2009 International Ethics Conference Proceedings
The University of Botswana

“Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine, and Research”

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Proceedings of the
2009 International Ethics Conference
The University of Botswana

“Retrieving the Human Face of Science:
Understanding Ethics & Integrity
in Healthcare, Medicine & Research”

The Conference was sponsored by the University of Botswana
in partnership with
United States Navy Medicine
&
The Graduate School of Nursing,
Uniformed Services University
Bethesda, Maryland
USA
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*Michael Whitecar*
This edition of the Journal of Research Administration comprises the Proceedings of the 2009 International Ethics Conference sponsored by and held at the University of Botswana on December 6-10, 2009. The university sponsored the conference in partnership with United States Navy Medicine in Washington, DC, and the Graduate School of Nursing at the Uniformed Services University in Bethesda, Maryland, USA.

The conference was entitled, “Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research.” It brought together renowned keynote speakers, distinguished lecturers, respondents, and panelists from all around the world.

Over 250 delegates were in attendance from the university, its new School of Medicine, worldwide scholars, international government officials, healthcare providers, and other interested citizens. The conference gave clear demonstration to the success that can be achieved through partnered scholarship, innovative vision, and mutual cooperation for promoting humanitarian assistance in support of those most in need in our world.

Applauded by the United States Ambassador to Botswana and other high ranking dignitaries, the university’s 2009 International Ethics Conference was a first step in hoped for collaborations and partnerships by women and men who have dedicated their lives to answering the cries of the poor for compassion, healing, and hope.

In this hope of the Good yet to come, the Society of Research Administrators International is honored to publish these Proceedings in the spirit of international friendship and educational enrichment.

Dr. Edward F. Gabriele
Editor, Journal of Research Administration
Contributing Authors

Linnea Axman, DrPH, is a Family Nurse Practitioner. She is the Command Research Integrity Leader and Lead Research Facilitator at the Naval Medical Center in San Diego, CA. In this position, she coordinates and facilitates graduate research projects for physicians, dentists, and allied health personnel working collaboratively with nursing research scientists. She also serves as the Regional Network Leader in Research Integrity for all medical treatment facilities in Navy Medicine West and an educational leader for the Navy Medicine Research Integrity Programs Network. Her research interests and efforts include development of culturally appropriate instruments for use in cross-cultural environments, and the effects of structural barriers on the delivery of care at home and abroad. She was the Department of Defense Core Team Representative on the U.S. Government Team for the President's Emergency Plan for AIDS Relief in Sub-Saharan Africa from January 2004 to May of 2006. She is a graduate of the United States Naval War College and is a Fellow in the American Academy of Nurse Practitioners (FAANP). Captain Axman received the prestigious Recent Alumni Achievement Award from The George Washington University in September 2007.

Denise Boren, PhD, is a Clinical Nurse Specialist with a focus on chronic heart failure. She retired from the Navy Nurse Corps after serving for 24 years. She is Assistant Professor and Chair of the graduate program at California State University San Marcos School of Nursing. She primarily teaches nursing research and theory, community health nursing and health promotion. Dr. Boren has been a consultant for care and support for people living with HIV/AIDS in Africa since 2004. She is an educator for the Prevention with Positives Program in Africa, and partners with Lesotho and Swaziland for an international community nursing experience for her students from the School of Nursing. Her research interests include health partnership and innovative ways to deliver health care to people with chronic heart failure and student and patient outcomes for the international community nursing experience. Dr. Boren received the Hughes Career Achievement Award, a prestigious alumni award from the University of San Diego, and the Women Who Mean Business Award from the San Diego Business Journal in 2009.

Wayman Wendell Cheatham, MD, FACE, board certified in endocrinology and metabolism, is Special Assistant to the Surgeon General of the United States Navy for Medical Research, Director of the Medical Research & Development Center within the Navy Medicine Institute for the Medical Humanities and Research Leadership, and Director of the Navy Medicine Clinical Investigations Program. With nearly thirty years of experience as a clinician and as a biochemical and medical researcher, Dr. Cheatham is a renowned pharmaceutical development and energy metabolism expert, having served as the senior executive in charge of research for one of the world's largest pharmaceutical companies. Just prior to his current position, he served as Assistant Vice President for Scientific Affairs and Medical Director of the MedStar Clinical Research Centers for MedStar Research Institute in Washington, DC. Dr. Cheatham is published in prominent clinical and scientific journals, including Annals of the New York Academy of Sciences, Clinical Diabetes, Diabetologia, American Journal of Clinical Nutrition and Immunological Investigations, and is a highly sought after lecturer for international medical
Edward Gabriele, MDiv, DMin, is Special Assistant to the Navy Surgeon General for Ethics and Professional Integrity. He is also Director of the Center for the Medical Humanities in the Navy Medicine Institute for the Medical Humanities and Research Leadership. Dr. Gabriele directs a variety of executive level Navy Medicine programs consistent with his four-fold responsibilities in healthcare ethics, research ethics, organizational systems ethics, and values formation and education. These programs include leadership as Executive Research Integrity Officer, Director of the Research Integrity Programs Network, Director of the Surgeon General’s Healthcare Ethics Advisory Council, and Director of the Surgeon General’s Research Ethics Advisory Council. He holds dual bachelor’s degrees in communications education and religious studies from Villanova University, a master’s in theology from the Catholic Theological Union, and a doctorate in liturgical theology, spirituality and education from The Catholic University of America. Dr. Gabriele is Professor of Clinician Education in the Department of Medicine at Georgetown University Medical Center, and Distinguished Professor in the Graduate School of Nursing’s PhD Program at the Uniformed Services University. He is Editor of the Journal of Research Administration published by the Society of Research Administrators International. The Navy Surgeon General recently appointed him as Editor of a new peer-reviewed, academic international publication, The Navy Medicine Journal. Dr. Gabriele was the concept originator and US Director for the 2009 Botswana Conference. He co-developed the conference in unison with the Sponsoring Directors at the University of Botswana.

Elizabeth Holmes, PhD, ABPP, heads innovative teaching development and assessment at the Vice Admiral Stockdale Center for Ethical Leadership at the United States Naval Academy, which has been referred to as developing the best experiential moral learning technology worldwide. Since 2004, she has been producing a library of interactive
In This Edition

simulations, transforming ethical leadership education. Over the past 30 years, Dr. Holmes has treated thousands of sailors and Marines as patients, facilitated hundreds of groups, taught 1,000 midshipmen, conducted numerous command investigations and research projects, and published extensively. Dr. Holmes has developed educational programs on a wide range of topics, including: ethics for the military, suicide and sexual assault prevention, eating disorders intervention, pain management, chemical dependency treatment, HIV/AIDS prevention and counseling, cardiac rehabilitation, combat and operational stress, and character and leadership development. Dr. Holmes, the daughter of a Navy family, was born in a Naval hospital and spent her formative years in Japan. She is a retired Navy Captain clinical psychologist who, during her career, traveled throughout Europe, Antarctica, Asia, and Africa, working with diverse people from many cultures.

**Joseph Makhema, MBChB, FRCP**, is a Physician of Internal Medicine and Director of the Botswana-Harvard School of Public Health AIDS Initiative Partnership for HIV Research and Education in Botswana (BHP). In this position, he manages and oversees HIV/AIDS research programmes of the BHP, develops the strategic framework and policies to create an environment conducive to research activities at BHP and liaises with and promotes networking, advocacy, and international collaboration within the institution. He is also a co-investigator on various international research protocols in Botswana that spans the globe. He has had a distinguished medical and research career and was elected Fellow of the Royal College of Physicians in 2008 and is currently the Chairperson of the Botswana Health Professions Council.

**Isaac N. Mazonde, PhD**, obtained his doctorate from the Victoria University of Manchester, United Kingdom, in 1987. Ten years later, in 1997, he became Associate Professor of Geography. He was appointed Director of the Office of Research and Development in 2005, following two benchmark visits. The first one, which focused on the structure and function of a research office in a developed university, was to four USA universities. It was undertaken in 2001. The second one was made to South Africa's main tertiary education institutions and research management organizations 2002/2003. Later in 2007, Prof Mazonde spent six weeks in Dundee, Scotland, United Kingdom, where he gained insight into innovation and commercialization activities of British universities. For three years he served as a member of the Southern African Research Innovation and Management Association (SARIMA); and has, since 2005, been a Board Member of the Rural Industries Promotion Company, a technology based institute in Botswana. Prof Mazonde is on the Advisory Boards of many international journals and has published extensively in the area of innovation.

**Paul Ndebele, MSc, PhD (cand)**, currently serves as Assistant Director for Research Ethics in the Office of Research and Development at the University of Botswana. He was a member of the Ethics Conference Organising Committee. Paul has several years of experience with medical, health and social science research, including the review and monitoring of research. Paul worked for the Medical Research Council of Zimbabwe from 1999 to 2005 in the area of Human Research Oversight. He was then appointed Deputy Director and Assistant Visiting Professor in the Fogarty Funded Program in International Research Ethics run
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jointly by the Centre for Bioethics in Eastern and Southern Africa (CEBESA), College of Medicine (University of Malawi) and Center for Ethics in the Humanities and Life Sciences at Michigan State University from Aug 2005—July 2008. He also serves as an Honorary Lecturer at College of Medicine, University of Malawi for various modules in the Master of Public Health Programme, and Adjunct Instructor at Michigan State University. He is a part-time Lecturer at Africa University for the Ethics in Health Care and Research module and Health Legislation.

Ellemes Phuma is a second year graduate student in Nursing Science at the University of Botswana. She works with Mzuzu University Malawi as an assistant lecturer in nursing ethics and professionalism. She has also worked as a clinical instructor in child and paediatric health nursing at Trinity College of Nursing, Malawi (2003-2004), and as a Nursing officer in-charge of adult medical ward at Chikwawa District Hospital, Malawi (2005-2006).

Vice Admiral Adam M. Robinson Jr. is the 36th Surgeon General of the Navy and Chief of the Navy’s Bureau of Medicine and Surgery. A native of Louisville, KY, he entered the naval service in 1977 and holds his Doctor of Medicine from the Indiana University School of Medicine, Indianapolis. Following completion of his surgical internship at Southern Illinois University School of Medicine, Springfield, he was commissioned. Vice Admiral Robinson’s first assignment was as general medical officer, Branch Medical Clinic, Fort Allen, Puerto Rico, before reporting to the National Naval Medical Center, Bethesda, MD, in 1978 to complete a residency in general surgery. His subsequent duty assignments included staff surgeon, U.S. Naval Hospital, Yokosuka, Japan, and ship’s surgeon, USS Midway. After completing a fellowship in colon and rectal surgery at Carle Foundation Hospital, University of Illinois School of Medicine (1984-85), Robinson reported to the National Naval Medical Center, Bethesda, as head of the Colon and Rectal Surgery Division. While there, he was called to temporary duty in 1987 as ship’s surgeon in USS John F. Kennedy and in 1988 as ship’s surgeon in USS Coral Sea. Dr. Robinson reported to Naval Medical Center, Portsmouth, VA, in 1990 as the head of the General Surgery Department and director of General Surgery Residency Program. He was appointed acting medical director for the facility in 1994. While at Naval Medical Center Portsmouth, he earned a Masters in Business Administration from the University of South Florida. In 1995, Robinson reported to the Commander, Naval Surface Force, U.S. Atlantic Fleet, as force medical officer. Following that, he reported to Naval Hospital Jacksonville in 1997 as the executive officer. In January 1999, as Fleet Hospital Jacksonville commanding officer, he commanded a detachment of the fleet hospital as a medical contingent to Joint Task Force Haiti (Operation New Horizon/Uphold Democracy). In August 1999, Dr. Robinson reported to the Bureau of Medicine and Surgery (BUMED) as director of readiness. He was selected as the principal director, Clinical and Program Policy, in the Office of the Assistant Secretary of Defense for Health Affairs in September 2000, where he also served as the acting deputy assistant Secretary of Defense for Health Affairs, Clinical and Program Policy. He was assigned as commanding officer, U.S. Naval Hospital Yokosuka from September 2001 to January 2004, after which he was assigned to BUMED as deputy chief
In This Edition

of BUMED for Medical Support Operations, with additional duty as acting chief of the Medical Corps. In July 2004, he reported as commander, National Naval Medical Center, Bethesda, Maryland. He assumed the duties as commander, Navy Medicine National Capital Area Region in October 2005. The author of numerous presentations and publications, Vice Admiral Robinson holds fellowships in the American College of Surgeons and the American Society of Colon and Rectal Surgery. He is a member of the Le Societe Internationale de Chirurgie, the Society of Black Academic Surgeons, and the National Business School Scholastic Society, Beta Gamma Sigma. He holds certification as a Certified Physician Executive from the American College of Physician Executives.

Michael Whitecar, MIS, is currently the Founder, President and Chief Executive Officer (CEO) of The Chief Information Group, Inc. (TCIG), a global information management consulting company. Prior to founding TCIG, Whitecar served as Chief Operating Officer (COO) of Park City Solutions, Inc., serving federal healthcare. Before entering the corporate sector, Whitecar served an exemplary 20-year career in the United States Navy as a Medical Service Corps officer retiring as a Lieutenant Commander. Whitecar’s naval career included submarine operations during the Cold War; and service as program manager, department director, consultant to the Navy Surgeon General, and a Chief Information Officer (CIO) of the US Naval Hospital Naples, Italy. During this tenure, the Joint Commission on Accreditation of HealthCare Organizations and Assistant Secretary of Defense for Health Affairs recognized him as a leader in discovering and deploying new internet technologies. Whitecar earned a Bachelor’s Degree in Computer Science from Park University in Parkville, Missouri, and a Master’s Degree in Management Information Systems from the Naval Postgraduate School, Monterey, CA. He also is a graduate of the Naval War College, Newport, Rhode Island. Additionally, he completed CIO graduate level courses/seminars at Case Western University, Cleveland, Ohio; and Software Engineering at Central Michigan University, Mount Pleasant, Michigan.
FROM THE EDITOR’S DESK
From the Editor’s Desk
Dr. Edward Gabriele

An international ethics conference in Botswana.

How did the journey begin?

In the Fall of 2007, I had transitioned into an executive position with one of the United States federal agencies to design, direct, and promote educational conferences and liaison development initiatives within the United States and overseas. Specifically, I was exploring the possibility of an international conference concerning the relationships between ethics, healthcare, medicine, and research. One evening, with that task in the forefront of my mind, a television commercial reminded me to download from iTunes a favorite song of mine by the British artist, Annie Lennox. My download led to a series of web searches that finally ended with my viewing her video-clip, Sing.

Sing caught me up in a whirlwind. I watched Annie Lennox move HIV+ women in South Africa to dance and sing themselves into a personal resilience beyond words. Tears streamed, and the index finger of my right hand pointed at my computer monitor, “I am going to do something about that.”

Until the early morning hours, I explored the southern African area and the health needs of the people of the region. I recalled various academic collaborations within the Society of Research Administrators International that I had enjoyed with a few colleagues at the University of Botswana. Over the years, they had made me increasingly aware of the critical mission that the University was leading for the benefit of those most in need.

Suddenly, the conference-concept exploded. It could meet a number of goals both practical and greater. Realizing the time difference, I raced into my office very early and called my colleagues at the University. The collaborations began.

From the start, the conference-concept needed a title that would act as a powerful metaphor. What came about was a need to capture not just the sharing of intellectual information for the enrichment of the brain, but, more importantly, the powerful energies of the heart for the deepening formation of persons and communities. Small wonder the conference title became, “Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research.”

The concept was slowly taking shape as a global force for the good—an act of systemic educational sharing with the ultimate goal of humanitarian assistance for the sick, the suffering, and those who care for them. Things seemed to be well on track.

Suddenly, though, an unexpected transition occurred that augmented the concept in ways beyond my imagining.

In May 2008, I was offered the opportunity to transfer back to Navy Medicine, the original government agency I had served starting in 1991. Back home at Navy Medicine,
Introduction

I became Special Assistant to the US Navy Surgeon General for Ethics and Professional Integrity. With my transfer, the concept had to come with me from my prior agency. I planned to present it to the Surgeon General hoping for his interest.

During my in-brief with Admiral Adam Robinson, I shared the story with him and told him the event was a concept that needed a home to be realized. The decision was his. Smiling he said, “Why wouldn’t Navy Medicine want to do this for others? That’s our mission. Let’s do it.”

The rest is history.

A wide variety of initiatives, planning meetings, and dreams brought about reality. The University became the actual sponsor led by its own Office of Research and Development. Partnering with the University were Navy Medicine and the Graduate School of Nursing at the Uniformed Services University of the Health Sciences. Including any number of private sector scholars and experts, it was astounding to see so many institutions and agencies provide for the conference faculty to take part in this signature event. We were especially honored that Archbishop Emeritus and Nobel Laureate Desmond Tutu agreed to be the opening keynote speaker.

Finally taking place in December 2009, the Botswana international ethics conference brought together distinguished keynote speakers, lecturers, respondents, and panelists. They addressed critical ethics issues for healthcare leaders and researchers, especially for the first class of medical students in the new School of Medicine at the University. In the end, it was absolutely a stunning success.

But a question needs to be asked.

“Was the conference a one-time story whose success is destined to fade quickly with the passing of each slideshow image on a laptop photo album? Or is there something deeper?”

During the development of the conference, we were delighted to make the acquaintance of the United States Ambassador to Botswana, Stephen J. Nolan. The Ambassador’s personal support and enthusiasm were incomparable. He commented often that the power of this event must go well beyond its closing. He urged us to find ways to ensure that the academic scholarship and interior formation energized in this conference continue to be important gifts and resources for others well beyond its closing. This publication answers the Ambassador’s urging in part.

The Proceedings provides you, our readers, with a means of entering into the experience of the conference keynotes and lectures. It includes diverse texts that address the importance of the conference. It incorporates reflections on how the conference touched the lives of those who participated. To secure the perpetuity of these texts and in the spirit of its own international mission, the Society of Research Administrators International agreed to publish the Proceedings as a special edition of its Journal of Research Administration (Volume 41, Number 2).
But yet still another question needs to be asked.

“Is this just an electronic or print moment in time, an artistic flash of interest celebrating an intellectual memory?”

No.

In the Greek tradition, icons are important and powerful. Many know icons as the painted images used in Greek Orthodox Churches. The images, though, are not simple, religious pictures. They represent something much more than pious imagery. They are pure art. They are metaphors; as such, they evoke and sustain a power deeper than one can imagine.

As metaphors, icons are sacred windows into the experience of the Ultimate. They are the means by which the limited imagination of the mortal enters into and is caught up in the overwhelming Presence of an “Other” who cannot be tied down to one age, one thought, one conceptualization. Icons are doorways to the sacred that overpower the individual and move one to change at the deepest possible level. They shatter boundaries and invite one into a dimension free of all of the restrictions of logic’s limits.

This Proceedings is essentially an invitation into an icon-experience. The experience is not the publication itself. No, this is an invitation into something that transpired in Gaborone, Botswana, at a university, for one short but seemingly limitless week, in the December of 2009.

One only needs to look at the image on the cover to understand what I mean. We see the face of a child whose eyes draw us into something many of us have tried to escape. The eyes betray a longing, a need, a burning anger. They want to know, “Why?”

This is the question that led several hundred people to Botswana to share, to hope, to dream, to protest the inequities that mar the innocence of the poor. They came in December 2009, without realizing it, to retrieve and never forget the human face of science. They came for a conference, and entered into something unfathomable. They left stretched beyond their limits to meet afterward with new compassion the eyes of those who look to us with longing, with the sheer and undiluted desire to be made whole.

Now, as you enter into the following pages: Will you be able easily to forget? Will you have the courage to enter into the icon and do something for those who need us most? How will you, with hands open and fingers pointing not at a monitor but at your own hearts, do something for and about them?
INTERNATIONAL ETHICS CONFERENCE

Retrieving the Human face of Science:
Understanding Ethics and Integrity in Healthcare, Medicine and Research

University of Botswana, Library Auditorium

6-10 December 2009

Conference organized by the University of Botswana in partnership with the
US Navy Medicine and the Uniformed Services University
Conference Programme

ABOUT THE CONFERENCE

The International Ethics Conference on Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research at the University of Botswana is a premier event that will be held December 6-9th 2009 and attended by delegates from all over the world. It seeks to bring together practitioners in the areas of healthcare, medicine and research to discuss integrity and ethical issues related to healthcare, medicine and research and will focus on such issues as Human Response to illness, Leadership and the Healthcare Professions, Tradition of Mentoring, Integrity of Research and Globalization and the Diplomacy of Science.

The conference will begin with pre-conference workshops on Sunday December 6th 2009 that will be held in 2 parallel sessions in the morning and afternoon. The pre-conference workshops will culminate with an African Braii in the Mokolodi Nature Reserve. The Conference itself will run from December 7-9th and will begin with the first keynote given by His Grace, Archbishop Emeritus Desmond Tutu, on “Human Illness and the Experience of Vulnerability”. This will be followed by a second keynote by the US Navy Surgeon General, VADM Adam Robinson, MC, USN on “Hearing the Cries of the Poor: Healthcare as a Human Response”. The final keynote will be given by Dr. Joseph Makhema, the Director of the Botswana Government / Harvard University Partnership on “Globalization and the Diplomacy of Science.” Conference evening events for networking and socializing will include receptions hosted by the Vice Chancellor of the University of Botswana and the US Ambassador to Botswana.

