Notes

Preface

1. The report was published as Kohn, Corrigan, and Donaldson 2000. Even according to conservative estimates of the number of deaths resulting from medical error (44,000), “More people die in a given year as the result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516).” The “national costs” of harmful medical mistakes—the combined costs of health care, lost income, and other expenses resulting from these injuries—“are estimated to be between $17 billion and $29 billion, of which health care costs represent over one-half.” Ibid., 1-2.


3. The classic text on human error is Reason 1990. For an essential discussion of all types of medical harm, including nosocomial infection and harms resulting from inappropriate care, see Sharpe and Faden 1998. Rubin and Zoloth 2000 includes many useful and important essays, notably Lucian L. Leape’s authoritative yet concise overview, “Error in Medicine,” and also addresses the issue of mistakes made within the context of clinical ethics consultations.


ONE: Narrative Ethics

1. For a summary and discussion of the disclosure obligation, see chapter 6.


9. Ibid., 262.
10. Ibid., 260–64. Childress's critique of narrative overcorrection focuses on interpretations of the "Dax" case, the personal narrative of a severely burned patient that is perhaps the most well-known case study in bioethics.


13. Medical humanities scholars such as Tod Chambers also apply literary theory to the case study, a time-honored teaching tool in bioethics. Chambers argues that these "factual" third-person accounts of medical cases are shaped by multiple genre conventions and should properly be read as fiction. Chambers 1999.


15. Ibid., 3.

16. Ibid., xi.

17. Ibid., xi. Hawkins identifies a "problem" with Kleinman's model in that it encourages clinicians to view the patient's account not as a coherent narrative from which the physician can learn, but as raw data that the physician must organize into a proper story so that he can then say what it means: "The patient, then, only 'speaks' through the physician's capacity to listen, understand, and interpret" (179n5).

18. Ibid., xii.


20. These distinctions were made by Professor La Capra 2003.

21. This not to say that a story an author believes to be an accurate representation of the memory of her own lived experience cannot be factually untrue, in the sense of being a fantasy.

22. "Narrative form alters experience, giving it a definite shape, organizing events into a beginning, a middle, and an end, and adding drama — heightening feelings and seeing the individuals involved as characters in a therapeutic plot. Writing about an experience — any experience — invariably changes it." Hawkins 1993, 14–15.

23. Ibid., xii. Concerning the difference between their goals, Frank writes, "For Hawkins, the 'study of pathography' has as its goal 'in restoring the patient's voice to the medical enterprise' ... my goal is restoring the patient's voice to the patients themselves, or enhancing a developing self-consciousness among ill people that they are more than medical patients." Frank 1997, 31–49, at 48n15.


25. Ibid., 161.

26. Consider, for example, one of the greatest examples of the form, Dorothy Sayers's *The Nine Tailors*, in which a suspicious death (of a thoroughly unlikeable character, admittedly) is assumed to be and investigated as a crime, then determined to have been a bizarre accident. The detective fiction of Karel Capek, who introduced the genre into Czech literature in the 1920s, and, more recently, of Alexander McCall Smith, in his novels set in Botswana, often have little to do with crime-solving and more to do with investigating puzzling events or probing moral dilemmas. See Capek 1994, vii–xii.

27. For Sacks's description of the etiology of the clinical tale, see Sacks 1990, vii–ix.


31. Albert Wu makes this point when he describes the physician in the aftermath of error as the second victim of that error. Wu 2000, 726–27.

Two: Physicians’ Narratives

1. The Harvard Medical Practice Study includes the following publications, which are often referred to, in the following order, as “Harvard study” 1, 2, 3, and so on: Brennan et al. 1991; Leape et al. 1991; Localio et al. 1991; Weiler et al. 1993; Weiler, Newhouse, and Hiatt 1992; and Johnson et al. 1992.


8. Hilfiker 1984. A slightly revised version of this article appears as a chapter entitled “Mistakes,” in Hilfiker 1985, 72–86. All quotations refer to the original article. According to the biographical note in Hilfiker (1985), the author was born in 1945 and so would have been 39 years old when “Facing Our Mistakes” was published, and 33 years old at the time of the incident described at the beginning of this article.

