising demand for neuroenhancements brokered by psychopharmacological stimulants to give the struggling academic or physician the necessary competitive edge to excel in their demanding professional environment. We see our national heroes in baseball and other professional sports falling prey to the allure of the shortcut to achievement and greatness through artificial stimulants and muscle building hormones.

As a new father, I feel this siren calling to me as well. The song is simple enough, seemingly innocuous. What parent does not want the best for his/her child? Indeed, the pursuit of perfection comes in many forms, some of which we have chosen to ignore. The most radical of these are the sorts of emerging biotechnologies that the Center engages on a daily basis. It is, however, the subtle forms of perfectionism that demonstrate how pervasive this desire has become to our everyday frame of reference. As I play with my son, I drift toward thoughts of how to stimulate his growing mind, how to make the most of each opportunity to teach him and create opportunities for knowledge and awareness of the world. What early parent does not find himself/herself dreaming of their children with idealized terms like prodigy, genius, gifted? And then it hits me, I have already begun to accept the allure of perfectionism.

This realization was brought home to me as I read through a book entitled *Hothouse Kids* by Alissa Quart. The connection to perfectionism may not be readily apparent. In her volume Quart unpacks the experiences of various hothouse kids and their parents' desires to help them achieve their full potential. She speaks of the rise of the edutainment industry and extreme parenting, all of which seek to squeeze out a few additional IQ points from our children in the pursuit of giving them options. In short, a category once withheld for a very small segment of all youthful humanity is now marketed as the unrealized potential of every child if only a parent would purchase this product or enroll his/her child in that particular program. The edutainment movement and the cottage industry of activities, programs, and products surrounding it are all a part of the pursuit of perfection for our children. In her lament over the threat to childhood, Quart decries the loss of unscripted imaginative play and its replacement with a curriculum that she describes in overtures to Aldous Huxley's *Brave New World* assembly-line approach to spawning designer progeny.

And this is where the second realization sinks in for me. The pursuit of perfection is most obvious when we begin altering the nature of what it means to be human from a biological standpoint. For anyone reading *Brave New World* for the first time they likely are horrified by the genetic engineering of humanity into various classes (from the Alphas to the Epsilons). But, in Huxley's dystopia, the nature vs. nurture debate is put to an end. Both are fully exploited for utilitarian ends, from the utilization of "Bokanovsky's Process" to the "Neo-Pavlovian Conditioning Rooms." It is here that the subtle allure of perfectionism often is overlooked in the shift in perception that has made advanced and gifted the new norm. Where children become venues of competition to secure the future wellbeing of their parents. Where we lose a notion of enjoying humanity in its everydayness of the mundane and normal. This is the delicate balancing act that we perform as we envision a truly human future. A future in which we celebrate the achievements of the elite and the marginal. Where we value the person for his and her given personhood apart from any functionalist reductionism that quantifies the value of a human person purely in terms of their physical or intellectual prowess, or their awards and accomplishments. Where we celebrate the testing of physical human limitations through sport and realize that it is those very limitations that demonstrate our common humanity. It is about coming to terms with our embodiment in finite human bodies that we realize what it means to be truly human. Where we recapture a common sense notion of normal that is not captive to some slippery slope of society's changing mores, and where therapeutic and enhancement are clearly differentiated and have currency. Where the motivations that may one day lead us to the dilemma of designer babies are exposed in their now seemingly innocuous nascent states. It is here that we begin to see a way beyond perfectionism.

1). Keller, Julia. "Oh well, whatever, never mind," *Chicago Tribune*. August 13, 2008.
2). Quart, Allisa. *Hothouse Kids: How the Pressure to Succeed Threatens Childhood.* New York: Penguin Press, 2007.

Center Updates

Resources – In June 2008 CBHD undertook a massive digital library project in which all of the Center's audio and video resources will be converted into digital media and accessible online. The resources previously were available for purchase in either cassette, CD, or VHS formats. With the increasingly dated nature of these media formats, the Center staff initiated the conversion of these media into useful formats for years to come. During the conversion, we apologize that these resources will be unavailable. Check our website (www.cbhd.org) throughout the late fall for the deployment of these digital resources.

Working Groups – The Center hosts three working groups led by our consultants in the areas of clinical ethics, biotech ethics, and neuroethics. Each of these groups is working to generate a variety of resources that include case studies published in a variety of journals, bibliographies and constructive works. Presently, the Center is seeking to develop a network of scientists and researchers committed to the core principles of Judeo-Christian Hippocratism in the scientific context to better engage the emerging technology conversations. Several informal and formal meetings are in the works, so if you are an individual fitting this description or know of someone else who does, please help us to get in contact with them by sending us a note at info@cbhd.org.

Various Conference Opportunities – CBHD staff and friends often attend a variety of professional meetings and special conferences throughout the year. Some of these meetings include among others, ASBH, AAR, ETS, SCE, ASA, and AAAS. If you are a member of any of these organizations or others and attend their annual meetings, we are looking for informal ways in which we can network and utilize the potential to gather together during these events. If you will be attending these events and would like to network, please contact us at info@cbhd.org to let us know of your interest.

Staff Activities:

Michael Sleasman, PhD

- In June led a workshop entitled "Thinking through Technology" at the National Conference of the Christian Medical & Dental Associations. The audio and print version of this talk were included as part of *The Bioethics Podcast* available at www.cbhd.org/podcast.
- In early October spoke in a special session at Lincoln Christian College and Seminary on "Bioengagement and the Church: A Survey of Resources and Strategies" as part of the Strauss Lecture events.

Hans Madueme, MD Research Analyst

- Appointed Book Review Editor for *Themelios.*

Jessica Minor, MA 2007-2008 Research Intern

- Matriculated in Duquesne University's PHD/DHCE (Doctor of Healthcare Ethics) Program.

Jay P. AuWerter, MDiv Research Intern

- Matriculated in Case Wetern Reserve University's JD/MA (Bioethics) Program.

Fellows:

Sharon Falkenhemier, MD

- Book Review, "Ethics & AIDS in Africa: The Challenge to Our Thinking," Anton A. Van Niekerk and Lorette M. Kopelman, (Left Coast Press, Inc., Walnut Creek, CA: 2005) to be published in the upcoming Ethics & Medicine 24:3.
- Presented a paper in May 2008, "A Historical Perspective on Medical Codes and Human Research Ethics," at the 79th Aerospace Medical Association Scientific Meeting in Boston.

Agnetta Sutton, PhD

- New book, *Christian Bioethics: A Guide for the Perplexed*. (T&T Clark, 2008).

Dennis Hollinger, PhD

- Was named the sixth President of Gordon-Conwell Theological Seminary and Professor of Christian Ethics.

Robert Cranston, MD

- Appointed the Medical Director for Medical Subspecialties at Carle Clinic and Carle Foundation Hospital in Urbana, Illinois.

New Resources Available for sale at www.cbhd.org/xcart:

Recent Books

Plenary Sets (MP3) from Recent Conferences

Healthcare & the Common Good

Extending Life