KEYNOTE SPEAKER PROFILES

Archbishop Emeritus Desmond Tutu was born in 1931 in Klerksdorp, Transvaal. He graduated from the University of South Africa in 1954, was ordained as a priest in 1960 then obtained a Master of Theology in 1966 in the UK. From 1967 to 1972 he taught theology in South Africa before returning to the UK as the Assistant Director of a theological institute in London. Archbishop Tutu was the first black South African Anglican Archbishop of Cape Town, South Africa, and primate of the Church of the Province of Southern Africa (now the Anglican Church of Southern Africa). He received the Nobel Peace Prize in 1984, the Albert Schweitzer Prize for Humanitarianism, the Gandhi Peace Prize in 2005 and the Presidential Medal of Freedom in 2009. Archbishop Tutu has also compiled several books of his speeches and sayings and is holder of various honorary doctorates from a number of leading universities in the USA, Britain and Germany.

Vice Admiral Adam M. Robinson Jr. assumed duties as the 36th Surgeon General of the Navy and Chief of the Navy’s Bureau of Medicine and Surgery on August 27, 2007. VADM Robinson entered the naval service in 1977 and holds a Doctor of Medicine from the Indiana University School of Medicine. Following completion of his surgical internship at Southern Illinois University School of Medicine he was commissioned. VADM Robinson holds fellowships in the American College of Surgeons and the American Society of Colon and Rectal Surgery. He is a member of the Le Societe Internationale de Chirurgie and the Society of Black Academic Surgeons. He is the author of numerous presentations and publications and his personal decorations include the Distinguished Service Medal, Legion of Merit (two awards), Defense Meritorious Service Medal (two awards), Meritorious Service Medal (three awards), Navy Commendation Medal, Joint Service Achievement Medal, Navy Achievement Medal and various service and campaign awards.

Joseph Makhema is a Physician of Internal Medicine and Director of the Botswana-Harvard School of Public Health AIDS Initiative Partnership for HIV Research and Education in Botswana (BHP). In this position, he manages and oversees HIV/AIDS research programmes of the BHP, develops the strategic framework and policies to create a conducive environment for research activities at BHP and liaises with and promotes networking, advocacy and international collaboration within the institution. He is also a co-investigator on various international research protocols in Botswana that spans the globe. He has had a distinguished medical and research career and was elected Fellow of the Royal College of Physicians in 2008 and is currently the Chairperson of the Botswana Health Professions Council. He has participated in the development of policies and procedures for the establishment of a Medical School at the University of Botswana and is currently a Member of the University Council.
## Conference Programme

**Pre-conference Workshop (Centre for Continuing Education Building)**  
**Sunday December 6th 2009**

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### Registration

*Registration*

*Lobby, CCE Building*

### PARALLEL SESSIONS - MORNING

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<tr>
<th>Room 4</th>
<th>Room 7</th>
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<tr>
<td>Chair: Dr. Nthabi Phaladze</td>
<td>Chair: Dr. L. Mokgaltthe</td>
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<tr>
<td><strong>Ethics, Law and Regulatory Affairs: The International Experience</strong></td>
<td><strong>International Research Proposal Strategies</strong></td>
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<tr>
<td>J. Michael Slocum, JD (Slocum &amp; Bobbie P.C)</td>
<td>Linnea Axman, DrPH (US Navy Medicine)</td>
</tr>
<tr>
<td>Jason Robert, PhD (Arizona State University)</td>
<td>Eric Elster, MD (US Navy Medicine)</td>
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<tr>
<td>Rekha Kumar, PhD (Department of Law, UB)</td>
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### Refreshment Break

**10:30** - **11:00**

### Wellcome Trust Lunch

*Staff Lounge*

**12:30** - **13:30**

### PARALLEL SESSIONS - AFTERNOON

<table>
<thead>
<tr>
<th>Room 4</th>
<th>Room 7</th>
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<tr>
<td>Chair: Dr. Nthabi Phaladze</td>
<td>Chair: Dr. L. Mokgaltthe</td>
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<tr>
<td><strong>International Collaborations: A Practicum</strong></td>
<td><strong>Clinical Trials: An Introduction to International Requirements</strong></td>
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<tr>
<td>J. Michael Slocum, JD and associates, Jason Robert, PhD; Leps Maleke, PhD</td>
<td>Wayman Cheatham, MD</td>
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<td>Eric Elster, MD</td>
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<td>Exnevia Gomo, PhD</td>
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<td>Linnea Axman, DrPH</td>
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### Refreshment Break

**15:00** - **15:30**

### African Bush Brail

*Makolodi Nature Reserve*

**19:00** - **23:00**

*Transport from UB CCE Parking Lot to venue at 18:00*

*Return from venue to UB CCE Parking Lot at 23:00*
# Conference Programme

## Main Conference (University of Botswana Library Auditorium)

### Monday December 7th

<table>
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<td>9:00</td>
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<tr>
<td></td>
<td>Module 1: Chair: Dr. T. Mokoena, Faculty of Health Science, UB</td>
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<tr>
<td></td>
<td>Welcome: Address: Professor B.K. Otholang, Vice Chancellor, UB</td>
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<td></td>
<td>Opening Keynote 1: Human Illness and the Experience of Vulnerability:</td>
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<tr>
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<td>Archbishop Emeritus Desmond Tutu</td>
</tr>
<tr>
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<td>Vote of Thanks: Dr. E. Gabriele, US Navy Medicine</td>
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**Refreshment Break**

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<td>Keynote Respondents:</td>
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<td>Dr. T. Massara, Faculty of Medicine, UB</td>
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<td>Dr. K. Fitzgerald, Georgetown University Medical Center; Dr. A. Dhill, Steve Biko Centre for Bioethics, Witwatersrand University</td>
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**Panel Discussion:**

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<td>Panel Discussion:</td>
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<td></td>
<td>Mr. R. Salem, Salem Law Group; Dr. K. Selpone, Department of AIDS Prevention and Treatment, Min of Health, Botswana; Dr. Jason Robert, Arizona State University</td>
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**Standard Chartered Bank Luncheon**

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<td>13:30</td>
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<td>Module 2: Chair: Prof. M. Mazzone, Office of Research and Development, UB</td>
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<td>Opening Keynote 2: Hearing the Cries of the Poor: Healthcare as a Human Right: VADM Dr. Adam Robinson, US Navy Surgeon General</td>
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**Panel Discussion:**

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<td>Dr. G. Anabwami, BCCOE, Botswana; Dr. B. Cohen, US Navy Medicine; Mr. P. Ndebele, Office of Research &amp; Development, UB</td>
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**Refreshment Break**

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<td>Keynote Respondents:</td>
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<td></td>
<td>Dr. S. Tjoa, Department of Nursing Science, UB; Prof. B. Abugaz, Dept of Chemistry, UB; Dr. Eric Bahre, US Navy Medicine</td>
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**Vice Chancellor’s Reception**

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### Saturday December 8th

- **Registration**

### Wednesday December 9th

- **Registration**

### Sunday December 8th

- **Registration**

### Thursday December 10th 2009

## Post-conference Workshop on Ethics and the Pharmaceutical Industry (Library Auditorium)

### Post-conference Workshop on Ethics and the Pharmaceutical Industry (Library Auditorium)

#### Thursday December 10th 2009

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<td>Chair: Prof K. Bhagat</td>
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**Pharmaceutical Companies Lunch**

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**AFTERNOON FIELD ACTIVITIES**

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<tr>
<td><strong>Botswana Baylor Children’s Clinical Centre of Excellence</strong></td>
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**End of Conference**

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Poster Presentations

The following posters were accepted for presentation after undergoing rigorous review. They will be displayed in the Auditorium for the duration of the Conference. Poster presenters will be available during refreshment and lunch breaks to discuss their posters.

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<thead>
<tr>
<th>Poster No.</th>
<th>Author(s)</th>
<th>Poster Title</th>
<th>Author affiliations</th>
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<tbody>
<tr>
<td>0122</td>
<td>B. Sikatayo</td>
<td>Clinical Trials: Do participants understand the consent process? The case of Misisi Township in Lusaka—Zambia</td>
<td>Ministry of Health, Zambia</td>
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<tr>
<td>0124</td>
<td>L. Schoeman</td>
<td>The Human Face Of Informed Consent: An Equalizing Factor In Vulnerable Populations</td>
<td>Department of Medical Oncology, University of Pretoria</td>
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<tr>
<td>0125</td>
<td>S. Rominski</td>
<td>Creating a Charter For Collaboration: The Ghana-Michigan Collaborative Health Alliance for Restaping Teaching, Education and Research (CHARTER) Project</td>
<td>University of Michigan</td>
</tr>
<tr>
<td>0126</td>
<td>J.R. Gaie</td>
<td>The theft called research? Some traces of injustice</td>
<td>Department of Theology and Religious Studies, University of Botswana</td>
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<tr>
<td>0127</td>
<td>G.M. Ssebunnya</td>
<td>The Eclipse of the Good Physician: A Trifocal Perspective on Medicine as a Moral Enterprise</td>
<td>St. Augustine College of South Africa</td>
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<tr>
<td>0128</td>
<td>S. Shaibu</td>
<td>Ethical issues in Community Health Nursing in Botswana</td>
<td>School of Nursing, University of Botswana</td>
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<tr>
<td>0130</td>
<td>R. Thakur</td>
<td>International Collaboration: Ethical Issues &amp; Efficiency</td>
<td>Botswana-UPenn Partnership, National Health Laboratory</td>
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<tr>
<td>0131</td>
<td>1R.B.L Zinyama-Gutsire, 1R. Chekera, 1R. Ruzario, 1S. Munyati, 1P Ndebele, 1E Gomo, 1M. Phiri-Shana, 1F Tsuirmanri, 1R. Gunda, 1O. Zenda, 1L. Goma, 2R.B.L Zinyama-Gutsire, 2M. Chekera, 2R. Ruzario, 2S. Munyati, 2P Ndebele, 2E Gomo, 2M. Phiri-Shana, 2F Tsuirmanri, 2R. Gunda, 2O. Zenda, 2L. Goma,</td>
<td>Monitoring clinical trials for ICH-GCP compliance and protocol adherence: A case study of the Medical Research Council of Zimbabwe experiences.</td>
<td>1Medical Research Council of Zimbabwe 1Biomedical Research and Training Institute 1University of Botswana 2University of Malawi</td>
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<tr>
<td>0132</td>
<td>AB Kgaodi, LK Majuta, FD Madzimbandu</td>
<td>The Teaching of Medical Ethics in the Undergraduate Curriculum at University of Botswana School of Medicine</td>
<td>University of Botswana School of Medicine</td>
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Conference Programme

Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research

CONFERENCE SPONSORS

Botswana Medical Aid Society (BOMAID)

Botswana Public Officers Medical Aid Society (BPOMAS)

Embassy of the United States, Botswana

Motor Vehicle Accident Fund (MVA)

Standard Chartered Bank Botswana

Wellcome Trust (United Kingdom)

The Organising Committee is also very grateful to the University of Botswana in its entirety, US Navy Medicine and the Uniformed Services University Graduate School of Nursing, Conference Speakers and Chairpersons, Delegates and all groups, institutions and individuals who have contributed directly or indirectly towards the success of the conference.

Conference Directors: Prof. I. Mazonde; Dr. J. Jackson-Malete; Mr. P. Ndebele; Dr. E. Gabriele

US Planning Committee: CAPT P. Kelley, CAPT L. Axman, CDR J. Maye, Dr. E. Antosek, Dr. C. Parsons
Prelude
Reflections on the International Ethics Conference in December, 2009

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Email: mazondei@mopipi.ub.bw

Author’s Note
The opinions presented in this text are those of the author and do not reflect the official policy or positions of the University of Botswana (UB). The conference was supported financially and in-kind by the following organizations in alphabetical order: Botswana Medical Aid Society (BOMAID), Botswana Motor Vehicle Accident Fund (MVA), Botswana Public Officers Medical Aid Society (BPOMAS), Embassy of the United States, Standard Chartered Bank Botswana, University of Botswana, and Wellcome Trust (United Kingdom). With the University of Botswana as the sponsor, the conference was partnered with two United States government organizations, Navy Medicine and the Graduate School of Nursing at the Uniformed Services University.

Abstract
This prelude reflects upon the international ethics conference that was held from December 6-9, 2009, at the University of Botswana in Gaborone, Botswana. Seeking international partners and then forging mutually viable and effectively working links with them is the life blood of a university in a developing country. This partnering is necessary largely because a university in a developing country often lacks resources and affirmation. The resources it lacks range from intellectual capital to funding for its scholarly endeavors. This paper demonstrates how the University of Botswana, as an example of a university in a developing country, has reached out to join hands with a resource-endowed community in the western world through putting up a world class and modern international conference on ethics, one of the most topical concerns in academia.

Keywords: Ethics, globalization, engagement, human dignity, health care.
Prelude

Summary

Any event that is held by an academic institution has a purpose. This paper explains the context within which the conference was held, its significance, and how it will shape the University of Botswana as it moves forward.

While a conference has objectives, there are always people behind it who initiate the idea and determine how that idea will be implemented. The usual practice is to deal with this matter at the institutional level, emphasizing institutional activities. However, in this particular case, it is difficult to follow that route because the main actor, Professor Edward Gabriele, represents a number of institutions: the Society for Research Administrators International (SRA), US Navy Medicine, and the US Uniformed Services University Graduate School of Nursing. It was through his work in them all that he took the opportunity to engage members of the University of Botswana in holding this first-ever conference in Botswana. In particular, in his capacity as the Editor of the Journal of Research Administration, Professor Gabriele worked with Professor Isaac N. Mazonde and Dr. Jose Jackson-Malete and helped them publish, with Dr. Jeremy Sugarman, an article on ethics (Mazonde, Malete, & Sugarman, 2007). The bond grew and a relationship was forged, resulting in the conference and in the research collaboration that the two parties are now vigorously pursuing between the University of Botswana on the one side and many colleagues around the world on the other.

In its strategic plan, officially known as A Strategy for Excellence, the University of Botswana lists several priority areas in which it will engage. The two most applicable to the matter at hand are Engagement and Improving Research Performance. Essentially, Engagement is about reaching out to real and potential stakeholders, as in forging links between the university and industry. Engagement can also refer to international collaboration in research. Improving Research Performance is by and large self explanatory.

The world class conference on healthcare ethics held at the University of Botswana from December 6-9, 2009 addressed these two priorities in a resounding manner. That global event, a joint collaboration among the University of Botswana, US Navy Medicine, and the US Uniformed Services University Graduate School of Nursing, was graced by two prominent men of international stature. These were His Grace, the Archbishop Emeritus Desmond Tutu, a renowned Anglican Church cleric and an accomplished anti-apartheid activist; and Vice Admiral Adam Robinson, the US Navy Surgeon General. Simply put, a major goal of US Navy Medicine is to reach out to victims of natural disasters and hazards, such as floods or earthquakes or tsunamis, wherever they occur. The international conference was therefore a meeting point that addressed the goals of both the University of Botswana and US Navy Medicine.

The theme of the conference was Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research. Essentially, this was an educational conference whose stated goal was to bring together practitioners from Botswana and experts in health care, medicine, and research from around the world to discuss issues of integrity and ethics related to these professions. Government officials, military officers, and health industry leaders came together over the three-day conference.
In his welcome remarks, the Vice Chancellor of the University of Botswana, Prof Bojosi Othlhogile, highlighted the core theme of the conference through his observation that “Medical science has led to advancements in knowledge and improvements in health and human life. Yet each day, practitioners in the areas of health care, medicine, and research confront difficult questions that need responses as they seek to conduct themselves in ways that are expected by society.” He continued, “I have no doubt that this conference will add to the overall quality of life of Botswana and Southern Africa.” Batswana* expect that research will be conducted as a public good with the broad aim of raising the quality of life. The country’s leaders look to researchers for the development of innovative ways to face the threats of malaria, cholera, tuberculosis, and various other infectious diseases.

The human element in healthcare delivery, the second major aspect of the theme of the conference, was emphasized by Archbishop Tutu in his presentation of human illness and the fragility of life. In this context, he acknowledged the tremendous global health care challenges facing practitioners but reminded all present not to forget that, above all else, sick people are human beings. “We must remember that people are more than a physical body or a biological machine. We must remember that the people in front of you seeking medical care are complex individuals with a bundle of emotions,” said Tutu.

In a manner that clearly put in high relief the global mission of US Navy Medicine, Vice Admiral Adam Robinson’s keynote address underscored the critical need for global partnerships aimed at meeting common challenges. Articulating this need, Vice Admiral Robinson observed, “In this uncertain world, the United States and other nations have continued to forge greater bonds of trust and cooperation with people and countries around the world to contribute to the common good.” He continued, “It is a common good symbolized by this medical convention, a first of its kind here in Botswana, a truly remarkable gathering of government officials, military officers, and industry leaders to discuss health care issues that we all must meet head on.”

The conference had great significance and direct benefit for the University of Botswana because it addressed the role of science and diplomacy, and discussed opportunities to integrate ethics and integrity into institutional and national policies and programs. A major outcome of the conference was the development of future discussions that will take place between the University of Botswana and various international colleagues, including those from US Navy Medicine, regarding which diverse organizations can collaborate for mutual development and growth.

The national importance of this entire endeavor was articulated by His Excellency, Stephen Nolan, the US Ambassador to Botswana, when he said, “This conference will go a long way to bolstering our already strong relationship with the people of Botswana. It was significant for the University of Botswana to host such a major gathering that brought together so many leading practitioners and thinkers about ethics in health, medicine, and research. The conference put the University on the map and also highlighted the important role played by US Navy Medicine.”

A few organizations contributed to the success of the conference by making donations. These included Botswana Medical Aid Society (BOMAID), Botswana Public Officers Medical Aid Scheme (BPOMAS), Embassy of the United States, Botswana Motor
Prelude

Vehicle Accident Fund (MVA), Standard Chartered Bank Botswana, and Wellcome Trust (United Kingdom).

The Conference Organizing Committee is greatly indebted to these organizations for their financial support. The committee is also very grateful to the University of Botswana in its entirety, US Navy Medicine, and the Uniformed Services University Graduate School of Nursing, conference speakers, chairpersons, delegates and all groups, institutions and individuals who have contributed directly or indirectly towards the success of the conference. Special mention is made of the Office of Research and Development staff, who served as the Conference Secretariat, and the Logistics Team.

* The term “Batswana” refers to the citizens of the nation of Botswana.

References

Opening Keynotes

Human Illness and the Experience of Vulnerability: A Summary and Reflection upon the Opening Keynote by His Grace Archbishop Emeritus Desmond Tutu

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Author’s Note

This paper presents a summary of the opening keynote delivered by His Grace the Archbishop Emeritus Desmond Tutu, who was the Guest of Honor at the international ethics conference held December 6-9, 2009, at the University of Botswana in Gaborone, Botswana. His Grace gave the opening keynote on the morning of Monday, December 7, 2009. His Grace did not read a formal paper; rather, he had a few notes that he referred to during his talk. In that context, this paper is an attempt to reconstruct the talk on the basis of the notes that were provided by his office, what appeared in the media, and the author’s reflections upon the content. The author thanks Ms. Tuma Matose for the notes that form the basis of this paper.

Abstract

In his speech, Human Illness and the Experience of Vulnerability, Archbishop Tutu used his experience, eloquence and humour to emphasize the vulnerability of human beings during illness. The Archbishop emphasized the need for healthcare professionals to realize that patients are not simply numbers or cases, but fellow human beings who are in need of a helping hand.

Keywords: Ethics, vulnerability, poverty, disease and sickness, activism, human dignity, health care.

Summary

Writing this article has been the most challenging yet exciting task that I have ever undertaken. It is exciting because of the stature of the keynote speaker. It is also challenging because, as one of the news correspondents who covered the conference stated, “Archbishop Tutu’s talk, titled: Human Illness and the Experience of Vulnerability, inevitably becomes a fruit salad of sermon, philosophy, health advice, storytelling and comedy.” Although he kept his audience captivated throughout, the Archbishop crisscrossed between themes and meanings, a very interesting presentation but at the same time very hard to capture precisely.
Throughout his career as a cleric in the Anglican Church, Archbishop Tutu, a Nobel Prize laureate and political legend, has had great concern for the plight of the poor. His views were formed as a child growing up in a country governed by the evils and discrimination found in apartheid, the system of government in which people are segregated along color lines. During his early youth, he developed a health condition that deepened his desire to reach out to the sick in society, especially to those individuals made more vulnerable by their socio-economic circumstances. These two influences, apartheid and illness, had a major impact on him as a child, and ultimately as a man who we all know has had a significant impact on how the world views human dignity, the politically disenfranchised, the poor and the sick.

Desmond Tutu began his speech by underscoring the complexity of the human body:

The human body is an amazing organism that shows God's creation at its best. It boggles the mind just to imagine how it functions. We must be thankful that God has blessed some of us here with the ability to understand a good deal of the human body's most arcane workings to be able to help heal some of its malfunctioning organs.

The Archbishop then turned to medicine, which he defined as the discipline devoted to healing human beings through experiences that were acquired over a long period of time, spanning different phases of history. He clearly emphasized that medicine is a combination of science, practice, and art.

He then went on to discuss a different yet related subject; the vulnerability of humankind. He observed that, “the human animal is, by its nature, incomplete and not self-sustaining. We are contingent beings who rely upon the rest of creation and on diverse relationships in order for us to exist and live. We are at best, interdependent and at most, completely dependent.” In other words, we as human beings are open to the forces of nature and the presence of others. Though at times we mistakenly act or believe otherwise, we ultimately cannot control our universe. Part of the experience of human incompleteness and the human experience of lack of control is the reality of vulnerability.