9. In accounts of error that are written by clinicians who practice in the United States, it is sometimes hard to figure out what went wrong or who was responsible. On the one hand, confronting one’s own fallibility is one of the conventions of the Bildungroman of medical school or residency, in which early-career physicians recall, in painstaking detail, their technical, professional, and moral indoctrination into the culture of medicine. In an especially popular example of this genre, Perri Klass writes “mistakes are how you learn” (Klass 1987, 94). Yet when Klass herself describes a possible mistake that she (evidently) made, she distances herself from this incident by adopting a narrative device that she uses nowhere else in her book. At the beginning of the chapter that includes the incident, Klass describes the members of a team on duty over a weekend. One of the students on the team “is more than a little like me . . . We can call her Elizabeth, which is, in fact, my middle name” (Klass 1987, 251). It is “Elizabeth” who is directed to inject Dilantin into a patient’s IV line; it is “Elizabeth” who may have delivered the drug too quickly, causing the patient’s blood pressure to plummet; it is “Elizabeth” “who is trembling from having almost killed someone” (Klass 1987, 267). Klass is not on duty this weekend; it is “Elizabeth’s” life and “Elizabeth’s” mistake that she is narrating.

10. Anonymous focus group participant, quoted in Gallagher et al. 2003, 1005.


13. Pierluissi et al. 2003, 2838.


17. Ibid., 1004.
19. Ibid., 356.
22. Konner 1988, 46; see also Klass 1987, 115.
23. For a description of this model, see Pollack et al. 2003, 205.
24. For a description of this model, see Shapiro 2003.
25. For a description of this model, see www.narrativemedicine.org/research.html (accessed March 25, 2004). See also Charon 2001.
27. This phrase was used by Edward Dauer in his presentation at the January 2002 meeting of the Promoting Patient Safety project at the Hastings Center (Dauer 2002).

T H R E E: Patients’ and Families’ Narratives

4. Localio et al. 1991, 245. The precise figure cited in the study is 1.53 percent.
5. Ibid., 245.
7. Goeltz 2000. A version of this story was read into the record of a U.S. Senate hearing on “Patient Safety: Instilling Hospitals with a Culture of Continuous Improvement,” June 11, 2003. References to this version of the story are cited as “Testimony of Roxanne J. Goeltz.”
8. Goeltz, “Testimony,” 2. The “Testimony” version of this narrative says that Mike’s parents were called “shortly after 3:00 a.m.,” whereas the earlier version says “4:00 a.m.” See Goeltz 2000, 4.
10. Ibid., 2.
11. “M & M” in Ofri 2003, 201. The issue of whether to “clean up” after a death or bad outcome, before allowing the family to see the patient, is a complicated one. A hospital chaplain reports that, at one hospital where she had worked, the practice after an emergency-room death had been to clean up the room “totally”—mop up the blood, empty the trash—before bringing the family to see the patient’s body. Although this practice was intended to spare the family any further anguish, the hospital changed its practice after hearing comments from family members who observed the tidied-up room and concluded that the staff did not “do” enough to save their loved one. As a result, according to this chaplain, “we stopped being so neat and clean” (Martha Jacobs, personal communication). What this story has in common with Danielle Ofri’s story, which has a different clinical context, is that, in each case, the clinicians made an effort to look at the situation from the perspective of the grieving family and acted in the interest of their emotional well-being. By contrast, the clinicians in Roxanne Goeltz’s story evidently made no such effort.
15. Ibid., 3.
16. Ibid., 4.
17. Ibid., 4.
18. Ibid., 4.
21. Other organizations created by injured patients and their families include PULSE (Persons United Limiting Substandards and Errors in Health Care), which collects and circulates “real life stories and experiences” as a means of providing emotional support to injured patients and their families and as teaching tools for patient-safety advocates and the general public. www.pulseamerica.org (accessed March 27, 2004). Another organization, Voice4Patients, whose mission is “empowering patients to be their own health care advocates,” also collects and shares “stories and suggestions” from injured patients and their families. www.voice4patients.com (accessed March 27, 2004). Other advocacy-oriented Web sites and publications collect and publish “stories” of medical harm that may be based on personal narratives, interviews, or other primary source material, but are to be distinguished from the actual narratives composed by patients or family members themselves. See, for example, the “Stories of Medical Malpractice” posted on the Web site of the Center for Justice and Democracy, an organization that opposes tort reform initiatives that would curtail patients' rights to sue after medical injuries. www.centerjd.org/stories/index.html (accessed March 27, 2004). See also Gibson and Singh 2003.
24. On March 8, 2005, a Google search on “medical error” yielded 124,000 hits.
25. www.nancylim.org (accessed March 21, 2004). All subsequent citations refer to documents located on or created for this Web site. Because the Web site includes many different documents, some of which are not paginated, each quotation or other reference is cited with its own note rather than via internal citations. The link for all citations is www.nancylim.org; the Web site does not generate links to some individual pages. A narrative description of the location of each citation is provided in the accompanying note; in most cases, sections of the Web site and documents within each section are accessed by using the toolbar on the left-hand side of screen.
27. Details of Lim's initial injury are summarized from the “Birth announcement” document, located on the time line section of the Web site. This document was evidently written and distributed many months before Lim's death (accessed March 21, 2004).
28. Details of Lim's symptoms prior to her final hospitalization, and the events leading to her death, are summarized from several documents, including “Letter to friends.”
("death announcement") located on the time line section of the Web site and various depositions located on the time line and legal documents sections of the Web site (accessed March 21, 2004).