The Archbishop’s keynote continued along this same path regarding the essential vulnerability of the human person. Although we marvel at the awesome power of modern medical science, such as the power to conquer the ravages of disease, prolong a threatened life through the replacement of essential organs and relieve and dignify the pains and discomforts of terminal illness and old age, the danger is that we become blinded to the essential frailty of the human condition. We are perpetually exposed to a wide variety of never-ending factors with which we must cope.

One of the constant dangerous experiences humans confront is illness. Today, we are acutely aware of the overwhelming presence of illness in human life. HIV/AIDS, pandemic influenza, the increase of cancers: these are but three major illnesses that have shaken human society’s false assumptions that we control our universe or that we are invulnerable. Human illness is a subtle reminder that we are not immortal. Our finitude is something that shapes not only the days of our lives, but the images we have of ourselves as individual and distinct persons.

Illness, whether slight or major, creates in the human person an experience of vulnerability and alienation. One theologian colleague has pointed out that the liturgical
theologian Charles Gusmer comments in his work, *And You Visited Me*, that sickness alienates the person from the real world including work, family, and the real or idealized self. It also can create a sense of alienation from God.

Sickness also is a direct challenge to human pride, the kind that often leads us to assume we are in control. More deeply, illness touches our internal fear of finitude and death, sometimes leading us to become people who deny death. Tragically, as “death-deniers,” our fear of being seen as vulnerable and needy leads us, even subconsciously, to want to push away from our eyes and hearts others who are sick because they remind us of what we fear the most. Archbishop Emeritus Tutu gave health practitioners excellent advice:

A patient needs to be handled as a human being worthy of dignity. A patient is not just a case; he is a bundle of anxieties and concerns. A patient has concerns - he worries about death: ‘What will happen to my family if I die? Who will pay the rent? Who will pay the school fees?’ We truly are fearfully and wonderfully made. But we are not just marvelous machines. A great saint once spoke of the paradox of our futile longing for the infinite. The paradox of the finite made the infinite. We long for immortality. We long, in our own mortality, for endless life.

This longing for endless life has also lead to the growth of the kind of science and technology that is devoted to prolonging life or masking the aging process. Tutu quipped, “Many industries have been built solely on the obsession with immortality—from the cosmetics industry’s simple make-up to plastic surgery.”

Turning his attention from science and technology to metaphysics and religion, he addressed a topic he knows well based on his background as a teacher of religious studies at the Universities of Botswana, Lesotho, and Swaziland. Archbishop Tutu noted that in the “Judeo-Christian tradition and other faith traditions… vulnerability, though a base human experience, is not the end for the believer. The experience of vulnerability and alienation are not ‘The End.’” Rather, the Tradition of Faith proclaims that there is something more. In all four of the gospels, the image of Christ on the cross can be interpreted as a proclamation that God loves humankind and the world so much that God decided to embrace fully our experience of vulnerability and alienation as an act of solidarity, an act of pure and unmitigated Passionate Love. While medieval believers such as Anselm of Canterbury reflected that the death of Christ was a type of ransom for our sins, we can perhaps reflect something different.

Out of his own Christian tradition, the Archbishop continued with a contemporary interpretation of some of his basic religious beliefs, namely that the Passion of Christ is a passion that reveals a God who embraces our fear, our fragility, our experience of sickness, death, and the alienation that arise from human illness. The Passion of Christ is a proclamation of solidarity in response to human vulnerability and fear. It is the story of a God who loves us so much as to be everything to us.

This love is exemplified in the familiar parable of the Footprints in the Sand. Numerous depictions of this parable have been shared over the years, and usually depict a pathway created by the footprints of two individuals who are evidently walking side by side in the sand. At some point however, one set of footprints disappears, creating a mystery as to what happened to the person whose prints disappeared. By way of explanation, Archbishop Tutu noted that the remaining footsteps were those of Christ. When the man who was walking with
Christ wondered why his footsteps sometimes disappeared, Christ answered, “My child, at the point where you do not see your footsteps, it was when that I was carrying you because the road was too rough for you to walk.”

Archbishop Tutu further explained this story in the context of the conference’s theme by noting that:

Like the ever-changing cycle of the seasons, life has the soothing warmth of its summers and the piercing chill of its winters. But if one will hold on, he will discover that God walks with him, and that God is able to lift you from the fatigue of despair to the buoyancy of hope and transform dark and desolate valleys into sunlit paths of inner peace.

The listeners were moved by the significance of the parable, even though most had heard the story before. The emotions evoked by his delivery, conviction, and intellect were significant, as was evident by the reaction of the audience. Depicting the Archbishop’s style for touching others, the correspondent of a local paper said:

‘God waited’… then Tutu shuts his eyes, his hands up in the sky, his fists clenched and then he contorts his face in sudden ecstasy, as if something painfully pleasurable is coursing through his veins: ‘God waited until the moment was just right’… Next, the Bishop opens his eyes, which sparkle as if they just discovered something new. ‘It is a remarkable thing if you really think about it,’ he adds, smiling at the stunned faces before him. He holds that smile for a moment, and now all the professors, diplomats and the journalists have momentarily turned into a congregation. Silence. Eyes fixed upon him.

The Archbishop touched on his own life experiences when facing death specifically related to his recent diagnosis of prostate cancer. “I just came out of hospital, taking treatment for this problem.” Clearly shaken by this news, the audience members were transfixed due to the shock of this news and concern for his mortality but also most probably due to the somber prospect of the world waking up one morning to the news that this man, who caressed warring South Africa to forgiveness and some level of healing, has himself succumbed to a mortal illness.

Sensing the audience’s concern, Tutu commented that much of what he was talking about in this speech came to him as he walked out of the hospital after his cancer treatment. The magic of creation is that life is precarious, hanging on a knife-edge from which it could metamorphose into nothingness in a nanosecond. Even though death is always waiting at life’s door, the issue is not to mourn the inevitability of death as such but rather to celebrate the life we have, for we possess that life amidst the impending reality of our eventual demise. Death, therefore, serves to illustrate how special life is, the way hunger explains how special food is, the way that drought explains how special rain is.

A news correspondent who covered the presentation by Tutu observed, “It is an experience watching Tutu after gliding up there in philosophy and theology landing quite expertly onto the topic of the day - the challenges of the health sector in the demanding modern world.”
Reflection

After his speech, the gathering broke for tea. Tutu was mobbed as the people from the head table walked with him. People wanted to touch him, snap a photo, or better yet just be with him. His assistant, a heavy-set man in a suit, highly polished leather shoes, and a ready smile, walked by his side. Dwarfed by the people around him, Tutu, who is small of stature, was visible every now and then, when he slowed down or stopped to laugh, which he did often. The VIPs went to another room where food was being served. Tutu was led to a room where he sat down for a briefing by his assistant while the crowd waited for him outside. Two women waited at the door. They tried to walk in, but they were turned back. The assistant came to the door and let them in. They held Tutu’s hand in turns. They bowed. A few more people walked in and emerged with smiles.

But the crowd would not stop. The assistant raised his hand, palm facing the group. “I want the media folk now,” he announced. Soon I was in Tutu’s presence. He looked smaller than he did earlier. I was more curious about his personal experiences than the business of the day. I discovered that, in 1970, 10 years after becoming a priest, Tutu joined the Universities of Botswana, Lesotho, and Swaziland, the precursor of the present University of Botswana, as a theology lecturer. He was based in Roma, Lesotho. He often came to Gaborone to lecture at the Botswana campus.

He sat back in his chair with hands clasped together, a smile covering his face. “I have returned home,” he started, raising his eyes to look at the ceiling of the giant library building, then at the people walking through the book stalls and the crowd milling about. “When I used to come here to lecture in the Theology Department, it was a ramshackle thing. It had those white walls, what do you call it, this material…” he paused. “Asbestos?” I offered. “Yes, asbestos,” he affirmed. “This is fantastic. This is a different world,” he said, looking around in amazement like a toddler in a toyshop.

Turning his attention from the present physical surroundings to modern Africa, Tutu noted that despite its recognizable progress, Africa faces major challenges, among them HIV/AIDS, unemployment, undemocratic systems, and a lack of education. Young people of southern Africa no longer hold the cultural mores that were evident in his time as a young person. “The simple message you have to tell them is that HIV is not curable, so the best cure for it is to avoid getting it,” he said matter-of-factly.

Tutu has a very simple approach—solving any political problem starts with the recognition that citizens have rights and that they have to be respected. In this spirit, he commented to me that, “If you look at the Zimbabwean situation, it is the Black who is oppressing his fellow Black. In the past, we used to struggle so we could win our freedom from the white man because he was oppressing us, but now the people in Zimbabwe are oppressed by their fellow African. It makes you wonder.”

“Perhaps, it is power,” I offered. He queried in response, “Are Africans the only people with power? In fact, in the world, if you look at it, African leaders have little power. So why should they be the ones most intoxicated with it?”

The man at the door looked at his watch. Once, and then again, he peeped into the room, finally stating, “It is time.” At that moment, the Tutu experience came to an end for me. Or, I thought to myself, has it only just begun for me, and for many others?
Hearing the Cries of the Poor: Healthcare as Human Response

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Editorial Note
This following is the text of the second of the opening conference keynote addresses. This keynote was presented in the afternoon of Monday, December 7, 2009. It was followed by three responses.

Authors’ Note
The author gratefully acknowledges the remote and proximate contributions of CAPT Michael Krentz, CAPT Brian Dawson, CDR Joseph Surette, and the members of his staff in the preparation of the manuscript. The opinions represented are those of the author and do not reflect the official policy or positions of the United States Government, the Department of Defense, the Department of the Navy, or Navy Medicine.

Abstract
The keynote address of Vice Admiral Adam Robinson, Surgeon General of the United States Navy, summarizes the integration of healthcare humanitarian assistance as central to the Navy’s mission of defending and promoting world peace. Citing various examples of current programs and initiatives, the address explores the critical place of human hope as central to the fundamental act of healthcare. In this respect, the keynote gives visible expression to the central metaphor of the conference itself, “Retrieving the Human Face of Science.”

Keywords: Navy Medicine, healthcare, humanitarian assistance, soft power

Keynote
Your Grace Archbishop Tutu, Your Excellencies Ambassador Nolan and Distinguished Leaders of the Government of Botswana and the University, colleagues, students, and friends. It is a deep honor to be with you all today and lead this afternoon’s keynote session. I am honored and privileged to follow Archbishop Tutu’s outstanding presentation this morning. To take part in this special conference with such distinguished leaders whom I have long admired is certainly one of the highlights of my naval career. Thank you for inviting me and for asking me to be part of this important conference.
I am a firm believer that events like this provide each of us with an opportunity to help advance our shared goals and interests. Today’s exchange allows us to speak openly about where we are and, more importantly, where we want to go. As a result, there is a lot of incentive for us to share our opinions and ideas today. Even more importantly, we are here because we want to celebrate a significant milestone for the university and for Botswana.

The University of Botswana has enjoyed a long and distinguished history from its remote origins in 1950, through the establishment of diverse movements a decade later, to the place of honor that the university holds today in this region. You indeed are an amazing community of scholarship and learning.

I am deeply aware of the immense responsibility you continually undertake to serve those who suffer from disease and illness. We are kindred spirits in this partnership as we share an abiding commitment to stretch hands across the water in the solidarity of healthcare. I am in admiration of your leadership to stave off various infectious diseases such as HIV, malaria, cholera, tuberculosis and others. As a physician and as a healthcare leader, I am very conscious of our mutual bond to defend against disease in every nation and every culture, and to bring to everyone not just prevention or intervention, but the joy that comes with quality human living.

In our mutual mission of healthcare, our efforts are achieved when we bring to others a sense of enrichment that touches individuals, their families, their communities, their nations—and in doing so—the world.

We are joined together in this common mission. And this joint mission is why I feel privileged to join you this week and into the years to come, to build with one another a world filled with love, hope, and security founded on the premise of compassionate care for all.

In this uncertain world, the United States, as well as other nations, has continued to forge greater bonds of trust and cooperation with people and countries around the world to contribute to the common good. It is a common good symbolized by this medical convention—a first of its kind here in Botswana, a truly remarkable gathering of government, military, and industry leaders.

This past August, the university’s commitment to medical leadership has taken on a new and profound depth as it has welcomed its first class of medical students. I salute you. I welcome you. I cannot tell you how wonderful it is to be here as a physician and a witness to the passion for healthcare education and leadership as it takes root here. You are delivering this university as a community of hope. Creating this atmosphere of “Hope” is what I would like to speak with you about today.

As the United States Navy Surgeon General, I have the unique opportunity to serve not only my nation, but also humanity. This service is manifested most dramatically in the notion of humanitarian assistance. Because in humanitarian assistance we lend assistance to those people around the world in need. We help them—we bolster security and stability—and, most importantly, WE CREATE HOPE.
Navy Medicine, along with the rest of the United States Department of Defense, realizes that the promotion of world peace is dependent upon more than weapons and/or political alliances. World peace is also dependent upon security and stability. Where there is security and stability, we also find hope. And hope is the essence of what fires our souls and provides light in our world. Hope becomes the beacon that shows us the way from darkness and desolation (abandonment) to light and (community) life.

The United States Navy’s Cooperative Strategy for 21st Century Seapower serves as an example of this light/beacon. This strategy is a beacon that shows just how important are military forces and trained health professionals around the globe to the international order.

This strategy promotes security and stability; but it also serves to establish hope and prosperity by emphasizing “soft power”—the power of humanitarian assistance that serves to provide training, education, and security for all and in so doing establishing an infrastructure of health, wellbeing, and contentment that are the necessary ingredients of hope. For only in hope can we build the foundation of respect and tolerance that becomes crucial in establishing and maintaining world peace. If you will allow me, I would like to serve as the catalyst for that discussion, by giving you my perspective on the subject.

First and foremost, our people expect their military forces to remain strong. They want us to protect them and our homeland, and they want us to work with partners around the world to prevent war.

Nothing threatens world security and prosperity like war. Our new strategy says that it is as important to prevent war, as it is to win war.

To prevent war, we must attack the seeds of instability and hopelessness where they exist. Human suffering moves us to act, and the expeditionary character of our maritime forces uniquely positions them to provide assistance as the vanguard of interagency and multi-national efforts. While we still train our forces to fight and win our nation’s wars alongside our allies, we have adopted a serious focus on humanitarian assistance and disaster response to help those in need to attack instability and insecurity, so that we help our partner nations create conditions where hope can flourish.

This recognition has resulted in the increased focus on the importance of proactive humanitarian assistance operations. Yes, we have been involved in these types of missions since our beginnings, but they were done in a rather ad hoc manner. As a result of our newest maritime strategy, we now have elevated these important missions to the same level of importance as war fighting. We now actively train and equip our maritime forces to perform this important mission that brings about partnerships as well as fundamental and meaningful relationships resulting in hope.

Our Navy-recruiting slogan reflects the importance of this new course we have set for ourselves. We refer to our Navy as a “Global Force for Good,” and we have found this message has resonated among our nation’s youth.
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You see, the ultimate mission of our United States Navy is simple: To defend those who cannot defend themselves. Arising from this spirit, United States Navy vessels over the centuries have been the mechanism that the American people have used to extend themselves outward to help others in need. Wherever there has been poverty, famine, disease, war, injustice, or danger, the people of the United States have launched Navy vessels to provide protection, food, clothing, healthcare, and the compassionate care of young Sailors lending a helping hand and heart to those in need of safety and security. Whether it has been in Indonesia after the tsunami, or helping the people of New Orleans after Hurricane Katrina, this is the platform of selfless service from which Navy Medicine will always build its mission around the world. This is the meaning of humanitarian assistance—protecting others even when it places us in harm's way—extending ourselves for the benefit of those in need.

As Surgeon General, I lead Navy Medicine every day in putting a human face on the words “humanitarian assistance.” Navy Medicine is not only willing and able to participate in these missions; we do so enthusiastically. Our healing hands symbolize soft power, which forges stronger relationships with other nations and lessens the chances of armed conflict. By doing this, humanitarian assistance missions enhance the protection of our homeland and way of life.

Let me illustrate my point of the importance of these missions by relaying a story from the devastating earthquake that hit Pakistan in 2005. Thirty days after the Kashmir earthquake hit the isolated, mountainous region of Pakistan-administered Kashmir, an injured man hobbled into a United States disaster relief hospital near Muzaffarabad*, approximately 12 miles from the quake's epicenter.

He said he had followed the “Angels of Mercy,” the local Pakistani-nickname for the U.S. Navy helicopters that were making countless runs every day—day after day—to provide food, medicine and supplies while shuttling people back and forth to safety. Somehow this man got down off the mountainside, hobbled in and walked past all the other hospitals to get to us. He had a compound fracture of his leg and our doctors could not believe that this man could travel so far with this injury. They immediately took him into surgery; they were there for hours just trying to cleanse his bones. I am pleased to report that he survived, with his leg.

That is just one story in a calamity that claimed the lives of more than 75,000 men, women and children while leaving another 100,000 injured and 3.5 million homeless in one of the most isolated and desolate areas of Pakistan.

This was certainly an area where hopelessness was flourishing.

Our naval forces arrived there within 48 hours after the earthquake hit and got to work to help alongside other United States and international agencies under the guidance of the United States Ambassador to Pakistan.
We brought a hospital with medical capabilities—including orthopedic, general surgery and internal medicine assistance—and worked with the government of Pakistan to provide food, supplies and medical assistance. We also sent another self-sustaining land-based hospital and 125 engineers from Naval Mobile Construction Battalion 74 (Seabees) who immediately cleared roads, set up shelters, and built schools.

Prior to this earthquake, more than 80 Pakistani healthcare facilities existed in this area; however, the event destroyed all but two, and they could barely operate.

The villagers were not used to the quality and scope of American medical care. Among other things, we brought in a Navy hospital from Okinawa. We had 2 surgical suites, 24 intensive-care-unit beds, 36 medical-surgical beds and 60 medium-to-minimal-care beds.

Humanitarian assistance is so important because it has a powerful impact on people, on relationships and an understanding of our American values. According to estimates, our relief and follow-up efforts saved half a million lives in Pakistan during this mission, which led to overall improved relations and trust with the country itself. Through our humanitarian assistance missions, we learn about one another, and in so doing we develop relationships—relationships on a personal level, professional medical relationships, military-to-military relationships, and relationships between our governments.

From relationships comes the concept of trust—a reliance on integrity, strength and surety—and the ability to have confidence in one another.

Trust is vital. While our naval forces can be surged, trust cannot. Trust is built over time, through dialogue and working together on common goals. Cooperation and trust built in times of calm become the major building blocks for effective crisis response when it is needed. Many of us saw this first hand during the tsunami relief effort in South East Asia over three years ago. We were able to have a tangible impact on human suffering arising from that horrible and devastating event. Ships designed for battle provided help to people in need as our forces responded without hesitation, with the kind of enthusiasm that arises when the mission involves rendering assistance to fellow human beings.

Responses such as this require an unprecedented level of integration among our military forces and enhanced cooperation with the other instruments of national power, as well as the capabilities of non-governmental agencies and others. By sustaining dialogue and understanding, we can build confidence and trust, whether in formal alliances, partnerships or simple exchanges of information. This is the essence of providing care and assistance and enduring security and stability. This is the foundation of establishing world peace.

Today, our ships and Sailors are engaged in proactive humanitarian aid missions all over the world—from South America to the Pacific to the West Coast of Africa. These humanitarian engagements are now part of our normal routine, and Navy Medicine is a vital part of this mission.
Opening Keynotes

We support regional humanitarian operations by providing preventive medicine services, healthcare training, and other similar efforts, while always respecting the host country’s culture and customs. From our experience, we have developed a successful model of healthcare education and training for host country providers. This will lead to local sustainable activities that will provide long-lasting benefits to help overcome healthcare barriers in resource poor communities.

Please allow me to highlight a few of our recent missions:

1. In 2007, the amphibious ship, USS *Peleliu*, conducted a 4-month humanitarian mission called “Pacific Partnership,” visiting the Philippines, Vietnam, Solomon Islands, Papua New Guinea, and the Republic of the Marshall Islands. During this mission, Peleliu provided a variety of medical, dental, educational and preventive medicine services to more than 31,600 patients.

2. In 2008, the hospital ship, USNS *Mercy*, also participated in “Pacific Partnership,” serving as a platform for military and nongovernmental organizations to build and cultivate relationships with the Republic of the Philippines, Vietnam, the Federated States of Micronesia, Timor-Leste, and Papua New Guinea. This mission treated more than 90,000 patients. Among those treated were more than 14,000 dental patients and more than 1,300 surgery patients in various locations throughout the Western Pacific.

3. Our other hospital ship, USNS *Comfort*, deployed this past April to participate in “Continuing Promise 2009,” a 120-day mission to South and Central America. The ship traveled to Haiti, the Dominican Republic, Antigua and Barbuda, Colombia, Panama, El Salvador and Nicaragua, spending between 10 to 12 days in each port. During the course of the deployment, our medical teams treated more than 100,000 patients, completed 1,657 surgeries, dispensed 193,961 prescriptions, 30,785 pairs of glasses and 11,940 pairs of sunglasses. The dental department extracted 4,444 teeth and treated more than 15,000 people. The local animal population was also seen by ship's veterinarians, who treated 13,238 animals. Both domestic and farm animals were seen for a variety of medical issues.

4. Early in the year, Navy Medicine Reservists participated in four medical readiness training exercises in Jamaica, Honduras, Dominican Republic, and Guyana. These two-week deployments provided primary care at remote locations in conjunction with the Ministry of Health of each host nation.