30. This header appears on all pages of the Web site (accessed March 21, 2004).
32. The most recent update is an article dated August 11, 2002; see "News Forum" (tool bar at top of screen), www.nancylim.org (accessed March 21, 2004).
33. Barnes was awarded two "wrongful death" settlements on behalf of his son. The documents describing the terms of each settlement are available at www.nancylim.org or see "$750,000 first settlement" and "We settle in chambers" links on the time line section (accessed March 21, 2004).
38. Barnes is trained as an economist and, at the time of his deposition, was working for an economics think tank. See Michael Barnes deposition, 180. Available in Legal Documents, www.nancylim.org (accessed March 21, 2004).
39. Readers will notice other parallels between the stories told by Gilbert and Barnes: both stories take place in northern California in the early 1990s, and both authors work for the University of California.

FOUR: Disclosure

3. Ibid., 20.
8. Bethge 2000, 813. Based on Bonhoeffer's notes, which were preserved, Bethge dates
the initial drafting of the essay to April–July 1943, when Roeder’s interrogations took place, although Bonhoeffer first mentions the essay several months later, when he has resumed work on it. (Bethge 2000, 811, 813; Bonhoeffer 1997b, 130, 158–59, 163–64).


11. Elshtain 2001, 361. The Tegel essay has not been included in the Ethik volume of Dietrich Bonhoeffer Werke (DBW 6), the authoritative scholarly edition (the English translation of this revised edition was published by Fortress Press in 2005), nor in the DBW edition of the prison letters, Widerstand und Ergebung ["Resistance and Submission"], (DBW 8). Rather, "Fragment eines Aufsatzes: Was Heisst die Wahrheit sagen?" has been included in a volume entitled Konspiration und Haft ["Conspiracy and Imprisonment"]: 1940–45 (DBW 16), which has not yet been translated into English.

12. This functional definition of “full disclosure” within the context of medical harm is derived from the policy and practices of the Lexington (Kentucky) Veterans Administration Medical Center (the “Lexington Model”), whose approach to disclosure is discussed in chapter 6.

13. The following discussion of Bonhoeffer’s writings on truth telling is indebted to Elshtain’s invaluable close reading and analysis in “Bonhoeffer and Modernity” (Elshtain 2001, 360).


17. Ibid., 270–71.

18. Bonhoeffer 1997b, 171n2. In a note on the text, Bethge writes that this passage postdates the rest of the essay (he was one of its three recipients) and suggests it may have been written as late as autumn 1943. More recently, the DBW editors date it as “ende 1942?” (Bonhoeffer DBW 1998, 8, 38). Bethge’s suggestion that Bonhoeffer may have written the passage on the “view from below” as late as autumn 1943, when he was revising the essay on truth telling, is tantalizing.

19. Ibid., 17.

20. Bonhoeffer 1995b, 358. Subsequent references to the Tegel essay have not been cited internally because of the textual problem described in n11: Although this text has traditionally been appended to Ethik, it is no longer considered to be part of that work, and thus internal references to Ethik may be misleading.

21. Ibid., 359.

22. Ibid., 359.

23. Ibid., 359.

24. Ibid., 359.

25. Ibid., 359–60.


29. The phrase “moral shelter” is used by S. M. Reverby in her essay, “More than Fact and Fiction: Cultural Memory and the Tuskegee Syphilis Study,” Reverby 2001, 26,
28n33. Reverby notes that it was contributed by the “first anonymous reader of this paper.”

30. “A spoke in the wheel” is the English rendering of a metaphor within “Bonhoeffer’s famous analogy for the church’s responsibility in his 1933 essay, ‘The Church and the Jewish Question.’ There Bonhoeffer says that the church’s responsibility in the case of a vehicle run amok (i.e., the German state) is not only to bind up the victims fallen under the wheels but to grab the wheels by the spokes in order to stop them.” Green 1997, 224. Green notes that this phrase, although used by several English-language Bonhoeffer scholars and translators, perpetuates an “unfortunate ambiguity” with respect to Bonhoeffer’s meaning: “In English, a ‘spoke’ can be either a part of the wheel itself . . . or a stake thrust into the wheel to bring it to a halt.” The translation should clearly convey the latter definition.

33. Bethge 2000, 851. With respect to Bonhoeffer’s attention to professional ethics, it is worth mentioning that, within the field of bioethics, Bonhoeffer may be identified as a medical ethicist and somewhat anachronistically claimed as a proto-bioethicist. This identification stems from “The Right to Bodily Life” and related material in Ethics, in which Bonhoeffer reflects on euthanasia and eugenics. This material, in turn, was informed by his involvement in efforts to help several German doctors uphold their professional obligation to “do no harm” by refusing to comply with the Nazis’ euthanasia policies. See Bethge 2000, 688, Bonhoeffer 1995b, 142–85, in particular 159ff; see also Elshtain 2001, 353–54, and Chapman 1999, the latter of which lists Bonhoeffer among the “major Protestant theologians and ethicists” who were “midwives to the birth of bioethics” (224). According to Bethge, Bonhoeffer “spoke with his father,” Karl Bonhoeffer, a prominent physician and retired professor of psychiatry and neurology, “about giving [the doctors] authoritative medical documents that they could use as grounds for refusing to hand their patients over” (688). Historian Michael Burleigh, who has researched the Nazi euthanasia program, writes that “[Karl] Bonhoeffer was and remains a controversial figure,” particularly among German historians of medicine, in efforts to understand German attitudes towards euthanasia and eugenics prior to as well as during the implementation of the Nazis’ policies. Burleigh 1994, 11–12, 118, 293.
34. Bonhoeffer 1997b, 17.
37. Ibid., 1.

**FIVE: Apology**

2. Cohen, a law professor and economist, is also a scholar of Jewish ethics; Taft, a
longtime plaintiff’s lawyer, who now works as a consultant, has been both a student and a dean at Harvard Divinity School.

3. On the Truth and Reconciliation Commission’s use of language and practices derived from religion, see Minow 1998, 55, 78. Minow points out that the TRC neither required offenders to apologize as part of the disclosure of their offenses, nor required those harmed by apartheid to forgive the offenders, although she cites professor and human rights activist Andre Du Toit’s comment that, under the leadership of Bishop Desmond Tutu, “the influence of religious style and symbolism” on the TRC was significant.

4. On apology after medical error as cultural expectation, see Berlinger and Wu (2005).


7. Dating of statutes and descriptions of case law and pending legislation reflects Cohen (2002), except when the status of legislation has changed subsequent to the publication of Cohen’s article; in such cases, dates and descriptions reflect the author’s own research.


10. For a detailed discussion of the background of this law, see Taft, 1151, cited in Cohen 2002, 827.


15. Cohen finds the Connecticut bill “ambiguous” regarding the protection of admissions of fault, although the lack of reference to “sympathy,” which is typical of the majority of “I’m sorry” laws, implies that “apology” is inclusive of sympathy plus admission of fault. See Cohen 2002, 831–32.


19. The settlement that Nancy Lim’s family was offered following her death was based on the substandard care Lim received during a hospitalization for complications resulting from the initial surgical injury.