Each successful mission, performed with joint and coalition forces, other U.S. government agencies, non-government agencies, and host nations, builds strong and lasting partnerships. From the foundation of mutual respect and understanding grow the best quality healthcare and partnerships. This environment of trust between U.S. military services, agencies, and our international partners is the legacy of these humanitarian missions and helps secure our future.
Our humanitarian assistance efforts continue, with missions planned and underway. Our hospital ships, Mercy and Comfort, have been invaluable assets in this role as they are unobtrusive and neutral. They are all about compassion. We offer humanitarian assistance because, when you look at human compassion on a global scale, this is an opportunity for us truly to help people in need.

We are now implementing a wide range of programs in Africa as well that are preventive in nature and are designed to help build capacity in the African nations, so that they can have a better chance of providing for their own security, as they have expressed a will and a desire to do. The Navy is proud to be a part of those efforts throughout the continent. We seek to be a friend to the continent of Africa, its nations and its institutions. All of our efforts focus on adding value to our engagement efforts and neither disrupting nor confusing ongoing United States government and international programs.

Many of you may have also heard of our African Partnership Station mission that has maintained a continuous rotation of ships throughout West African/Gulf of Guinea countries to help build capacity training with local African forces to help bolster maritime security in this important region. This effort has now been expanded to include countries in South and Southeast Africa.

We take a proactive and forward-looking stance to ensure that the partnerships we build today last well into the future and that they are relevant for meeting the goals set by our government as we partner with the nations of Africa. We will continue to support our U.S. government partners and civil military activities. These activities not only provide outstanding training and experience for those in our military communities such as doctors, engineers, and veterinarians, they support African humanity and capacity building and bring goodwill to the African people.

I am proud of this work. Our strategy focuses on opportunities—not threats; on optimism—not fear; and on confidence—not doubt.

It recognizes the challenges imposed by the uncertain conditions in a time of rapid change. Furthermore, it recognizes the incredible responsibility each of us has in working together on common objectives. We will not always agree on words; but we must always agree to talk. I believe we have entered a new era, one in which our countries, in forging bonds of friendship and cooperation, can lead the way to a time of peace, prosperity, and security.

It has indeed been a pleasure to be here to recognize the importance of Botswana and the commitment of the United States to forge a stronger relationship with one of Africa’s most important and dynamic states.

Thank you again for this opportunity to speak with you today.

*Muzaffarabad is a town in northwest Kashmir, at the confluence of the Jhelum and Neelam rivers. It is the chief city and capital of Azad Kashmir, which is administered by Pakistan. Muzaffarabad is a trading center. Much of the city was destroyed by an earthquake in 2005.*
Character, Leadership, and the Healthcare Professions

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Editorial Note
This following is the text of the first of the conference’s distinguished lectures. This lecture was presented in the morning of Tuesday, December 8, 2009. A panel and general delegate discussion followed.

Author’s Note
The author gratefully acknowledges the contributions of Ms. Rose Ciccarelli in editing the manuscript. The opinions represented in this text are those of the author and do not reflect the official policy or positions of the United States Government, the Department of Defense, the Department of the Navy, or Navy Medicine.

Abstract
The presentation by Elizabeth Holmes, PhD, summarized the integration of character and leadership development in the education of healthcare professionals. Citing the mission, vision, values, graduate attributes, and various examples of current programs and initiatives from both the United States Naval Academy and the University of Botswana, the presentation explained the importance of professional development based on ethical leadership and courageous moral decision making. In this regard, this distinguished lecture gave visible expression to the conference title, “Understanding Ethics and Integrity in Healthcare, Medicine, and Research.”

Keywords: Ethical leadership, healthcare, profession, moral decisions

Introduction
Mr. P. Khulumani, Director of the Ministry of Health, Botswana, Your Excellency Ambassador Nolan, and distinguished leaders of the Government of Botswana and the University, colleagues, students, and friends:
It is a deep honor to be with you all today and lead this morning session. I am honored and privileged to follow Archbishop Tutu’s outstanding presentation. Like him, I feel “a little bit breathless” to speak in front of such an audience. Thank you for inviting me and asking me to be part of this important conference.

I invite you to join me this morning on a transformative path of professional growth. Let us together travel the journey outlined by the United States Naval Academy (USNA) and University of Botswana (UB) to becoming leaders of character.

**Mission and Vision**

What could the United States Naval Academy and the University of Botswana have in common?

Each has a timeless mission: At the USNA, it is “to develop midshipmen morally, mentally, and physically and to imbue them with the highest ideals of duty, honor, and loyalty in order to graduate leaders who are dedicated to a career of Naval service and have potential for future development in mind and character to assume the highest responsibilities of command, citizenship, and government.”

The vision at the USNA is to provide leaders of great character, competence, vision, and drive to transform the Navy and Marine Corps and serve the nation in a century of promise and uncertainty.

The mission of the UB School of Medicine is “to prepare skillful, productive, ethical, and compassionate physicians who advance and apply in humanistic and professional manner scientific discovery and technological innovation to health care needs of individual patients, their families, and larger societal groups.” Specifically, the University of Botswana states that it will “provide excellence in the delivery of learning to ensure society is provided with talented, creative, and confident graduates.”

To achieve its vision, the University of Botswana values its students, as is shown by its pursuit of “creating a holistic environment which ensures that learning is their central focus and by establishing a range of learning, social, cultural, and recreational opportunities that will facilitate the full realization of their potential for academic and personal growth.” The University of Botswana also values “cultural authenticity by ensuring that the diversity of Botswana’s indigenous values and cultural heritage forms an important part of the academic and organizational life of the institution.” Clearly, culture plays an important role in all human interactions. Isn’t it interesting that both the University of Botswana and the Naval Academy are invested in the importance of valuing culture?

**Curriculum for Developing Ethical Leaders**

Midshipmen learn about ethical leadership at the USNA through a combination of classroom instruction, personal learning, and professional interactions. The goal is for midshipmen to understand leadership and what it means to be a leader of character. During their four years, midshipmen study leadership, human behavior, ethics, law, and character, along with individual, group, and organizational behavior.
In their first year, midshipmen learn about organizational dynamics and how to lead themselves. The following year, they focus on ethics and moral reasoning for the military leader. In their third year, midshipmen take a class on leadership theories and applications. In their final year, the classroom training focuses on law for the junior officer and technical skills for their selected service.

Midshipmen attend the Capstone Moral Leadership Seminar their last year. It is their final academic opportunity to discuss and apply concepts related to leadership, character, and ethics learned over the previous years before they leave the USNA for the fleet. In this seminar, midshipmen are also exposed to Last Call, an interactive simulation that teaches ethical decision-making. Last Call can be downloaded on the web at www.usna.edu/ethics.

**Graduate Attributes and Professionalism**

What else do both academic institutions value in their graduates? Each school has identified nine desired attributes. At the USNA, graduate attributes include: to be prepared to be role models of ethical behavior and moral conduct, to be courageous leaders who take responsibility for their personal and professional decisions and actions, and to be leaders who recognize and value individual excellence regardless of gender or cultural and ethnic background. The UB aims to create graduates who are “independent, confident, self-directed, critical thinkers, professionally competent, reflective parishioners, innovative, socially responsible, and thereby marketable and competitive nationally and internationally.”

Along with a degree, the USNA graduate receives a commission into either the Navy or the Marine Corps. Borrowing from the work of Samuel P. Huntington, officership as taught at the Naval Academy is the practice of being a commissioned Naval officer inspired with a unique professional identity that incorporates four interrelated roles: warfighter, servant of the nation, member of the Naval profession, and leader of character.

Similarly, upon graduating from the UB School of Medicine, the title Medical Doctor will be bestowed. The graduate enters a profession where the practice of being a licensed physician or nurse or dentist brings a unique professional identity that incorporates four interrelated roles: medical expertise, servant of the nation, member of the profession, and leader of character. Professionalism is at the heart of the healthcare profession. A profession is seen as a special type of vocation when it includes expertise, responsibility, and corporateness. I would also add a fourth — as both the Naval Academy and the University of Botswana do: leader of character.

The medical professional is an expert with specialized knowledge and skill. Expertise is acquired through prolonged education and often painful experiences. Institutions of advanced education and research are required for the extensive learning and transfer of that information. Continued professional contact is evidenced by ongoing education in the form of journals and conferences. The healthcare professional is a practicing expert, working in a social context, performing a public service, such as promotion of health, which is imperative for the public good. The medical profession as a whole is a moral entity based on self-imposed professional ethics and inspired by identified values that guide its members. The members of the healthcare profession share a strong sense of group consciousness. This bond of dedicated work and social concern is illustrated by the members’ professional organizations and clear levels of competency. Being a professional is a lifelong calling.
How do we describe leaders of character in a profession? Leadership is the process of influencing others to accomplish a goal. Character is composed of those moral qualities that make up the nature of a leader and shape his or her actions. The leader of character seeks the truth, does what is right, and demonstrates the moral courage in the face of adversity to act accordingly. Becoming a leader of character, according to VADM James B. Stockdale, entails setting noble goals of great moral worth, taking active steps to pursue those goals, being willing in pursuit of those noble goals to accept costs and pay the price personally, and being willing to ask, even order, those close to you to accept similar costs and to pay a similar price. In *Thoughts of a Philosophical Fighter Pilot*, Stockdale wrote, “We as warriors must keep foremost in our minds that there are boundaries to the prerogative of leadership: moral boundaries… failure of leadership’s nerve and character are terminal, catastrophic…”

**VADM James B. Stockdale Center for Ethical Leadership**

Our mission is to “empower leaders to make courageous ethical decisions.”

What characteristics make good leaders? The literature on leadership suggests that good leaders share the following attributes:

1. Self-knowledge: They know their own strengths and weaknesses and can live in their own skin.
2. Consistent behavior: They have a steady, predictable manner.
3. Ability to communicate: They do not under-communicate as most people do.
4. Compelling vision: They have a magnetism that inspires and energizes people.
5. Act as agent of change: They understand that change is constant.

In the final analysis, good leadership comes down to these four C’s:

1. Competence: Good leaders are committed to being good at what they do.
2. Confidence: People want to know what their leaders think, and those leaders have enough desirable self-confidence to communicate their perspective.
3. Caring: People need to know and feel that their leaders care about them.
4. Challenge: Good leaders perceive problems as challenges, not obstacles.

What would help leaders to make courageous ethical decisions? Leaders need a practical, pragmatic tool for making moral choices. They need a systematic way to recognize issues, decide what to do, and then act on their intentions, particularly when there is no time for reflection.

**Teaching Ethical Decision Making**

Several years ago, I started to explore the idea of using interactive multimedia simulations as a way to develop courageous ethical leaders. Research on the subject found that ethical decisions are influenced by moral intensity. Thomas Jones (1991) identified four moral intensity factors that affect decision making. These variables influence people in varying degrees, based on the power of the situation. The first factor is social consensus, what we believe our group thinks about the moral dilemma. The second factor is proximity, or the cultural, physical, psychological, or social nearness of the decision maker to those affected.
by the moral decision. The third factor, magnitude of consequences, refers to the degree of harm or benefit from the decision-maker’s action. The last factor is probability of effect, or the likelihood that harm or benefit will occur. The moral intensity of the situation increases as the magnitude and probability of effect increase.

James Rest (1994) pioneered a four-component approach to decision making, which combines cognitive-development, social, behavioral, and psychoanalytic perspectives. Rest asserts that, when confronted with an ethical dilemma, individuals move from moral awareness, the recognition of a moral situation; to moral judgment, the evaluation of choices and outcomes; to moral intention, choosing how one intends to act; and lastly to moral action, the actual behavior in the situation. A failure at any place in the process could result in a failure to make an ethical decision.

![Ethical decision-making model](image)

**Figure 1.** Ethical decision-making model.

In the first step, there is gut-level recognition that the situation is morally charged. Moral emotions such as anger, fear, shame, or empathy are aroused. The decision-maker’s gut is answering the question: “Is there something wrong here?” Is a person, community, or ideal at risk? Is there a dimension of right and wrong here, or are competing values at work?

Assuming that the situation raises an ethical issue, the next step is to weigh various rational options. The aim is to distinguish right from wrong, better from worse, and between competing obligations. The decision-maker is also weighing possible actions. These kinds of questions may be asked:

1. What action produces the most good and the least harm?
2. What action respects everyone’s rights and dignities?
3. What action treats everyone equally—or if not equally, then at least proportionately and fairly? How would I want to be treated?
4. What kind of person will I be if I act or do not act in this situation?
The next step is to decide what to do or not do. Deciding what to do also means marshaling the courage to act, often in the face of great opposition.

Sometimes, people can recognize an ethical dilemma, decide “the right thing to do,” resolve to act, and yet do not. The power of other people present is a common explanation used for failing to act morally. In this last step, a person carries out his or her decision, in spite of opposition or possible consequences.

We validated these theories with research on populations of midshipmen and Navy chaplains. The next step was to develop a systematic way in which people could recognize issues, decide what to do, and then act on ethical dilemmas, particularly under stressful conditions. Our approach was to combine an interactive multimedia simulation with a practical, pragmatic model for making ethical decisions in real time.

The Stockdale Center has produced a DVD library of five simulations with a selection of moral dilemmas. Midshipmen, enlisted, and junior officers encounter many situations that have ethical dimensions, and they learn a systematic, logical process to help resolve these dilemmas. Because the situations often involve universal issues—such as fairness, truth-telling, determining how to deal with inappropriate behavior—ethical decision-making skills learned in a realistic computer environment can be applied to real-life situations. Participants can practice making hard choices and face possible consequences in a safe cyber-environment.

How do these simulations work? Imagine that you are playing a character and immersed in a realistic world that you see on your computer screen. Your peers in this world look to you as a social leader. You're presented with a situation that you sense has moral and ethical dimensions. Maybe there's a party where underage girls attend. Maybe you discover a possible sexual assault. Maybe your best friend is asking you to go along with a deception. Maybe your ambition places your future in jeopardy. Whatever the situation, you're faced with a series of decisions. Because the simulation is interactive, every choice you make spins the narrative off in a different direction. Each choice or combination of choices brings ramifications and consequences. You can experience how your decisions affect the outcome. The first time you grapple with the scenario's dilemmas, you do so instinctively, without guidance, hoping for a positive outcome.

A tutorial accompanying the simulation then provides the guidance. Each of the simulations comes with a practical, step-by-step model that walks you through a decision-making process, going from moral awareness through moral action. After this tutorial, you have the opportunity to return to the scenario and experience it again, applying the steps in the tool to work your way through the dilemma.

Learning to apply an ethical leadership decision-making model assists the learner in developing the moral “muscle memory” required in high-stress, morally ambiguous situations. Difficult ethical decision making becomes easier when it is built on a foundation of ongoing practice. Learning to walk the steps from moral awareness is an indispensable skill for an ethical leader.
Lectures

We have been able to teach ethical decision making, using cutting-edge technology developed by Will Interactive, an award-winning producer of interactive educational technology. Will Interactive is a pioneer of a new genre of education and entertainment media known as the virtual experience and has trademarked the virtual experience immersive simulation (VEILS) system. Over the past four years, using interactive simulations combined with an ethical decision-making model has yielded positive quantitative and qualitative assessment results. More than 5,000 future Naval officers have learned to be better ethical leaders through this engaging educational technology.

Conclusion

The shared wisdom in Botswana about patients and doctors provides its own take on ethical decision making. Julie Livingston writes in *Debility and Moral Imagination in Botswana* that the “essential character of each Tswana person is unique….” She goes on to highlight each chapter with a Setswana proverb that I found also applies to each step in ethical decision making.

Moral Awareness: “Pelo e ntle ke leswalo la motho.” = A good heart is the medicine of a person.

Moral Judgment: “O se tshege o oleng, mareledi a sale pele.” = Do not laugh at the fallen; there are slippery places ahead.

Moral Intention: “O re go lemoga ngaka le bolwetse o bo lemoge.” = If you are too smart to pay the doctor, you had better be too smart to get sick.

Moral Action: “Moeng ngaka, o sididila babobodi.” = A visitor’s arrival, like a doctor’s, heals the sick.

So we have journeyed through the process of becoming a leader of courage in a noble profession, whether that profession is officership or healthcare. What a journey! I have condensed more than four years of education and professional development into one hour. Finally, I’d like you to reflect on the following: What are your own core values? What are the attributes you want to develop? What is your life mission? Do you want to be a leader in your chosen profession? Will you develop your moral muscle and be a courageous ethical decision maker?

I leave you with a Jane Adams quote. She was a pioneer social worker, a feminist, an internationalist, and Nobel Peace prize winner. Jane Adams said, “Action indeed is the sole medium of expression for ethics.”

Thank you again for this opportunity to speak with you today.
References


The Tradition of Mentoring  
Part I: Mentoring the Researcher

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Editorial Note
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Author’s Note
The opinions in this text are those of the author and do not reflect the official policy or positions of the United States Government, the Department of Defense, the Department of the Navy, or Navy Medicine. The author is indebted to the mentorship and contributions of thought and substance to many of the concepts provided to this lecture by CAPT David Harlan, MC, US Public Health Service.

Abstract
This text is a summary of reflection points and notes from Part I of a two-part lecture on the Tradition of Mentoring. In this lecture, basic historical concepts on the origins of mentoring were reviewed. Of particular importance were several reflections concerning how effective mentoring differs from other forms of leadership and training in the professions.

Lecture Summary and Reflections

Origins

Although the term mentor is used widely in a variety of implied connotations, few understand its history and the context of its classical definition. It is this definition that provides the basis for creative freedom to spawn the purest of scientific research, well supported by ideas already tested.

Mentor comes to us from the reservoir of Greek mythology, where the story is told of Odysseus as he prepares to leave for the Trojan War. He entrusts Mentor, his closest friend,
with the primary responsibility of guiding and developing masteries in his son, Telemachus. During the course of the story, Athena, the goddess of wisdom and a particular patron of Odysseus, comes to Telemachus to pass on the gift of wisdom. At that time Odysseus had been at war for over 10 years, so suitors were pursuing his wife, Penelope, in an attempt to convince her that her husband was dead. As a result, Athena, finding herself the target of collateral attentions, needed to protect herself from these suitors, who were always nearby. She therefore took on the form of Mentor, who the citizens knew to be training Telemachus. In becoming Telemachus’ mentor, Athena provided him with wisdom, the inspiration to learn of his father and to emulate him in providing protection for his mother. Interestingly, what arises from the story is that Mentor (Athena) seeks to instill in Telemachus a sense of protecting that which is good and learning that which is best. It is a story of teaching someone to prevent harm and advance the good.

Where this classical definition is retained in modern use, the term mentor implies a trusted friend, counselor, or teacher—one who is more experienced and who may have a traditional opinion, but tests the application of divergent opinions through elaboration, as they develop, in the mind of her or his protégé.

Examples from Philosophy

The three greatest philosophers, writers, and scientists of all time—Socrates, Plato and Aristotle—were in direct lineage of a mentoring thread. Socrates mentored Plato, who mentored Aristotle. We do see differences in the philosophical treatises of these three great figures, however, so it goes without saying that mentoring does not equate with copying or developing sameness. Instead, mentoring is a determinant of discipline and the ability to apply knowledge to skill.

For example, Socrates, Plato’s mentor, held in highest priority ethics, the ironic method of teaching and adherence to truth, in its most unloaked clarity. He employed the teaching method of illustrating, which is akin to parable telling, but used actual fact in demonstrating a poignant twist of motive, cause and effect.

Plato subsequently led the development of what we know as Western Philosophy. Although he was like a conjoined twin to Socrates, he did not copy his mentor. Instead, he expanded and developed the concept of applied ethics and the application of logic while suggesting that the basis of what was true in this world, from which logical explanations were to be based, was a portion of gifting from the higher beings or gods.

Aristotle, in turn, could never be accused of copying Plato as he stirred the origins of the scientific method by promoting the value of the empirical rather than accepting what is as a gift from on high. While he applied the ethics and morality of Socrates and the logic of Plato, his use of science and empirics was his own. He went on to develop the application of these concepts into politics and metaphysics. He did not believe that one waited for the passive expression of science and empirics, but vigorously espoused scholarship.

A fourth great figure in the ancient world of Greek and Macedonian civilization was Alexander the Great. This astounding military leader was mentored by Aristotle who, after 10 years,
realized that had had completely “filled” Alexander with his formulas, and so passed him on to Leonidas for further mentoring. This transference exemplifies wisdom, as it suggests that mentors must recognize when they have contributed all they can to their protégé’s experience, then pass them on to individuals who can nurture the progression of new skills.

Other Historical Examples

Among other ancient and contemporary examples that are valuable to recall:

1. According to biblical record, Elijah mentored Elisha. In the traditional mentoring process, the protégé typically selects her or his mentor, but in this case Elijah chose Elisha. This relationship endured multiple tests following its inception; Elijah tries to send Elisha away, but he does not wish to go. This example, the reverse of what we customarily experience today, suggests a healthy maturing of the mentor-protégé relationship.

2. Near the end of the Middle Ages, both the nature of education and the approach to mentoring changed. The Renaissance, Reformation, and Counter-Reformation were volatile periods. As the development of scholars was no longer bound to one or another religious denomination, we find examples of mentoring that resulted in extremely fruitful intellectual development. We see the introduction of the concept of universal opportunity for development of intellectual capability of the masses. This change developed in part thanks to the mentoring of Jan Amos Komensky by the advocate and Irish Jesuit William Bathe, Johann Piscator, Heinrich Gutberleth, and Heinrich Alsted. So effectively did Komensky apply this method of mentoring students who came from the masses, that he was later persecuted under the Counter Reformation.

3. Johann Sebastian Bach mentored his son, Johann Christian Bach. He in turn mentored Mozart, 21 years his junior, by offering to this recognized genius the same “head start” his father had provided him.