20. For a discussion of the automotive context of the Massachusetts law, see Taft, 1151, cited in Cohen 2002, 827. Connecticut’s proposed legislation notes that the law would apply to “motorists and others.” Jonathan Cohen mentions that the legislative debate over California’s law included a description of how the law would apply in the case of a driver who, while using a cell phone, collided with another car. See Cohen 2002, 829.

22. For a discussion of media coverage of “I’m sorry” laws in several states, see Cohen 2002, 831.
25. Information about COPIC’s role in the passage of HB 1232 comes from the following sources: Appleby 2003, 5B; COPIC Topics 2003a.
30. It is worth noting that nurses involved in cases in which error or negligence is alleged tend to be punished more harshly than physicians, and this may affect nurses’ willingness to report mistakes they have made or observed. According to a study conducted by the National Patient Safety Foundation to assess the educational needs of physicians and nurses with respect to improving patient safety, nurses reported that although “it is a part of the nursing task and responsibility to report error,” nurses, who “are not generally empowered within the hierarchy of medical professionals,” may fail to report error because of “the system’s punitive procedural processes,” as well as “fear and/or humiliation” and, above all, the belief that reporting errors “will not result in actual change.” See VanGeest and Cummins 2003.
32. Cohen 1999a, 1012.
33. Taft 2000, 1142.
34. Cohen1999a, 1060–61, see also 1064.
35. Taft 2000, 1139.
36. Ibid., 1152–53.
38. Schneider 2000, page 3 of PDF of article.
40. Desmond Tutu, quoted in Schneider 2000, 4. See also Shriver 1995, for a variation on this quote—“If you steal my pen and say ‘I’m sorry’ without returning the pen, your apology means nothing” (224)—and a description of its context.
41. A recent editorial in a leading medical journal makes a similar point concerning apologies after medical mistakes: “While apologies by definition deal with the intangible aspects of injury, they do not eliminate the need to address the tangible aspects as well.” Frenkel and Liebman 2004, at 482.
42. Bonhoeffer 1955b, 66.
43. King in Wogaman and Strong 1996, 351.