4. Freddie Laker, the founder of discount air fares (unheard of at the time he promoted them) mentored Richard Branson, the multi-billionaire who not only has championed more realistic airfares but combined them with superior and innovative service and accoutrements.

5. The Tour-de-France champion, Eddy Merckx, mentored the record-shattering Lance Armstrong.

6. Dr. Steve Brodie, an internationally lauded scientific genius in neuropsychochemistry, mentored Drs Erminio Costa, Julius Axelrod, Candace Pert, and Sol Snyder in his laboratory. While Dr. Brodie was never so recognized, all four of his protégés were nominated for the Nobel Prize in Science and one, Julius Axelrod, won this honor. This example suggests that mentorship can be broadcast rather than dependent on some magical chemistry or a unique fit between mentor and protégé.
The Relationship of Mentors and Mentees: Convergence and Divergence

Are mentors both friends and friendly? Not necessarily, but they do care about the mentee. For example, Sir William Osler mentored Drs. Ochsner and Cushing, and Gertrude Stein; Robert E. Lee mentored Generals Jackson, Stewart, and Longstreet.

Vince Lombardi, coach of the Green Bay Packers, mentored football stars, including Bart Starr, Paul Hornung, Bill Curry, and Jerry Kramer, who was quoted as saying, “Lombardi treated us all the same, like dogs.” Willie Davis, another of Lombardi’s protégés, said after both his father and Lombardi had passed away: “I loved my dad and think of him often. I think of Coach Lombardi every day.”

It is important to understand how role models, teachers, and mentors differ.

Table 1. The Differences Between Role Models, Teachers, and Mentors

<table>
<thead>
<tr>
<th></th>
<th>Role Model</th>
<th>Teacher</th>
<th>Mentor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Function</td>
<td>An ideal to which one can aspire</td>
<td>Transmits knowledge</td>
<td>Guides a protégé to learn attitudes and difficult skills</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Moral/ethical rectitude, courage, vision, energy</td>
<td>Empathy, the ability to “engage,” subject matter expert, selflessness</td>
<td>Moral/ethical rectitude, empathy, experience, honesty, selflessness</td>
</tr>
<tr>
<td>Visibility</td>
<td>Often famous, well-known within the community</td>
<td>Often anonymous</td>
<td>Variable recognition within and outside the community</td>
</tr>
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</table>

The role model does not rely on a direct interaction with a student. Others may spontaneously wish to emulate the role model without the latter being aware of them at all. Mohandas Gandhi and Theodore Roosevelt are leaders who have been recognized as role models but not mentors.

The teacher, on the other hand, is in contact with, and directly influences, the student over a defined period, during which the mentoring relationship achieves variable clarity, dependent to some degree on the success of the didactic process. Almost immediately following this educational period, there is very little if any continuation of the mentoring process. Both mentor and mentee diverge, though not without a lasting impact.

Some Points for Reflection

Cartoonist Charles Schulz produced the following two tests to reflect the effectiveness and durability of various people who have influence over others:

Test #1
1. Name the world’s five wealthiest people.
2. Name the last five Heisman trophy winners.
3. Name the last five Miss America contest winners.
4. Name ten people who have won the Nobel or Pulitzer prize.
5. Name the last half dozen Academy Award winners for Best Actor and Actress.
6. Name the last decade’s worth of World Series winners.

Test #2
1. List a few teachers who aided your journey through school.
2. Name three friends who have helped you through a difficult time.
3. Name five people who have taught you something worthwhile.
4. Think of a few people who have made you feel appreciated.
5. Think of five people you enjoy spending time with.
6. Name half a dozen heroes whose stories have inspired you.

The lesson inherent in Schulz’s tests is that the people who made a difference in your life are the ones you knew cared about you.

There are also lessons to be learned wherein role models, leaders, and mentors share equal effectiveness. Consider, for example, the concept of humility noted by Mohandas Gandhi, who said, “It is unwise to be too sure of one’s own wisdom. It is healthy to be reminded that the strongest might weaken and the wisest might err.”

Likewise, Alexander Hamilton, a well respected leader, said,

“In common life, to retract an error, even in the beginning, is no easy task. Perseverance confirms us in it and rivets the difficulty… To this, we may add that disappointment and opposition inflame the minds of men and attach them still more to their mistake.”

Sir William Osler identified “That greatest of ignorance – the ignorance which is the conceit that a man knows what he does not know.”

In 1907, Osler addressed the Congress of American Physicians and Surgeons, saying:

The limits of justifiable experimentation upon our fellow creatures are well and clearly defined… For man absolute safety and full consent are the conditions which make such tests allowable. We have no right to use patients entrusted to our care for the purpose of experimentation unless direct benefit to the individual is likely to follow. Once this limit is transgressed, the sacred cord which binds physician and patient snaps instantly. Risk to the individual may be taken only with his consent and full knowledge of the circumstances… Enthusiasm for science has, in a few instances, led to regrettable transgressions of this rule.

A hallmark of mentoring in medicine and clinical research is the philosophy, “primum non nocere,” or “first, do no harm.” In many cases, the ends do not justify the means.

Sir Thomas Huxley, also a revered mentor, wrote, “Sit down before fact as a little child; be prepared to give up every pre-conceived notion; follow humbly wherever and to whatever abyss nature leads, or you shall learn nothing.”
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Character and courage are common threads shared by leaders, role models, great teachers, and mentors. George Washington said, “Labor to keep alive in your breast that little spark of celestial fire called conscience,” and Abraham Lincoln declared, “To sin by silence when we should protest makes cowards of men.” The Reverend Martin Luther King, Jr. noted that, “In the end, we will remember not the words of our enemies, but the silence of our friends.”

The appropriate selection of the mentor, the responsibilities of the parties and the process of assessment, communication and bilateral benefit, are inherent if the following sequence is applied:

- Recruitment
- Selection
- Training the mentor
- Matching
- Contact
- Building the relationship
- Outlining of roles and tasks
- Communication
- Assessing and addressing discovered needs
- Strategy formation and adjustment
- Mentoring of the mentor
- Recognizing that there may or may not be an end

The value of mentoring lies in its potential to avert the situation described in this poem:

I DON’T KNOW

There is something I don’t know,
That I am supposed to know.

I don’t know what it is I don’t know,
And yet I am supposed to know it.

And I feel I look stupid if I seem both not to know it—
And not to know what it is I don’t know

Therefore, I pretend to know it.
This is nerve-wracking since I don’t know
What I pretend to know,
Therefore I pretend to know everything.

Anonymous

The less of this lament that occurs in our world, so much the better.
The Tradition of Mentoring
Part II: Leadership and Mentoring in the Culture of Healthcare

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Editorial Note
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Author’s Note
The opinions presented in this text are those of the authors and do not reflect the official policy or positions of the United States Government, the Department of Defense, the Department of the Navy, or Navy Medicine.

Abstract
Leadership is a multifaceted construct. It requires mentoring as a lifelong experience. Leadership is not an isolated phenomenon, but an activity completely interrelated with those one leads. It can never be separated from its essential community or organizational context. This makes the experience of mentoring all the more critical. Adding yet to its complexity are the principles and responsibilities that leaders must develop continually over time. To ensure successful leadership, the experience of mentoring requires four important pedagogies for mutual engagement between mentors and the leaders they seek to serve and guide. The four signature pedagogies are those developed by the Carnegie Foundation: interpretation, contextualization, performance, and formation. Effective mentoring in the contemporary world of leadership inevitably requires a new paradigm for understanding and giving living expression to the individual growth and development that leaders and their organizations must experience with one another as communal partners. Such a series of new and evocative paradigms is all the more critical in healthcare communities where servant leadership and professional service touch the human person at the most vulnerable and critical junctures of life.
Introduction

In the second half of this afternoon’s presentation, I would like to discuss with you the complex yet fascinating interplay of leadership and mentoring in the culture of healthcare. Healthcare providers, regardless of role, inevitably exercise some form of leadership. Effective leadership requires equally effective mentoring. Contrary to some misconceptions, mentoring is a lifetime process. It never ends. It is also far deeper than simply the acquisition of technical skills and behaviors. True leadership, especially in the extremely sensitive arena of healthcare as a human service, requires a never-ending quest for personal as well as professional improvement. What makes this even more complex is that this leadership comes about not just in any ordinary context, but in the highly charged and extremely critical context of healthcare. Unlike many other realities, healthcare gathers human beings at the most sensitive moments of life. Therefore, the exercise of leadership and the mentoring required for leaders have a special and intricate value.

To understand this complexity, I will reflect with you upon five specific areas. First, we will explore the culture that is healthcare and the role of leadership and mentoring within. Second, we will review the basic principles of healthcare ethics that give shape to healthcare leadership and mentoring. Third, we will consider briefly four areas of responsibility in healthcare. Fourth, we will reflect upon four signature pedagogies of the Carnegie Foundation that can be valuable approaches for establishing long-lasting, positive experiences of leadership mentoring. Finally, I will reflect upon an image for sustaining and advancing the meaning and mission of healthcare leadership for the future. It is my firm belief that my final comments provide a critically needed re-imagining of the fundamental goals and content for the continuing education and ongoing mentoring of leaders in healthcare.

Mentored Leadership in a Zone of Cultural Contest

Leadership is a multifaceted construct. In organizations, we can identify leaders, managers, and technicians. While their relative areas of responsibility necessarily overlap, technicians are generally responsible for carrying out operations. Managers provide tactical direction for those operations. Leaders are those who strategically oversee all areas of the organization’s tactical delivery. At an even higher level, leaders are those persons and groups who coalesce and integrate all tactical directions and operations with the general mission, purpose, and strategic or long-range plan of the organization itself. From another perspective, leaders are responsible for calling a group to its ultimate purpose, its Being.

I would not say that leaders are necessarily born. Leadership is not necessarily genetic. However, it does draw upon personality traits and innate skills and abilities. It does require significant nurturing and education. It also requires personal and professional mentoring. I do not think it would surprise any of us, when we think about historical circumstances, that it is too easy for the authority of leaders to devolve into tyranny and authoritarianism. This is one reason why the ongoing formation of leadership is as important as is continuing education in leadership skills. Leadership affects and is influenced to its very root experience by one’s psychology, community background, values system, experience, and personal goals.
Within this context, it is easy for us to see why mentoring is critical. Just as it is true in any of the professions or in academics, mentoring is the means by which knowledge, skills, and abilities become grafted and integrated into the values formation of the individual leader. The “what” is married with the “who.” This is a lifelong task and it is filled with deep and abiding challenges.

In ancient Greece, philosophers said that society and each person are guided by one’s “telos,” one’s end-point. We might surmise that a telos is one’s personal North Star guiding the vessel of our lives. Mentoring is that critical and deeply important lifelong formative experience that continues to draw one’s attention to one’s North Star --- and to evaluate how well or how poorly one is following the North Star. The mentor will call attention to the motivations and inner workings of the self that keep one aligned with one’s telos, with the path that is best and surest.

Concomitantly, it is critical to remember that leadership in healthcare has its own beauty and challenges. At this juncture, it is important that we recall that, from a particular perspective, healthcare is a culture. It has many constitutive parts. Like other cultures, healthcare organizations and communities have shared language, patterns of communication, abilities, vision, behaviors and approaches. As a culture, healthcare itself has shared meanings.

At this point, it is likely important for me that I share with you a personal reflection. Over the last half-century in particular, our healthcare institutions have been looking for ways to reduce costs, to improve benefits, and to ensure efficient delivery of services. In short, healthcare organizations and their professional leaders have tried to enact sound business practices. Yet when we observe a variety of examples, we wonder whether the proverbial carriage has gotten in front of the horse. Healthcare seems to have been made into a business.

But is this a worthy or appropriate equation? Healthcare always must make use of the best business practices and models. But healthcare must never be allowed to become a business in the ordinary sense of that word. It is a human service. It is not a business transaction or a commodity. It is not just what civilized people do for those citizens who are sick. As an ethicist, I contend that healthcare is an absolute human right because it defends, protects, preserves, and increases the dignity and worth of each human being.

To be caught up in the complexus that we call healthcare, we need to recognize that it is fundamentally a community partnership among patients, families, communities, providers, and organizational leaders. To accomplish the goals of healthcare and the quality improvement of human life, one can never approach any aspect of healthcare as simple or easy to enact. Healthcare is not a set of clear operations that require occasional maintenance like a software upgrade. Walk through an emergency room and hear the cries of those who are suffering. There is no upgrade that can take away their pain. Look into the eyes of those who are present to a dying family member in the intensive care unit. There is no technical improvement that can erase the ambiguity and loss that makes white the knuckles of those grasping the guardrail on a bedside. Perhaps we prefer to make healthcare into a business because it is easier to handle. Yet for those of who know in ourselves the depth of suffering that comes with human illness, we understand that the caring for those who are sick is far from easy. It costs us in ways that can never be captured on a spreadsheet or ledger. Hence,
Lectures

educating and forming those who would be healthcare leaders requires a very different, in fact a very ancient, form of mentoring. Mentoring is not about academic advisement. It is not about performance appraisal or laboratory supervision. Mentoring, real mentoring, is about entering into companionship in what is the inevitable vortex of human relationships at those junctures of human life that are most vulnerable. Such an experience can never be a business. In fact, its reality is beyond words. It is much like the image of Virgil who accompanies Dante throughout his journey into the Inferno.

This image of entering into a vortex came home most powerfully to me when I was in doctoral studies. My doctoral area involved ritual studies and the social sciences. One of the nearing graduates eventually published on a concept of rituals that spoke of them as “zones of cultural contest.” As she theorized, ritual is a zone in which cultures and individuals engage in a heated wrestling, an “acting out” of sorts, of values, goals, beliefs, and fundamental meanings to human life. The image she portrayed has stayed with me through the years.

In fact, based upon my initial reading of my former colleague’s work, I have come today to believe that healthcare itself, just as other cultural processes, is a zone of cultural contest. In it, the various partners collide over needs, expectations, assumptions, resources, ethics, belief systems, and values. As a zone of cultural contest, healthcare is a place of volatile change agency. Underneath the often-frantic activity of healthcare, there is an ever-changing sea of paradigms always shifting. It is an experience of ultimate complexity especially in the diverse relationships among patients, families, communities, and the healthcare institutions to which they come for help. Where then might this place those who are healthcare leaders?

Without question, healthcare leaders are in the very epicenter of a zone of cultural contest. Healthcare leaders stand at the crossroads of every professional and personal interaction that happens within their communities. If they truly are leaders, they hear all. They experience all. They are impacted by all the questions. They must continually navigate the community through every experience and assist the group to maintain fidelity to its mission, its Being. Leaders’ service in this context can never be perfunctory or mechanical.

Perhaps because of the overwhelming immensity of it all, there are those who choose the more facile pathway of keeping accounts and metrics. Yet for those who stare boldly into the very meaning of healthcare itself, there is the never-ending challenge to renounce every form of power, territoriality, and ego so that the needs of the other are greater than the needs of the self. For the institution, this means that leaders are called to public service on behalf of the public trust.

Trust. A curious concept. Never easily given. Never easily achieved. Always must be earned. It is easily bruised. It can be broken. It can also be mended, but only with intense effort and care. It requires a transparency to self that, unless authentic, will never permit anyone else to be transparent back to you. And this is where mentoring is needed.

As I said earlier, mentoring is not about academic advisement. It is not about professional supervision or performance appraisal. Real mentoring is the experience of allowing someone else to be your companion on the journey to mirror back to you exactly who you are and what you do so that your own paradigms shift for the greater good continually and without end.
But changing to achieve what? What might be the guides for mentoring leaders in healthcare today?

**Ethics in Mentored Leadership: A Question of Tradition and Principles**

As a culture, healthcare has an ethos, a fundamental character. Over many centuries, this ethos has been articulated into four traditional ethical principles. I believe that these principles are the foundation for what needs to be “passed on” to leaders in the act of mentoring. One might say that these principles are the foundation also for the ethos of mentoring. Before proceeding, though, I do want to point out that I have reflected on these four traditional principles and have added a fifth. Let me leave that fifth principle and my reason for its addition until I come to it specifically.

The first of the ethics principles in healthcare is that of respect for persons and their autonomy. The place of human rights has a long and volatile history. We do not need to recount that. We know that it has been a long and arduous path of inquiry as to what constitutes human nature and the human person. We know intimately well, as recently as the last hundred years, of the myriad ways in which tyrants and the powerful questioned the humanity of some peoples and races. Yet there has been the consistent cry from ethics that the human being has a fundamental right to respect and dignity. Healthcare as a human service is one of the chief expressions by which society upholds the dignity of each individual and each person's right to self-determination, to autonomy. In the experience of mentoring for leadership there is a critical need to identify and address the leader's role in preserving and protecting the human dignity of patients and their autonomy. Concomitantly, mentors need to be aware of those areas in the lives of their protégés that could reveal human bias and the temptation to power. If and when these instances become visible, the mentoring experience can call the individual to a greater sense of authentic leadership by addressing issues, discovering their origin and meaning, and taking the steps to move beyond these so as to be more deeply committed to the good of the other and not the self.

Correlatively, it has occurred to me over the years that the ethical principle of respect for persons is influenced greatly by Western society's emphasis upon utilitarian individualism. From our emergence into what some call the modern era, we have a tremendous respect for the rights of the individual. Yet none of us lives as an island. We are not isolates. We are contingent beings who live our lives ever “in context.” Hence, I suggest that respect for persons requires a new ethical principle in partnership, namely respect for communities and their traditions. When a patient comes for care, they do not come alone. They bring with them, even if only invisibly, families, relationships, local communities, neighborhoods, the world. I have found it wonderfully refreshing in the last several years to listen to physicians and nurses who speak of systems medicine. Together with those who understand the nature of palliation as a total human experience not just for the dying or chronically ill, the treatment of patients is not the treatment of a single disease, a single cell, a single entity. Rather, one treats the whole person, and part of my whole personhood is all the “others” to whom I belong. In essence, then, arising from the ethical principle of respect for persons, mentored leadership must lead the leader to a greater commitment to care for, respect, nurture, and advance the communities from which we come and the communal nature of who we are as human beings.
Third, traditional healthcare or medical ethics speaks of non-maleficence. This is the very familiar, “Primum non nocere.” First, do no harm. In traditional clinical bioethics discourse, this has particular meaning for the choices that one might explore to treat a patient. Will a chosen curative path ultimately cause more harm than good? What is the best course of action that will decrease pain within the long-range consequences for prolonging with quality this patient’s ability to live? This is the traditional and extremely important base experience. However, in line with our discussion here, I would suggest that mentored leadership needs to raise this ethical principle up in a nuanced fashion. If leadership is about caring for the other, mentoring must raise up all the possible avenues by which the service of the self will increase harm and negate or decrease benefits. What approaches might I enact that might increase any measure of harm to the patient and all the others to whom the patient is connected? Do I understand the forces of “malevolence” that could be operative within me as leader, even subconsciously? How am I to remain aware of such forces and how they subtly or overtly “first do harm? This is a very exacting principle. It requires one to look into the mirror of the self and see the possible. Hence, mentoring is critical to looking at the self honestly and courageously.

The fourth traditional principle I wish to comment upon is that of beneficence. Bene facere. To do the good. Leadership not only must avoid that which would harm, but must also move toward the best possible avenues for the benefit of others. The evaluation of benefits is not automatic. Many times, there are a whole series of benefits that could be available. How does one choose the best? I suggest that there is no one simple equation or algorithm. Each situation has its own circumstances that will give shape and color to the decisions that have to be made. However, what is key is that leaders in healthcare understand the complexity of ethical decision-making. Much as we heard earlier today from Dr. Elizabeth Holmes, we must avoid biases, subconscious or otherwise, that would lead us to believe that ethics is the acquisition of easy moralistic answers to complex ethical situations. We are complex beings. The situations in which we live and find ourselves are equally complex. We need to learn to live within the shades and nuances of life, both personal and professional. In this complexity, one of our most human tasks is to evaluate and discern what is the greatest good for this person or this situation given what we know at this time. In healthcare leadership, mentoring is critical to assist the leader to acquire ever more deeply a personal sense of courage to engage in ethical decision-making. Comfort creatures as we are, we can gravitate toward the easy answer. Yet healthcare leadership is exercised in the most uncomfortable of all human contexts — the context of human fragility. It takes a tremendous sense of sensitivity and internal humanness to assess critically what are the best possible choices. Hence, mentoring for beneficence is an experience of personal and professional formation that opens up the whole human person to understand the magnanimity of the best choices and what may be their long range results and implications for all.

Finally, there is the ethical principle of justice. In clinical or healthcare research, this principle is often the basis for ensuring that risks and benefits are equally shared by participants or patients, and that no one part of the population is placed more at risk or is more privileged than any other. This is one important aspect. In terms of mentored leadership, something else strikes me. Justification is itself a term that has its origins in theology. From early Judeo-Christian thought, there is an understanding that the justice of God is not really about the doling out punishment of sin. Rather it is the filling up, or justifying care, for all those things that we lack. I find this an intriguing perspective for mentored leadership.
How able am I to see and understand the experience of “lacking” that is evidenced in the lives of those who come to us for care? How sensitive am I to how this particular person’s experiences are lacking? Do I understand the possible rage at not feeling complete? How able am I to be present to this raw experience in another person? As an instrument of justice, admitting that there may be nothing at all that I can do to help, am I at least able to face the unseemly paradoxes, ironies, discomforts, and agonies that inevitably are part of the healthcare experience? Obviously mentoring has to be involved to assist me to become ever more deeply an authentic leader in this context.

In the final analysis, healthcare is not just about medicinal cure. One might entertain that the above ethical principles remind us that real healthcare is cure + care + compassion. Such an arithmetic is never easy. It does not always add up the way we wish. Sometimes the hard realities and complex choices that face leaders seem insurmountable. Often we will fail. We must. We are only human. But there is the need to hold on to the above broad principles of ethics that help to guide our journey into the never-ending vortex of healthcare leadership. The continual presence of mentors in our lives is a critically important resource from which we can never afford to stray. Mentored leadership is essential to remembering our various responsibilities. Now, let us turn to those responsibilities by way of reminder.

**Target Areas of Responsibility for Healthcare Leadership**

It is important for us to recall four areas of major responsibility in healthcare leadership. It is these areas that become the zones of cultural contest that require a clear understanding of and commitment to ethical principles. Briefly let us recall these areas of responsibility before moving on to consider strategies for sound mentoring for leadership.

The first and clearest area is that of patient-centered responsibilities. Without belaboring the issue too greatly, it really can never be said enough that our first commitment must be to the care of those who come to us in need. The origins of healthcare are in human service. They are the longing and desire of the caring person to meet the needs of those who suffer. As I reflected earlier, I believe that there are segments in our institutions that find it easier to care for the “business” of healthcare than the caring that is health. Simply, the magnitude of what it means to care for the sick and the dying is enormous. It is far easier to care for metrics and two dimensional outcomes reports. Yet the nature of healthcare itself is about people and the volatile zones of life in which they find themselves. We are called into that circle of volatility. Not to enter is to betray the fundamental purpose of who and what we are called to be.

To care for others in this way brings us to a never-ending commitment to academic and professional enrichment. Our knowledge, skills, and abilities are at the service of others, not the self. Unless we stay prepared and at the forefront of our knowledge and operational base, we risk harming others or harming the initiatives, programs and resources that we are meant to steward and lead for the benefit of others. We humans have an incredible temptation toward inertia. There is always the danger that one can believe that, upon achieving the doctorate or another degree, one knows all there is to know. Yet there is no resting place. There is no time or plateau in our lives where we ever will know enough, be proficient enough. To care for our own dignity and to care for the good of others must always lead us to know more, to understand more, to practice more proficiently, to care more, to “be” more.
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Such caring is not just about my individual relationship with patients and their families. It also is about how our institutions are shaped, formed, and advanced over time. In a day and age when nations and individuals have been threatened by new forms of terror and oppression, our institutions must stand ready for new forms of service and healthcare leadership. One of the exemplars that leads us in this fashion is healthcare and medical research. Research, like healthcare itself, is not a commodity or a business. It is part and parcel of healthcare delivery. Unless it is so aligned, it fails. It has no relationship to its ultimate meaning. It loses its ethos and can devolve into practices that violate the fundamental humanness of healthcare. One only needs to read the newspaper accounts of ethical violations that have happened during clinical trials in developing nations to realize how this can happen. While research is not the only form of what I am sharing with you at this time, it is a central example of how our institutions have to remain open to new and sometimes uncomfortable places of change. What is our mission yesterday may not be our mission tomorrow. As human needs mutate over time, our institutions need to stand ready for the ever possible. As mentored leaders, one of our clear contributions is to call our institutions to be attentive to the needs and opportunities that are calling us to change and advance for the good of others and their dignity.

Finally, healthcare is tied to the fundamental nature of the public trust. Our care for the sick and the needy is not simply an individual act of personal goodness or sentimentality. We are all well aware that society has an obligation to care for the less fortunate. We need not review those mandates here. They are well known to us all. Mentored leaders have at the core of our service a responsibility to the public trust. This area requires some important reflection for us all. I wonder if we say words such as “public trust” but then minimize their impact. Perhaps because the “public trust” seems so immense, we hear the words but never carefully consider the overwhelming price of what it means to be public servants as healthcare leaders. Ours is not a leadership or profession that belongs to me alone as if it is a private act. To enter into the zone of cultural contest that is healthcare is inevitably to wrestle with one’s responsibility to society. As human beings come to us connected to their communities and to society, when we bid them enter our institutions the care we give them powerfully touches the public trust that we individuals and our institutions must serve without compromise.

But how do we continually allow ourselves to be mentored for this type of leadership in healthcare?

I would suggest there exist strategies that help us maintain a continuous approach to personal and professional formation. Indeed, these are not areas in which we can ever enter alone. Mentoring is therefore a lifelong experience. These are important areas of growth and development for each of us and for those who grace us by being our mentors.
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Strategies for Ongoing Formation and Mentoring in Healthcare Leadership

The Carnegie Foundation in the United States has been developing and authoring a series of highly informative texts that address various aspects central to the education and formation of individuals entering the traditional professions: law, medicine, education, ministry/theology. Termed as “signature pedagogies,” the Carnegie Foundation presents a variety of approaches that are critical to the ongoing development in these professions. I believe that these are central to the continuing formation of mentoring for healthcare leaders. Let me share with you four that I have found particularly intriguing.

Before summarizing these for you, however, let me make a preliminary comment. Each of these pedagogies is an example of praxis. Praxis is an interesting word. It comes to us from a variety of disciplines. In essence, it means something akin to “action in reflection.” In other words, a praxis is an experience where someone is asked to stand apart from one’s experience and reflect critically and prudently upon its implications and meaning. In our society, we emphasize too often the acquisition and utility of information, as if information is a two-dimensional reality. In contrast, the information we glean from reflection on our lived experiences is not two-dimensional. It has significance and meaning. I invite you, then, to consider that the four Carnegie pedagogies I would like to share with you as lenses through which mentors and protégés can seek to understand the lived experience of healthcare leadership—and to reflect carefully and deeply upon the meaning of it all. This is an essential approach if one is going to grow and develop and mature in effective ways into the future. I find this interesting because, from my own academic background, of a particular insight that has challenged me over the years. In the 11th century Anselm of Canterbury defined theology as “faith seeking understanding.” In a non-religious sense, one might redefine this as “experience seeking meaning.” Or alternatively, we might think of it as “data seeking interpretation.” Mentoring is a unique, intense, and challenging experience whereby the mentor assists the protégé to interpret the data of one’s professional behaviors and come to a new awareness of their meaning. In the delicate world of healthcare provision and leadership, there is an intense and urgent need to be open to such awareness so as to approach the quantum leaps of revision that are always needed if we are to remain true to our calling for the service of those in need.

All this being said, let me now proceed to the four pedagogies I wish to share. The first is the pedagogy of interpretation. Social sciences and theology often talk about hermeneutics, the science of interpretation. Many years ago, I read a text that talked about the origins of this curious term. The author posited that within the word is the name of the Greek god, Hermes. Hermes, the messenger of the gods, would never come to deliver a message precisely. He would somehow take on different forms and play tricks on the recipient to get him or her to understand the message in curious and new ways. In a certain respect, Hermes would subvert the assumptions of the hearer. The pedagogy of interpretation seeks to get individuals to return to the body of knowledge of their profession and to understand it in fresh, new ways. For many of us in professional life, it is easy to believe that we have achieved perfect knowledge. Yet we know that not to be the case. Mentors have a particular responsibility to ensure that protégés continually revisit their body of knowledge. However, mentors need to urge protégés not just to “re-learn skills,” but more importantly to plumb the depths of the meaning of one’s profession and re-understand its body of knowledge in ways that would lead to discovery, innovation, and better leadership.
A second of these pedagogies is contextualization. Leadership is not exercised in a vacuum. It takes place in real time, with real people, in the real world. In every act of leadership, much like in language, there is the need to translate one’s service given the context in which one serves. As human beings, we all can find it easy to assume that others see or experience things exactly the way we do. Leaders need to be extremely careful to avoid this assumption at all costs. In each and every community, there are a wide variety of differing beliefs, values systems, structures of relationships, and base experiences that give rise to unique social psychologies. Mentors must assist healthcare leaders to reflect carefully and critically upon the contexts in which they may serve. They need to assist protégés to develop a well-developed sensitivity or “radar” to ensure that they are reading the contextual signals with some measure of accuracy. Sometimes, leaders are surprised when they find that they fail to communicate or relate successfully. Often, these failures are due to a lack of understanding about the lives, expectations, and systems of values operative in the communities they serve. Successful mentoring for healthcare leaders must therefore raise up issues of context.

A third pedagogy for successful leadership mentoring is performance. I would suggest that this is a very important yet very delicate area in today’s context. Over the last decades, a wide variety of professionals have tried to explore diverse ways of setting up measures for professional performance. Many of us have experienced these seemingly endless models for performance evaluation. As I have observed them, one of the facets that strikes me is how these are skewed toward quantitative measurement. Metrics of productivity are only one means for measuring performance. However, quantitative measures need to be balanced with qualitative approaches. For example, if I were a healthcare provider, I could be measured on the number of patients seen in any given day. However, there must also be an equal assessment of the quality of what occurred in those patient visits. To use the research of my doctoral peer that I mentioned earlier, mentors would do well to help protégés understand that together there is a need to explore the “performative meaning” of what is rendered, and not just the number of performances accomplished.

Lastly, there is the need to incorporate a pedagogy of formation into the leadership mentoring experience. Perhaps 20 years ago, the theologian James White published a work in which he integrated a variety of psychological and educational theories to address how humans develop and mature over the years. One of the very successful portraits he painted was how human beings are moved in successive stages of life to embody the things they do and the ideas or beliefs they espouse. In other words, there are invitations in life for all of us to put flesh on the words we use or the ideas we have. This is a longer way of describing the experience of formation in the professions. Formation is not about the acquisition of new or better skills. Rather, it is the process by which what we do makes a difference upon who we are as persons. It is the process, sometimes arduous, of evolving from utility to embodiment. It requires a never-ending wrestling within the self to face naivete, bias, or a lack of courage to change. It requires a challenging understanding that what I do as a professional is more than just behavior. It makes an impact on the person that I am. Inevitably, the experience of formation is one that leads me to a never-ending series of passages and transformations of the self as a person and as a professional. This indeed is an experience that is best done in companionship with one who understands, with one who is ever on the same road, with one who has earned human trust.
Four pedagogies. Four approaches for effective mentoring for healthcare leaders. These are the tools that we can take with us on the journey of mentored leadership in the healthcare professions. But what guide can we adopt that will help our journey succeed? What images might we keep before our eyes as we journey ever more deeply each day in the act of healthcare leadership?

## Conclusion

### A New Constellation for Guiding Mentored Healthcare Leadership

In the final analysis, what might serve as an overall guide for this approach to mentoring for healthcare leaders? I have been with Navy Medicine now for nearly 20 years. One of the abiding images I have from my community’s culture is the image of the ship being guided on its ocean journey by a north star. Sailors over the years navigated the oceans successfully by keeping their eyes fixed on the constellations in the sky. In the spirit of that image, let me close my remarks today by suggesting what I would like to refer to as three stars in a new constellation that guides the mentoring experience for healthcare leaders.

I need to repeat that healthcare is far deeper than the business models we use. It is deeper than just medicinal cure. We honor healthcare best when we remember that it is a systemic experience of cure + care + compassion that affects the whole human person and all the individuals and communities to whom the human person is attached. Such a systemic and comprehensive experience cannot be accomplished without the ongoing mentoring of healthcare leaders. This is central to giving flesh continually to the theme of this entire conference, *Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research.* Unless we keep mentoring an essential part of healthcare leadership, we indeed will forget the human face of science and healthcare. We will become that which we criticize the most. Our ship of service will run aground. How then do we stay not only afloat but moving forward to new ports of service on behalf of others in need? I suggest that we follow a new constellation made up of three stars: Presence, Prophecy, and Poiesis.

Judeo-Christian theology has debated and argued over the concept of “real presence” for centuries. Unfortunately, various religious denominations have stoked misunderstanding by concentrating only on the debate from the perspective of sacrament and ritual. The concept is understood far more effectively and with greater accuracy and ultimate significance when one remembers that the fundamental theological experience is not about real presence in sacrament, but the passionate human belief that the Divine is really and truly present to us as humans. We humans fear being alone. We stand in mortal dread of being both alone and lonely. It is part of our lot in life to be separated from each other. From the time the cord is cut at birth, it seems we are ever engaged in a long search to find that “other” who can satisfy the emptiness within. One of the most dynamic and demonstrative beliefs in the Judeo-Christian theological systems is the urgent belief that the Divine chooses out of love to be connected and “present” to us in ways that are radical, ways to the “root” or “radix” of the persons who we are. The Divine, who is portrayed as needing no other, chooses to pierce our lives and ravish us in love. We are therefore never alone. This image from theology gives us our understanding of the first star in our constellation. Healthcare leaders enter into the lives of others at the most vulnerable and frightening moments. Regardless of whether we are providers, financiers, managers or in any other position, when we walk
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through an emergency room or past a clinic waiting room, we must always remember that
we must be “really present” to those who come to our institutions. It might only be an act
of passing kindness or a simple word. Yet what we say and how we carry ourselves can be the
difference in how another person is able to negotiate the alienation that is part and parcel of
the experience of human illness. Real Presence. The first star.

The second star is prophecy. Prophets do not foretell the future. They forth-tell the
Truth. Biblical theology reminds us that the prophetic function was to call the community
to the task of its system of beliefs. Prophets often risked life and limb because they refused
to close their eyes to the contradictions of their societies—when people said they believed in
one thing yet acted in stunning opposition. Such was the case in early societies where tribal
peoples said they cared about the poor, but then refused to share with them their bread and
their compassion. When television advertisements call our attention to the less fortunate, it
is easy at that moment to feel something burning inside and caring. Yet when we walk out
into the streets and a homeless person comes to us, we feel afraid and perhaps run away. True
prophecy calls into question our behaviors and our inconsistencies. It calls for us ever to be in
need of change. I remember an old story I once was told about a soul food kitchen in a poor
area of Washington, DC. I have no idea if the story is true, but it makes the point. The story
says that a woman named “Mother Minnie” ran a kitchen out of her home. She used to stand
outside and invite people to come in: “You all come in now and eat.” But when a person
would come up to enter, she would grab him or her by the arm, look them square in the eye
and say: “But if you come in to eat, you all gotta be changed.” Prophecy is like that. Mentors
call out to us. Each time we enter into the realization that we are healthcare leaders, we break
open the bread of our profession. But are we ready always to be changed, to be deepened,
even at the price of personal pain and discomfort?

Finally, there is the third star—poiesis. This is the root word for our English term,
poetry. Yet it is rather untranslatable. It is best described in an experience. When I was much
younger, one of my favorite things was to go the seashore with my friends for weekends.
I loved to stay up all night and then watch the sun come up. There was a favorite place in
the seaside town I used to visit. I would be there by myself at the edge of a small rock jetty.
I would wait and wait through the hours before dawn in the hope of the light. Suddenly,
it seemed to me that something was appearing on the horizon. Right where the black sky
seemed to touch the dark ocean waters, it looked as if something were cracking open. Not
sure. Maybe it was my imagination. Maybe it was wishful thinking. But it seemed that a
small line of light was appearing. Not formed, ambiguous. Unclear. Yet my attention was
grasped. In some ways, this was the experience of poiesis—attentive and poised for the
possible but without knowing what it was nor being able to control it. All I could do was
wait for it to unfold. My job was to remain attentive and ready for what was about to be.
Poiesis is the critically essential star for mentoring healthcare leaders. Mentors and protégés
remain attentive to the invitations to change and deepen and grow and develop. We look for
signs and small cracks of something yet to be made apparent. And in that waiting we realize
that in so many ways we are not in control. We are instruments for processes and possibilities
that are always much larger than we ever could be. We anticipate that which is yet to come.
And in our waiting we learn to be servants of the possible, not rulers of the controllable.
These then are the three stars of a new constellation guiding the experience of mentored healthcare leadership. There is, of course, always, the possibility that one can refuse to board the experience and sail. That is always an option. Presence, prophecy and poiesis are not comfortable. They require being open to change both subtle and significant. Yet if we are to remain faithful to the wrestling in the zone of cultural contest that is healthcare, how can we refuse the journey?

Each of us, when we first entered into healthcare leadership, undoubtedly did so because we wanted to make a difference. Today, we are called ever to hear again the cries of the sick and the poor. Like Ulysses in the Odyssey, they are voices that call out to us. But they are not sirens who are luring us to our death. Well, maybe to a type of death—the death to self that is necessary for anyone who wishes to care truly for others in need. But these voices call out to us begging for the life that is truly found, nurtured, matured, and born each time we care enough to love and embrace those who need us most.
The Integrity of Research

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**Editorial Note**
This article is an expert report summarizing the distinguished lecture presented December 9, 2009 at the University of Botswana during the conference: *Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research*. A panel and general delegate discussion followed.

**Authors’ Note**
The opinions represented in this text are those of the authors and do not reflect the official policy or positions of California State University, the United States Government, the Department of Defense, the Department of the Navy, or Navy Medicine. We thank the following delegates for their individual insights, which contributed to this discussion: Dr. A.M. Jeffery, Dr. Kevin Fitzgerald, Dr. Kevin Russell, and Dr. Ann Thomas.

**Abstract**
This text is the foundation from which a distinguished lecture was developed focusing on the necessity for research in healthcare carried out with attention to issues of integrity, the hallmark of all commendable research. A cautionary historical review of research misconduct and related topics is provided. Research within a cultural context and the related subject of international collaborations are also discussed.

**Introduction**

It is not often that we have an opportunity to discuss the integrity of research with
our colleagues, and it’s even more uncommon to be presented with the opportunity to travel to the continent of Africa to discuss such issues. Yet that is where we, together with our expert panel, found ourselves in December 2009—speaking at the University of Botswana and interacting with our medical, nursing, and allied health colleagues.

We welcomed the chance to discuss research integrity, not with a regulatory eye, but with the aim of elucidating integrity as a necessary element of and, indeed, as synonymous with the conduct of excellent research. Why? Because research integrity requires a cultural shift in thinking beyond compliance; it includes excellence in scientific method, honesty in the selection of the test statistic, rigor in data collection and analysis, and the straightforward dissemination of findings and their realistic implications.

The Integrity of Research

A variety of definitions of research can be found in the scientific literature. As a framework for this discussion, health research was conceptualized as a formal, rigorous process requiring planned, systematic activity to discover new knowledge for the benefit of patients and society, including the study of the translation and application of evidence from research to clinical and public health or population-based practice (otherwise known as evidence based practice). This definition assumes that healthcare providers have a responsibility to ensure their patients receive care that reflects the most current knowledge available, and to understand the individual and larger societal-cultural matrix within which care is provided and research is conducted. This cultural matrix includes the learned and shared beliefs and values embedded in religion, kinship, politics, and language expression where the “individual and group identity” culture changes along predictable lines with changes in social, historical, physical, geographical, or technical realms of life.

First, Know Yourself

Fay (1996) provides us with additional tools as we strive to know ourselves, to care for others, and to conduct excellent research that demonstrates integrity. He asks us not to hide behind an illusory façade of neutrality to convince ourselves and others that we are objective, to acknowledge the intellectual equipment that we bring to the care and study of others, to be aware of the way we change those with whom we interact, to be accountable to those we are researching and caring for, to act in a way that is responsive to the evidence as best we can determine it, to assess explicitly what others do, and finally and perhaps most importantly, to seek out the criticisms of others with regard to our own research and care-giving activities. We put Fay’s recommendations into action during the Botswana conference.

We asked participants to turn to the person on their left, state their name and describe for that person whatever it was that made them distinctly who they were. They could not use the usual descriptors (e.g., sex/gender, race/ethnicity, marital status, or occupation); rather, they were encouraged to use experiences, activities, and relationships in their lives that they believed made a significant contribution to who they are. This was supposed to be a five-minute exercise, but the audience asked for additional time, and we finally had to rather forcefully bring everyone back to the formal lecture. The exercise was an enjoyable one and, even more importantly, it provided examples of how significant experiences, activities, and relationships had affected individuals’ lives—in some cases profoundly.
One participant shared his experience of having his original ideas and written materials “stolen” and later published in a peer reviewed journal. These events encouraged him to pursue a doctoral degree in the field of ethics. His comments could not have been more appropriate had he been “planted” as an overture to the next topic of discussion.

Research Integrity and Misconduct

Integrity has become a priority for universities, science foundations, academies, and health care organizations conducting research. The goal for healthcare research is the acquisition and application of new knowledge for the benefit of patients and society as a whole. Goal achievement requires excellence in scientific methods, honesty in data collection and analysis, and realistic interpretations of findings.

A simple yet encompassing definition of research integrity includes justice and honesty in proposing, conducting, and reporting research. A participant in the research integrity pre-conference workshop confided that she had developed the idea of writing an article on this topic and led discussions on the potential content for the manuscript. In developing the paper, she tried to contact the other prospective authors for collaboration, but they never returned her e-mails. Before she sent her paper to a journal editor, she was surprised and chagrined to see an article with her topic and ideas published—with her as sixth and last author. As with the previous example, this is a violation of integrity in the publication of one's creative work.

In contrast to research integrity, research misconduct is fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or in reporting research results. Fabrication includes deliberately manufacturing untruths and reporting them with the intent to deceive, or a failure to report research findings that contradict the investigators’ hypotheses. Falsification is changing or omitting research data or results, and is usually done to enhance the significance of the research findings. Plagiarism is the act of making use of another’s words, ideas, processes, and results without providing credit where it is due. Research misconduct does not include mistakes or inaccuracies made during the conduct of research and reporting of findings if they were innocent oversights, errors or omissions due to lack of knowledge or experience with research and publication.

Research misconduct has been a part of the literature since the 17th century. Duro Armen Baglivi (1668-1707) wrote a detailed report on the theft of his intellectual property in letters within a collection at the Library of Sir William Osler (Fatovic-Ferencic, 2007). According to the letters, this physician had invited a professor of medicine from Germany to review the manuscript he had written on patient care of wounds and ulcers. Without notice, the professor left with the papers. Dr. Baglivi’s colleagues advised him to publish parts of the manuscript immediately and to report the theft to associates in Germany. Due to his swift action, publications on the subject never surfaced in Germany.

Research misconduct became a public issue in the United States in 1981. Characteristic cases were those of American physicians who fabricated research data and submitted fraudulent articles for publication in prestigious biomedical journals. In these instances, the physicians sought out and invited respected experts in the medical field as co-authors. When the researchers were exposed, those who accepted the gift of co-authorship and credit for work they never performed were suddenly indisposed to share responsibility for the fraudulent papers. These cases brought the issue of gift co-authorship to light. Gift co-
authorship was used to enhance the likelihood that the work would be published because well-known, respected experts in the field were listed on the manuscripts. In fact, gift co-authorship was one of the reasons that the US Public Health Service created the Office of Scientific Integrity in 1989.

With all that was done to bring the research misconduct issue to the forefront, problems still existed. Research administrators gave good directions, rule of law provided good answers, and ethics asked good questions, but there were still an increasing number of cases of scientific misconduct. One year, a Bell Labs physicist published one paper every eight days—later it was found that 17 of the papers had been fabricated (Jones, 2003). Gift co-authorship continued. In one case, 20 collaborators and co-authors were found to be involved in one scientific publication, with only one author actually participating in any of the conduct or analysis of the research study.

The BBC news reported a notorious case of fabrication of a study in 2006. A cancer researcher from Norway concluded that anti-inflammatory drugs reduced the risk of oral cancer. The author claimed to have received $10.5 million in funding to conduct the study, which had been published in prominent medical journals. After investigation, it was disclosed that the researcher had fabricated over 900 subjects and case histories for data collection and analysis.

The principles of research ethics are coextensive but not synonymous with research integrity. Research ethics integrate the responsibility for academic and professional development, research protections, public trust, and institutional development. Responsibilities for academic and professional development include maintenance of excellent standards of honesty, professionalism and scholarship. The researcher must engage in sound research methodologies, publication practices, and responsible authorship and be open to peer-review and scholarly critique. Principles of research ethics serve as a “code of conduct” and professional standards for the investigator. In academic or professional settings, the researcher has the responsibility of modeling ethical conduct and integrity as a leader, mentor, and role model. For students, academic integrity is a responsibility in all scholarly endeavors.

Responsibilities for research with human subjects incorporate protecting the rights, privacy and confidentiality of these participants, along with the integrity of the research data collected. Subject enrollment into a study should be preceded by a thorough explanation of the research and informed consent without coercion. Protections also apply to research with animals, including the humane treatment of animals monitored by a veterinarian, and research with any potentially hazardous materials, including protection of the environment during the conduct of research.

Public trust responsibilities include compliance with rules and regulations in the conduct of research, protection of human and animal subjects, socio-cultural sensitivity in research collaborations with human subjects, integrity in the use of funding awards, and openness and honesty about actual, potential, and perceived conflicts of interest. Researchers have a duty to refuse to engage in research misconduct and a commitment to report these matters to those responsible for overseeing research integrity.

Responsibilities for the development of sound institutional practices by investigators include a relevant mission statement in professional research and education departments, supportive technology programs and transfer services, sound policies for dissemination of research
findings, and translational research that benefits the public. Institutional policies should encourage interdisciplinary and collaborative research where all rules for the relationship and intellectual property are decided beforehand. Collaborative research, particularly international research collaborations, can enrich and challenge the research experience.

**Challenges and Opportunities in International Research**

International research collaborations are growing exponentially. In fact, networking at this very conference has already resulted in ideas for national and international research collaborations. Keeping in mind the theoretical underpinnings of the philosophy of integrity and research previously presented, these collaborations require knowledge of others’ cultures, including languages, institutions, politics, and policies, and an understanding of the challenges that can and most assuredly will emerge during all phases of the research process.

Challenges that can and do occur when designing research include establishing the shared or agreed upon meanings of concepts and words. Diseases and illnesses must be fully defined and understood, the political and cultural appropriateness of research questions must be adequately vetted, and the availability of researchers to develop and conduct the research must be investigated and satisfied.

In a 2001 pilot study of the *Love Without Violence Empowerment Measure* conducted in South Africa with high school-attending youth, the word “belonging” was defined by participants in at least three different ways: belonging to a group of friends, translated into “gang;” a dyadic relationship of either two special friends or a girlfriend-boyfriend relationship; and finally, a member of a family group (Axman, 2009). In a follow-on evaluation of the *Love Without Violence* project, the lack of available researchers resulted in only a 4% exposure to the intervention under consideration. Inferring change due to the intervention alone or lack of change as failure of the intervention would not be realistic, responsible, or ethical.

Requirements of, and challenges to, planning international research collaborations include the need to establish a shared understanding of the meaning of adequate protection of human subjects, consent, privacy, and participants’ rights. It is a simple fact that not all Institutional Review Boards (IRBs) are the same—even within one nation.

Obtaining informed consent from parents and assent from minors in school-based research is always a challenge for the researcher; however, in some countries a school has the legal status of *in loco parentis*, which means that during the time learners are in school, teachers and principals have the legal authority of the parent. The international researcher may be bound by his or her country-of-origin’s regulations, which may require parental or legal guardian consent. Parents and guardians may not be familiar with providing informed consent, potentially creating unnecessary concern and suspicion about a research project and effectively limiting participation in that project.

International collaborations and cross-cultural research require attention to the community in which the research is being conducted. Community reactions to research may and do vary by region, state, or province, requiring careful consideration of the strategy for entre into each community.

In a 2005 community project developed to address the needs of Orphans and Vulnerable Children (OVC) in four provinces in South Africa, distal and proximal causes
were identified using participatory action (PA) approaches (Axman, Gray, & Blaschke, 2006). The perceived “causes” for the problem of OVC varied by community, as did the interventions chosen to address the problem. In Community One, the intervention was a Package of Care for the orphan or vulnerable child; in Community Two, a Parenting Skills Workshop was selected; a Drop-In-Center for Teens was recommended by the participants from Community Three; and funding for a Teen Pregnancy Prevention Program was requested by Community Four.

Creating and managing data sets, including ownership, access, and data control also present challenges during international collaborations. Related to data ownership is the matter of authorship, and within the broader topic of authorship are the differences inherent in writing style and etiquette. International collaborative agreements are entered into to address some of these issues, and the publication policies of leading health research journals can provide guidance.

Several institutions have attempted to address the need for guidance when creating international collaborative agreements in an effort to bridge the differences that have proven complex in past endeavors. Framed on principles of integrity, fairness, and confidentiality, the definitions and recommendations provided by the following organizations’ guidelines are excellent places from which to start to develop an understanding and address the intricacies of international research collaborations: the World Health Organization, the Organization for Economic Development, the U.S. Office for Human Research Protections, Georgetown University, and the John E. Fogarty International Center for Advanced Study in Health Sciences of the U.S. National Institutes of Health. This list is not exhaustive, and the reader is invited to explore the literature for additional resources.

**Responsible Conduct of Research**

Education programs dealing with responsible conduct in research were developed in the early 1980s in response to discoveries of research misconduct. Although research methods were part of the curriculum in medical and nursing education, there was obvious need for improvement. In the United States, the responsible conduct in research (RCR) rules are found in a variety of sources; they have evolved over time and are subject to continuing discussion and further development. One example of core elements for responsible conduct in research education is found in the original, though currently suspended, rule from the Office of Research Integrity, Department of Health and Human Services. This suspended rule has become one of the important guidelines for the following RCR educational core elements:

1. Data acquisition, management, sharing and ownership
2. Mentor and trainee responsibilities
3. Publication practices and responsible authorship
4. Peer review
5. Collaborative science
6. Research involving human subjects
7. Research involving animals
8. Research misconduct
9. Conflict of interest
Lectures

These nine areas are not exhaustive. New areas that will require the attention of RCR education programs are emerging, and include financial stewardship, undue influence, interdisciplinary cooperation, globalization and multiculturalism, sponsored research regulatory requirements, institutional mission development and relevance, and sound strategic planning. Regardless of the selection of core elements, development of sound RCR education programs should include substantive formative and continuing education and demonstrated accountability.

Changing the Culture of Research: Final Thoughts

Responsible conduct in research is more than regulatory compliance; responsible conduct in research requires integrity as its core. Research as a culture is not a business or process for the humane good, but a holistic approach to discovery and to the genius that informs the care we provide to our patients. We must remind our seasoned experts and inculcate our new investigators and caregivers with the philosophical underpinnings and building blocks for exceptional research and care-giving, not just because we must follow the rules, but because it is the right thing to do. Each of us needs to remember, ultimately, why we do what we do… to speak for those who might otherwise not have a voice, to effect positive change, and, quite simply, to make a difference.

References


Closing Keynote: Globalization and the Diplomacy of Science

Joseph Makhema, MBChB, FRCP
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Editorial Note
The following is the text of the closing keynote address presented on the afternoon of Wednesday, December 9, 2009. Three responses followed.

Author’s Note
The opinions presented in this text are those of the author and do not reflect the official policy or positions of the Botswana Harvard Partnership (BHP).

Abstract
The closing keynote address given by Dr. Joseph Makhema highlights the important issues that need to be understood in international research collaborations. Dr. Makhema uses his extensive experience in international research collaborations to illustrate the various challenges that collaborating partners in international research may face. He emphasizes that both diplomacy and justice are critical elements of international collaborative research.

Keynote
I thank the organizers for the invitation. The meeting comes at a unique time when there are efforts to strengthen capacity for both research-related activities and regulation of the research. Also, it comes at a time when there is unprecedented interest by various stakeholders in research linkages in Botswana. We at the Botswana Harvard Partnership certainly welcome all newcomers and hope that their efforts in Botswana and regionally shall drive research activities to a higher level, resulting in scientific research and new innovations actively contributing towards the diversification of the economy and development in Botswana. The conference also comes at the time when the School of Medicine is in its formative stages, so students, staff, and community members shall benefit from the outcome of deliberations. If the first two days of the conference are any indication, I can only hope that my presentation shall add value to the addresses that have preceded mine. I refer to the very pertinent key issues addressed in Archbishop Tutu’s opening keynote address on Human Illness and the Experience of Vulnerability, and the various contributions of other speakers and presenters.

Advances in scientific research and development have largely been vested in the developed countries. There is no doubt that science drives economic growth and development. The phenomenal growth and discovery of new information technologies is
an indication of how that aspect has contributed to economic growth in some countries. Countries that have prioritized science, such as Japan, have leapfrogged over others in various indices of development.

The topic at hand is *Globalization and the Diplomacy of Science*.

My definition of globalization in science is as follows: It is the process of increasing the connectivity and interdependence of the world’s scientific community in areas of research and scientific development. This definition has implications for the development of the physical and human infrastructure for scientific activities. It also implies homogeneity, benchmarking, uniformity of scientific processes, competencies and activities. Globalization in science, for me, is the trans-frontier ability to harness scientific and technological advances for the promotion of peace and sustainable development for the benefit of all countries individually and collectively!

Embedded in my utopian definition of the globalization of science is a moral and ethical obligation we have to ensure diplomacy, the equitable distribution of research and development opportunities, and of uniformity in scientific investment and resource allocation to ensure standardization of the physical and human infrastructure for scientific research and development. There are challenges to that definition, which is why I believe the organizers added the aspect of diplomacy… Hence, *Globalization and the Diplomacy of Science*.

Coming from an HIV/AIDS background, I have chosen to use the HIV/AIDS challenge as a case study to underpin various perspectives that relate to the topic at hand. Why? Because HIV/AIDS has catalyzed an unprecedented interest in global health. In turn, global health has been driven by the worldwide threat of new emerging diseases and different paradigms of the spread of diseases, such as severe acute respiratory syndrome (SARS), swine flu (H1N1), tuberculosis (TB) and malaria. HIV/AIDS and these emergent diseases have triggered new challenges for research and have stimulated collaborative approaches to address the problems they pose.

These disease-focused universal problems have encouraged decision makers in academic institutions—including those in the USA, Europe, and Japan—to prioritize and deploy resources for global health programs. These resources include investment in research, such as HIV research, to yield cost-effective and timely endpoints; this work needs to be located in high incidence geographic areas.

Vertical programs, such as the President’s Emergency Plan for AIDS Relief (PEPFAR), contribute to infrastructural developments mainly for HIV/AIDS, but also increasingly offer concessions to holistic/integrated approaches to disease management, including operational research/strategic information. In addition, we are increasing multi-site and network trials, thus enhancing the training of research personnel.

This plethora of interest in global health is not without cost, as the targeted countries where research and programming is to be undertaken seek certain reciprocities, including: 1) upgrading and strengthening of local infrastructure and capacity development, such as skills transfer; 2) in-country institution and local IRB demands for in-country research, also
known as the necessary ransom (an example of some of the demands includes provision of study interventions beyond the research period); 3) improvement of science, technology, and local standards of care, and thus an increase in ethical obligations and challenges for research and study equipoise; 4) prioritization of resource allocation in regards to the conflict between care and research; 5) a research agenda based on local public health priorities and local participation in concept development and research design; and 6) local investigator involvement in the entire research process to be undertaken in the developing countries.

All the above posturing in the globalization process for research science and development demands a new form of diplomacy and understanding based on mutual respect and the recognition of each other’s potential, role, and strengths. Clearly, research, development and science cannot, and should not, take place in an environment where the roles of the various stakeholders have not been clearly defined. There has to be a local principal investigator (PI), for example, when a multi-site network trial is to be undertaken. This person understands the relevant local cultural, environmental, and practical nuances that will impact the conduct of that research. The local PI would ensure that the application for the research meets local ethical and regulatory requirements prior to implementation. Research is not a franchise and should be contextualized to the local environment.

There are certain specific issues that are important to address in the context of Globalization and the Diplomacy of Science, once more using HIV/AIDS as a case study.

**Resources**

Most scientific resources for HIV/AIDS research and development have been and largely remain in the developed world. Until recently, investments in HIV/AIDS research were largely based on the scientific agenda for developed countries and research funding largely targeting developed world issues. Ninety percent of the budget for HIV/AIDS has been based on the B subtype of the virus, whereas 90% of the persons affected—70% of whom are in Sub-Saharan Africa—have contracted the C subtype. HIV vaccine design, investigational new drug (IND) research, and for that matter behavioural interventions, have been based on studies in the developed world.

While in certain areas such as drug efficacy, this approach has not had any negative impact, in some aspects such as HIV vaccines, there have been definite ramifications, including the failed Merck HIV vaccine trials. In this case, since the vaccine had adenovirus as the vector, there seemingly was an increased risk for HIV acquisition for the enrolled recipients who had high titres of adenovirus antibodies. This example demonstrates that research studies have to be undertaken in the environment where the intervention is to take place, including in the sub-population that shall be provided with the intervention. Very often these studies are undertaken as pilot projects, so they may not be instituted in an environment that is conducive enough to maximize testing of the concept and design. Notwithstanding benchmarking and standardization of research and scientific resources, researchers need to consider the applicability of the research design, irrespective of where the research and development (R&D) is to be undertaken.
Funding and Mechanisms of Funding

Funding has been obtained largely through competitive grant applications. This system has favoured investigators who have grant writing skills and proven research track records, and is a disincentive to upcoming scientists to apply for and receive money. Sources of funding have also been limited, with most being offered by the governments from developed countries and institutions such as the National Institutes of Health (NIH), the Bill and Melinda Gates Foundation, Wellcome Trust, and pharmaceutical companies. This situation has emanated from the high cost of conducting research, making it prohibitive for developing country governments and institutions to allocate money. For example, the cost of conducting an HIV Vaccine Trials Network Phase I study (HVTN protocol 048) in Botswana in 2003-2005 that enrolled 14 participants was $1 million per year for the three years it took to complete this research. It would have been impossible for the BHP to secure such funding from the Ministry of Health Botswana. Globalization has, however, resulted in new funding opportunities offered by new sources such as PEPFAR, the Global Fund, and the European and Developing Countries Clinical Trials Partnerships (EDCTP) program. These funding sources have provided opportunities for new projects on HIV/AIDS in the developing countries.

Regulation and Legal Framework for Research and Development

As new resources and stakeholders have been attracted to developing countries for research and development, the regulatory framework for research has in some instances been found to be inadequate, and the capacities of the local ethics institutions have been overwhelmed by the volume of research and the complexities of the research process. IRBs have worked tirelessly to fulfill their mandate, very often with scarce resources. At this point, I wish to personally acknowledge and commend their dedication and commitment towards their work. The need to strengthen those institutions cannot be overemphasized. I believe, in a transparent and coordinated way, that there should be a globalized IRB-capacity strengthening process and mechanism, in much the same way as we undertake multi-site trials in an ethical manner that would not be deemed to be influencing the review process. The independence and autonomy of the IRB should also be protected and the scope of its work should be, in my opinion, of a scientific nature removed from political influences.

Community Issues

To avoid exploitation, it is essential to ensure a fair distribution of the benefits of research to the communities where such research is being undertaken. It is also important to avoid the displacing local medical staff from pressing community clinical care needs and to focus only on research, and to ensure that disruption to services where research is being undertaken is minimized. There is a fine balance between the need for healthcare providers to balance their participation in research with their role as healthcare providers. All research and development must ultimately take into account the ethical hazards that may be part of the social, economic, and political landscape of the community.
Specimen Banks, Sample Storage, and Shipping

Very often as part of research activities either to validate or confirm a finding, one needs storage of samples and specimens in the event that a particular endpoint necessitates testing primary samples. It may also be important to store specimens for future usage in the event that a new technique becomes available for retesting, or to group specimens due to rare occurrence of endpoints. Storage is expensive and requires reliable quality management (QM) systems, including stable sources of power and backup methods. Shipping samples to international labs is necessary for the standardization of multi-site trials, analysis using techniques that are not available locally, and for long-term storage under specific conditions that cannot be maintained locally. That said, genuine skills transfer and capacity building should in no way be sacrificed.

While this shipping may result in delays and conflicts with capacity building, it should be undertaken for the above reasons. The conditions for storage and shipping need to be clarified, with clearly defined policies and consent by protocols. Ultimately, there must be resourcing and the establishment of local specimen repositories.

Principal Investigators, Capacity Building, and Mentoring

This issue was discussed at this conference along with the challenges associated with the brain drain. It is essential to invest in and develop research infrastructure for the retention of scientists in developing nations and to foster ethos for research and development. It is also important to develop structures that protect research time for promising government or private employees, and to develop expectations that local researchers should lead and publish some aspects of their studies.

Access and Delivery of New Therapeutics

There are moral arguments for participants and communities of R&D to access products of research and INDs undertaken in their communities. This is based on their altruism and moral ethical obligation to do so.

Complexities of Care

HIV and most science projects are not easily simplified into vertical programs. There is a need for expansion of diagnostic and therapeutic capacity. Future trials are likely to bring about increasing laboratory complexity such as phenotypic testing and propriety issues, human leukocyte antigen (HLA) typing such as HLA*B5701, (a type of HIV that is slow to replicate), and co-receptor tropism such as Tprofile, which measures the growth of HIV in response to different environments. There is an obvious need to reach out diplomatically to new partners in new fields.

Data Management

A study is only as good as the data it generates. Information technologies currently drive development, and concerted efforts to develop that infrastructure in the developing countries shall enhance and foster the Globalization of Science. Currently there are few bio-statisticians, programmers, and data analysts in developing nations.
Closing Keynote

Intellectual Property

There are cries to accept the intellectual property (IP) rights of scientists in developed countries and to develop systems and processes to protect those rights. This right to IP can come to fruition if local scientists are given the same opportunities to test their concepts and to lead and take part in network trials.

Recommendations

I would like to end by giving a few recommendations:

1. For globalization to occur, we need a Marshal Plan for Science to facilitate human and infrastructural development that elevates research and development infrastructure standards in developing nations to those practiced in developed countries—i.e., we must have institutions equivalent to the Massachusetts Institute for Technology (MIT) in Botswana—not only in Boston. We thus must have the financial resources to support local scientists, equipment, and reagents, and if not locally then regionally. In parallel, capacity building initiatives need to be strengthened to ensure demonstrable capacity to undertake the most complicated scientific research and development locally.

2. We need a harmonized approach to regulation in the same spirit as the International Conference on Harmonization. This could include the institution of a regional and international IRB for broader scientific perspectives and local IRBs for local cultural ethical reviews of concepts.

3. While endorsing network research like the AIDS Clinical Trial Group (ACTG), the International Maternal Pediatric Adolescent AIDS Clinical Trials (IMPAACT), and the HIV Vaccine Trials Network (HVTN), we should foster increased individually focused network capacitated research and training similar to the European & Developing Countries Clinical Trials Partnership (EDCTP), with a prescription for North-South, South-South collaboration.

Conclusion

In concluding, I wish to point out that, despite the aforementioned conflicts, I believe there has been demonstrable capacity for some local research and development, and that this capacity can be strengthened by the globalization of science. The current network multi-site model, although not perfect, is the basis for hope.

I will end now with a few words from Dr. Gerald T. Keusch, Director of the Fogarty International Center:

The future of science in developing countries requires investments in information technology, the creation of a culture of research ethics, and investments in modern science.

I thank you, ladies and gentlemen.
Postlude
After the International Ethics Conference, What is Next?

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Author’s Note
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Abstract
In this text, Paul Ndebele, a member of the Ethics Conference Organizing Committee, provides a summary of the conference and its achievements, and the way forward after the International Ethics Conference.

Introduction
The International Ethics Conference held at the University of Botswana from 6-10 December 2009 brought together over 250 delegates, speakers, and other participants from a wide range of disciplines. The theme of the conference, Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research, was topical for the delegates, who were a blend of healthcare professionals, academicians, lawyers, health policy makers, theologians, researchers, media professionals, retired professionals, medical and nursing students, and, interestingly, laypersons who attended both as consumers of medical services and as potential research participants. Though health professionals and researchers represented the majority, the mix clearly reflected the growing interest in bioethics amongst people of all social backgrounds, and an increase in the magnitude and momentum of the bioethics movement globally and in Botswana specifically.
Postlude

Summary of the Conference

The conference began on Sunday, December 6, 2009 with four pre-conference workshops held in two parallel sessions in the morning and afternoon. The pre-conference workshops were facilitated by teams of local and international experts, and provided a platform for the discussion of important questions in the area of international research. The workshops also provided guidance on preparing proposals to meet the ethical requirements of review boards. The sessions were very useful for young and up-coming researchers, and stimulated debates and discussions around the issue of post-trial access.

The workshops were followed by a Braai in the Mokolodi Nature Reserve—an experience that was aimed at showcasing Botswana's natural gifts whilst at the same time serving as a stimulant for networking. The conference itself ran from December 7-9, 2009 and offered a blend of absorbing and interesting plenary sessions and panel discussions. The keynote speakers, presenters, and panelists represented various disciplines ranging from health research, research administration, health policy, and public health.

The conference included three keynote addresses covering various aspects related to each of the three main areas of focus—healthcare, medicine, and research. Each of the three keynotes was followed by comments from respondents who had expertise in the topics presented by the keynote presenters.

The first keynote was given by His Grace Archbishop Desmond Tutu, a man held in high esteem both locally and internationally. The Archbishop is a man of natural talent; in his moving keynote he called for a shift of view from the patient as a “case” to a fellow human being in need of service. The Archbishop emphasized that all human beings become vulnerable during times of illness, as illness brings them closer to death. During this time of vulnerability, humans require fellow human beings to provide them care and support. He called for a more holistic view and respect of the patient as the centre of the healthcare enterprise. He added that ethical issues and their nuances must be debated not merely by doctors but all of civil society.

Vice Admiral Adam Robinson, the second keynote speaker, gave a moving address on the need for compassion in the delivery of healthcare, medicine, and research. He illustrated his ideas ably using examples from the US Navy and the role that it plays in assisting victims of natural disasters. In his talk on *Hearing the Cries of the Poor: Healthcare as Human Response*, the United States Navy Surgeon General emphasised the need for those who have resources to assist the less privileged in times of need. His discussion naturally flowed from Archbishop Tutu’s keynote, as he illustrated how the privileged can assist the less privileged.

The third keynote which was given by Dr. Joseph Makhema, Director of the Botswana-Harvard partnership, who emphasized the important issues that arise in international collaborative research. Dr. Makhema has considerable experience in this field and ably used his own experiences in his keynote address titled *Globalization and the Diplomacy of Science*. Dr. Makhema stressed that dialogue was necessary to ensure that research addressed the needs of host countries.
Three separate lectures focused on complementing the keynote addresses. Dr. Elizabeth Holmes from the Stockdale Center for Ethical Leadership, United States Naval Academy, gave the first lecture on Character, Leadership and the Healthcare Professions. This lecture highlighted the importance of training healthcare professionals to become leaders of character. The second lecture, The Tradition of Mentoring, was given by Dr. Wayman Cheatham and Dr. Edward Gabriele, both from United States Navy Medicine. The lecture highlighted the importance of mentoring in the process of creating professionals. The third lecture focused on the integrity of research and was delivered by Dr. Linnea Axman from United States Navy Medicine and Dr. Denise Boren from California State University. It focused on the various strategies that can be used in promoting professionalism in research. All three lectures were followed by panel discussions. The panelists included experts with extensive experience related to the topics under discussion.

The Way Forward

The conference provided a platform for sharing views, research findings, and expertise on a wide variety of ethical issues inherent in clinical care, public health, research in healthcare, and health policy. The deliberations successfully sensitized participants to the spectrum of ethical issues inherent in healthcare, medicine, and research. The sessions also enabled the participants to acquire skills to recognize ethical dilemmas and constructively deal with them.

The discussions were greatly enriched by the variety of disciplines represented. The conference also served as an important forum for networking that will no doubt yield new collaborations, including staff and student exchanges, collaborative grant writing, future conferences, workshops, and other opportunities. The participants who represented their institutions brought with them a wealth of experience and expertise. The new collaborations that emerged from this sharing of ideas and skills enabled the participants to take back new knowledge to their respective institutions. This dissemination of new ideas ensures that the benefit is shared, and that a “re-inventing of the wheel” is avoided.

Throughout the conference, one message came out clearly: whilst medicine, healthcare and research have played an important role in prolonging life to unexpected lengths, checks and balances are needed to ensure that humankind is well served. Concerns were also expressed regarding justice issues in international collaborative research and unjust health care policies and medical practices that are not patient-focused.

It was also clear that academic and training institutions, such as the University of Botswana, need to serve as a national focal point by initiating dialogue on improving professional practice by researchers and healthcare workers. Policy makers and practitioners must be guided by ethical principles in the development and implementation of policies that address research, healthcare, and medicine. On an individual level, it became very evident that ethics has an important influence on life decisions, and there is a need to provide space for ethical discourse in academic, public, and professional arenas. An ethics knowledge gap was identified among researchers and professionals and policy makers. This gap needs to be bridged so that individuals are empowered to make ethical decisions in alignment with their values and beliefs. One delegate summarized all this in one statement: “Ethics is about human beings living as humans.”
An important contribution of the conference was the dialogue initiated on bioethics education and the subject of mentoring as a key component in the training of professionals so that they can integrate ethical perspectives into their work. There is a need to sensitize health professionals and researchers to their respective roles in responsible communication of medical issues to the public and reporting on scientific research. In the future, focused training courses should be held for professionals working in the various areas of healthcare, medicine, and research, as each area has unique ethical issues.

The media also has an important role to play in framing ethical issues and the responses of the public, patients, and other parties. Future workshops, seminars, and conferences should continue to ensure that discussions and debates continue. Practitioners from developing countries should be a part of the development process for professional codes guiding any discipline. This activity would support Ubuntu’s belief that we all need to make a meaningful contribution towards the advancement of human society. Ethical principles are embedded in the African philosophy of Ubuntu, and the Ethics Conference provided practitioners, based in Botswana and other African countries, an opportunity for a focused discussion on how Ubuntu can be incorporated into medicine, healthcare, and research so they can all continue to serve society.

As the University of Botswana seeks to become a research-intensive university, there will always be the need to look back and check if the research enterprise has a “human face.” In the training of various cadres of health professionals, there will always be the need to ensure that these individuals are trained in such a way that they can highlight the human face of healthcare, medicine, and research. As one of the main producers of health professionals and policy makers, the University of Botswana has to focus on the bigger picture by addressing the question: What role can the University play in ensuring and promoting ethical practices in medicine, healthcare and research?

The conference has served as an important milestone that will ensure that training and research programmes at the University of Botswana are designed to serve society. In terms of possibilities of future collaboration, the conference serves as an important starting point, as it has served successfully in creating both local and international networks.
Epilogue

The International Ethics Conference: An Eye Opener

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Abstract
In this text, Ellemes Phuma, shares her experience and the benefits she derived from the International Ethics Conference held at the University of Botswana (UB). As a graduate student in nursing at that university, she provides her perspective on professional responsibility, compassionate healthcare, and the ethical role that healthcare professionals assume when dealing with vulnerable patients.

Introduction
The Ethics Conference held at the University of Botswana was the first Medical Ethics Conference I have attended. The conference, which was themed Retrieving the Human Face of Science: Understanding Ethics and Integrity in Healthcare, Medicine and Research, took place at the University of Botswana Library Auditorium from 6-10th December 2009. It attracted an audience of professionals from different disciplines, as well as students from Environmental Science, Nursing, Medicine, and Social Work. As one of the students who attended the conference, I was offered an opportunity to learn more about ethics in the area of healthcare and research.

Conference Overview
The conference, which started with a pre-conference workshop in parallel sessions on 6th December, had delegates from different countries. Some individuals who were not directly related to healthcare, medicine and research, were also in attendance. Presentations and discussions during the two pre-conference sessions I attended provided an insight regarding the importance of following appropriate ethical procedures when developing proposals in healthcare research and clinical trials.

On the first day of the conference, it was so impressive to see Archbishop Emeritus Desmond Tutu giving the opening keynote address. Archbishop Tutu is well known in Africa for his contribution to the fight against apartheid in South Africa and remains an important international figure due to his international involvement. In his address, Human Illness and the Experience of Vulnerability, he pointed out that human beings have emotions and psychological needs; when ill, they become vulnerable, requiring the caring hand of other human beings.
Epilogues

His presentation caused us, as healthcare providers, to reflect on our actions and interactions with consumers of healthcare services. I realized that in most cases we providers take a superior role over our patients, addressing them by the conditions they are suffering from rather than as individuals. We tend to forget that as “human beings, we are also vulnerable,” and at some time in our lives will also need care and comfort from others. It was from this perspective that I discovered that, as a student in the healthcare profession, I have a duty to improve my perceptions and attitudes towards healthcare consumers and be counted among the most respectful health professionals who live and work for others.

The keynote by Archbishop Tutu was followed by a second keynote address given by the US Navy Surgeon General, Vice Admiral Adam Robinson. In his address, *Hearing the Cries of the Poor: Healthcare as Human Response*, Vice Admiral Robinson gave examples of the various engagements by the US Navy in assisting individuals and communities in need. It was so interesting to see how the two keynote addresses were related. From this address it was clear that, as healthcare providers, we have the responsibility to respond positively to the needs of people in all settings who are made vulnerable by illness.

The keynote addresses by Archbishop Tutu and Vice Admiral Robinson were complemented by a series of lectures and panel discussions that provided an opportunity for further discussion. Of interest were the presentations on character, leadership, the healthcare profession, and the tradition of mentoring. It was emphasized that, as a noble profession, healthcare is challenging and requires leaders who are competent, confident, and caring. Since the quality of healthcare providers is influenced by the type of mentors encountered, leaders and academics in the healthcare profession should provide exemplary mentorship to students. The discussion reminded me that, as students, we sometimes tend to acquire skills and develop attitudes that will distort the human face. We need to step up and make a difference. Students need to be responsible for developing themselves in a way that will impress their mentors and benefit healthcare consumers.

We also had the opportunity to visit the technology expositions, where different posters displayed some of the interventions that are being used to reduce medical errors in institutions. It was noted that most of the medical errors that patients experience in healthcare institutions result from human factors and negligence. Most of these errors can be avoided if professionals follow standard procedures in healthcare. I realized that, as patient advocates, students and healthcare professionals should strive to ensure safety by reducing medical errors.

**Conclusion**

The conference was an eye opener to both experienced professionals and students from different disciplines. It provided delegates an insight into what it takes to become a competent, confident, and caring professional in the challenging healthcare profession. As a student, I learned that patients should not be looked upon as cases and numbers, but treated with respect as fellow human beings who are in need of a helping hand. As a healthcare professional, I realized that there is need to strive towards a service based on compassion, friendship, trust, and, above all, professionalism.
It is high time students in the healthcare profession become assertive in developing themselves as competent, confident, and caring professionals to change the current face of healthcare provision. To achieve this change, students need to acquire from their mentors only those attitudes and skills that will contribute positively to the healthcare profession. I am now not only looking forward to completing my studies, but also to serving my country—as a professional. I hope that all health sciences students at UB and other institutions will have the opportunity to benefit from similar events in the future.
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From Information to Transformation: Entering Out From the Conference Experience

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Editor’s Note

Michael Whitecar of The Chief Information Group wrote this closing essay. Mr. Whitecar directed the International Conference Educational Technology Demonstration Exhibit. His expertise as a computer scientist was instrumental in recording various sessions. His perspectives in this closing essay are an important reminder that what can occur educationally in a given moment only achieves its fullest potential when it is no longer just the transfer of information. Educational depth occurs only when one realizes that a given experience affords one with that gift of wisdom that makes for personal and professional transformation.

Reflection

There is a saying that one needs to go out onto the balcony to look inward from outward to reflect on their lives and surroundings. I am one for going out to my own balcony, but I did not realize that it would take a balcony over 8,000 miles away to appreciate truly and be thankful for who I am and what I have.

Upon accepting an invitation to attend and present at the University of Botswana, I did not realize that my one-week journey would have such an impact on my own life. When returning from Botswana, I stood on yet another balcony reflecting on the previous week. The feelings of gratitude, appreciation, and acceptance of diversity continually resonate in my mind as I think about my own reflections, the people of Botswana, and the children who make their country smile.

With that said, I am reassured that my family and friends know their place in my heart. Yet I feel the need to recognize publicly the people of The Chief Information Group (TCIG) who have been with my business partner Mike Green and me, for over four years. I am appreciative of their loyalty, character, and commitment to serve our clients.
Reflection is very important in life if we want to understand who we are, where we are, and where we want to be. One might think reflection is relatively easy; yet traveling halfway around the world to a far off continent causes a different and deeper experience of reflection. First, I obviously knew that I was no longer in a customary environment. Different types of people, their behaviors, their native languages: these all surrounded me. I was enveloped by a terrain of nature that is one of the most spectacular one can see. For a brief yet important week, I was jarred out of my regular life and catapulted into something vastly different. This moved my native ways of reflecting on life into new territory of its own. This altered my view on life and thrust me into a different perspective.

My first step to authentic and meaningful reflection is to be open and welcome all the things different around me. Living in America, I like to believe that I have the perfect life, but by widening my lenses during the conference, I was able to see different angles of the world. Seeing far better places does not mean that I wish to alter my life, but instead it changes me. Everything we do in life starts with a single thought and I am in control of the path to which the thought leads. It is with this thought that I was able to be open to this new-found awareness and to digest my new surroundings; I was able to grasp the person that I am and accept the person that I was to become.

I reflected in the hotel, as I walked a busy street en route to the University, and in the evenings as I attended dinners with some of the most interesting people I have ever met – some of whom only live but a few miles from me at home.

There was one particularly interesting moment. I was challenged with getting over jet lag when I was awakened by the most entertaining array of birds singing. I opened my hotel patio door and listened to a myriad of species of birds, feeling their melodies cascade over me. This was a beautiful indication of the start of a new day. They were an alarm clock that needed no introduction. I sometimes wonder if birds’ daybreak singing can be translated to “It is time to enter not just another 24 hours, but the experience of another Day of Brilliance.” Indeed, such moments move one to become lost in thought, pondering unknown desired futures for one’s life.

Locating the birds in the early morning hours was an interesting metaphor as to how picturesque and comfortable I believe my life has become. It seems like nothing is wrong where I come from, I have everything I need, and I have many things of beauty and convenience. Yet the truly important things in life steal into our awareness sometimes only with a slow and evolving dawn. The elemental things that people need are love of others, love of one’s self, friendship, and the ability to accept diversity. Reflecting on diversity is not a matter of race, religion or color, but the deep and abiding appreciation of our rich and unique differences. In this light, I reflect on a popular Setswana Proverb that I learned during the conference: Pelo e ntle ke leswalo la motho, translated as, A good heart is the medicine of a person. In the morning hours, the songs of birds led me to a different place. I began slowly with an internal dawn to explore the valuable parts of being human, of being a citizen of the world.

A few of us decided to take a tour of the city of Gaborone, the site of the university conference, with one of the local tour guides. To my surprise, the first visit was to the Museum of Botswana History. I come to visit a country, to digest a new culture, and my first point of entry was its museum! Our tour guide, who was also employed full-time as a
prison guard, was very proud of the museum. Usually I quickly glance at museum exhibits in quick succession; however, with this experience we spent 5-10 minutes per exhibit as the tour guide passionately taught our group about life in Botswana. This was one of my first experiences with a local citizen. The rest of the day included stops at other historical landmarks of the city from a local's perspective.

During my journey, I came to focus on the people of Botswana, discovering who they are, what is important to them, and how they might understand me as an individual. The streets were lined with vendors selling their wares, including prepared food from their own homes. Women carried umbrellas to protect their skin from the overpowering sunlight on this hot summer day. I could hear laughter and see expressions of joy. Many times I would ask myself “Why are they all so happy?” Living in America I am too often accustomed to comparing my lifestyle with those of others and then judging them. What I learned from my city tour was that the people would look forward to gathering in the street malls and engaging in friendly conversation with one another. As I would approach a vendor he or she would look at me as if I was the only thing that mattered at that time. Another lesson learned: The people focused on the “now” in life, not the past and not the future. I was inspired by this level of living, by what seemed in hindsight to be a deeper level of human maturity... something I feel I have been lacking.

As there were over 250 attendees at the conference I was able to watch many of them as I became the unofficial, yet official photographer. Using my new camera, I was eager to take candid shots of the attendees. In America many people would shy away from a camera lens. At the conference, the delegates would pause, look at me, smile in anticipation of a flash, and return afterward to whatever they were doing. After looking at over 500 pictures that I so proudly took, I realized that the delegates were very proud and happy. Not once did I hear anyone complain about government, politics, or the person next door. Given how life is in my own neighborhood, this was truly different—and refreshing!

My experiences at the hotel were equally powerful. I remember the night of my arrival. A gentleman took my luggage to my room. As he was doing this I was trying to figure out the exchange rate so that I could tip him appropriately. Unfortunately, I got the exchange rate backwards, and instead of giving him the equivalent of a few American dollars I only gave him about five pennies. Instead of staring at me in disappointment or anger, he simply looked and said “Thank you, is there anything else I can do for you?” I said “No,” proudly thinking that I met the standard. After I figured out what had actually taken place, I quickly left my room in search of the man to tip him correctly, but he was nowhere to be found. I told one of my conference peers about the situation and he stated, “No problem! The people of the hotel are not worried about such minute issues.” Amazing! People in America get very indignant if they do not receive a 20% gratuity even though the service might be substandard. This experience taught me something valuable. Many times in life what is valuable is not the business transaction, but the act of human interaction and care. Such moments remind us of the real virtue of gratitude, and the problems we have with greed and power.

Visiting outside the city limits of Gaborone many of us embarked upon a journey similar to Dr. Livingston’s along the Mirko Raner River. We encountered local villagers who were less fortunate than others, yet appeared happier and were more engaging. Many
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were walking the flank of the river in anticipation of gathering potable water to take back to their families. In one area we came across preparations for a baptism. Whether it was the priest preparing for the baptism or villagers seeking water, they all stopped to engage us in conversation. Like everyone we met during the entire week, they shared their knowledge of their great lands. When asked if we could take a picture, they instantly posed proudly for our souvenir snapshot; a healthy human pride in the act of meeting another. In a world too caught up in competition and greed, this was another gift on which to reflect deeply.

Another enlightening experience I encountered was visiting the Botswana Children’s Clinic and a children’s site known as SOS. The lobby of the clinic was filled with parents and many children. The majority of the patients were being treated for HIV/AIDS. It was deeply saddening but also equally encouraging, as many healthcare clinicians from around the world were eagerly providing assistance. I was surprised at the number of HIV/AIDS cases, not only in Botswana but all over the world. Education is critical to prevention, and this was a theme that was stressed in our conversations. The facility itself was fairly new; it was decorated with art that was created by many of the children. It made an impact; it moved me to want to do more—much more—not just for those close to me in my own neighborhoods, but also in lands far away. Something again moved deep within me. Looking into the faces of those who were ill made a difference. Realizing how much their parents looked at me with longing—something struck strings deep inside me and created some measure of music that will take much time to hear with sense and logic.

The SOS children’s site contained approximately 300 children, many with HIV/AIDS. The arrangements are similar to our foster homes in America. However, adoption is not an immediate priority. The priority for these children is healthcare, family and friends, education, and love. We toured the village, finding children playing in the field, working on computers, and producing musical sounds from instruments. Many of them quickly came to us and wanted to play.

I came across a young child who had a remote control car but no batteries. I took two double AA batteries from my camera and placed them into his car. The smile on this young child’s face was breathtaking. He quickly gathered his friends and most likely spent the remainder of the day playing with his remote control car. It was amazing to see how such a small gift, just two little AA batteries, could brighten someone’s day. Somehow this is making a huge difference in my life. I am not sure how, but it is. Coming to this conference has opened up dormant feelings I never could have expressed or anticipated. Hearing a new language, not just from lips but from hearts, made me hear sounds and speech in new and different ways. Seeing into the eyes of those who suffer is making me look differently at others, in fact very differently at myself and the comforts of life that I enjoy.

From this opportunity to journey to an international ethics conference, I gained new friendships both with individuals from home and from Botswana. Today these friends and I continue to talk. In fact, we talk a lot. Sometimes in emails. Other times, for those here in my neighborhood, over a meal. But we no longer talk just about the latest in sports, world affairs, American politics, or the latest minor disturbances. Rather, we talk about things that mean something. We talk about life, about helping others, and about holding close those things that matter most to us—our families, our friends, and those we work with. We talk now, amid laughter and closeness, about our desires and hopes. We talk about those in need.
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We talk about how we want to make a difference. And all this because, for a week too brief yet seemingly without time, we came to a conference and entered into something so much more.

Another Setswana Proverb—*O se tshego o oleng, mareledi a sale pele*. It translates as *Do not laugh at the fallen; there are slippery places ahead*. This is what I saw in the people of Botswana. I did not see judgment. I did not see color. I certainly did not see fear. What I saw were some of the most beautiful and happy people in the world. As an American I may have access to much. After my visit to Botswana, I have much more to offer those I now touch, because I myself was touched by an unexpected but most welcome experience.

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