Six: Repentance

3. LaFree and Rack 1996.
11. Ibid., 112, 117.
13. Ibid., 33.
15. The precise relationship between full disclosure and malpractice suits is still being debated, in large part because there are still so few hard data on the cost-effectiveness of full-disclosure policies that are carried out consistently in practice. As a result, hospitals may be tempted to forego full disclosure in practice until it is “proven” to be cost-effective—at other hospitals. This, of course, is a catch-22 and it circumvents the ethical obligation to disclose: if hospitals do not consistently disclose mistakes, there will never be sufficient data to demonstrate whether this practice is cost-effective. See Kachalia et al., 2003, 503.
16. For a description of a recent demonstration project conducted in Pennsylvania that studied the use of early, interest-based mediation in disclosure, with attention to compensation, see Liebman and Hyman July-August 2004, 22–32. For a description of a different approach, which uses mediation to resolve formal malpractice claims, see Brown 1998, 432–40.
17. Lamb et al. 2003, 77.
18. The researchers also found that risk managers who expressed the most concern about malpractice litigation were the ones who were the least likely to disclose mistakes. Lamb et al. 2003, 79.
19. This program is described in detail in Kraman and Hamm 1999. See also Hamm and Kraman 2001 and Kraman 2001.
20. The phrase “Lexington Model” is used by Hamm and Kraman 2001, 21. The phrase “humanistic risk management” is used by Kraman and Hamm 1999, 963. Hamm and Kraman’s affiliations are described by legal scholar Jonathan R. Cohen in his analysis of the Lexington Model, which includes interviews with Kraman, Hamm, and other Lexington VAMC staff; see Cohen 2000, 1452.
21. The circumstances of the error that gave rise to the Lexington Model are discussed in Kraman 2001, 254.
24. At the Lexington VAMC, the chief of staff discloses mistakes on behalf of the institution and individual responsible parties on the basis that “the ethical obligation is institutional,” particularly at a teaching hospital staffed largely by residents (Hamm and Kraman 2001, 23). In his critique of this aspect of the Lexington Model, Albert Wu contends that disclosure is “more naturally” the responsibility of the individual physician who has made the error. See Wu 1999, 971.
28. Contrary to the belief of many physicians outside the VA health care system, patients in this system can sue for malpractice, although they cannot sue physicians personally: “despite being immune from personal inclusion as a defendant, [VA] physicians are deposed, may have to testify, suffer damage to their reputations and, if a settlement or judgment is made, can be reported to the National Practitioner Databank (NPDB) and their state licensure boards.” Kraman 2001, 254.
33. Information about CHW’s history was provided by Carol Bayley, CHW’s Vice President for Ethics and Justice Education, in a presentation entitled “Changing Behavior Based on Core Values: A Project to Address Medical Mistakes in a Large Health System,” at a meeting of the Promoting Patient Safety project at The Hastings Center, July 12, 2001, and in subsequent conversations with the author.
34. Background information on the evolution of the “Mistakes Project” was provided by Carol Bayley, personal communication.
36. Ibid., 151.
37. Ibid., 158. The CHW Philosophy of Mistake Management is included as the appendix to this article.
38. Ibid., 158.
40. Ibid., 159.
41. Ibid., 154.
42. Berlinger and Wu (2005).
43. C. Bayley, personal communication.
47. COPIC Topics 1999, 4.
49. Copiscope 2001, 5; Copiscope 2003, 5. According to COPIC risk manager Leslie Taylor, as of December 31, 2003, 1,323 physicians were enrolled in the program (personal communication, March 8, 2004).
51. COPIC Topics 1999, 4.
52. COPIC Topics 1999, 5; Copiscope 2001, 5; Copiscope 2003, 5.
53. COPIC's 3Rs Program [participant newsletter], 1.
54. Copiscope 2003, 6; COPIC's 3Rs Program [participant newsletter], 2; see also Appleby 2003.
55. Copiscope 2003, 6; COPIC's 3Rs Program [participant newsletter], 2.
57. With respect to this trade-off, it is important to remember that the three institutions discussed with respect to their approaches to fair compensation stand in three different relationships to physicians and as a result must structure incentives and obligations differently. COPIC, as an insurer, is able to offer physicians in the 3Rs program unique incentives, such as opportunities to accrue points toward discounted-premium status through consistent enrollment and to earn continuing medical education (CME) credits by completing a seminar on disclosing unanticipated outcomes, but it cannot compel or encourage physicians to participate as a condition of their employment. See COPIC Topics 2002, 2; Copiscope 2003, 5.
61. Copiscope 2002, 2
62. Copiscope 2002, 2 COPIC urges physicians to discuss apology scenarios with risk managers before speaking with patients, given that an adverse outcome that does not result from a mistake does not require a fault-admitting apology.
63. Taft 2000, 1152–53.
64. In addition to the national no-fault compensation programs in the three Scandinavian countries and in New Zealand, “[s]everal small medical no-fault schemes have also been implemented in the United States to compensate specific injury types, including the Florida and Virginia schemes for birth-related neurological injury and the National Vaccine Injury Compensation Program.” Studdert and Brennan 2001b, 229.
68. See Luke 6:31; also Matthew 7:12.
70. Quoted in Appleby 2003.

SEVEN: Forgiveness

1. Kohn, Corrigan, and Donaldson 2000. This citation refers to the published version of the report, which was released in November 1999.
3. The eschatological dimension of kárho is discussed in Cooper-White 1995, 262.
4. In researching this chapter, the author benefited from many conversations, on Hindu and Buddhist traditions, in particular, with visiting international scholars at The Hastings Center.


6. The “one in five” statistic was cited by Bryan Liang, Professor of Law and Medicine, Southern Illinois School of Law, at the July 12-13, 2001 meeting of the Promoting Patient Safety project at The Hastings Center. The “one in four” statistic is derived from data reported by the 2000 U.S. Census (Liang 2001).


8. Ibid.


11. Werblowsky and Wigoder 1997, s.v. “tikkun ‘olam.” The author is grateful to Charles L. Bosk for drawing her attention to the recovered tradition of tikkun ‘olam with respect to the contemporary observance of Yom Kippur in particular.


19. In addition to sponsoring A Campaign for Forgiveness Research, the Templeton Foundation’s Program to Encourage the Scientific Study of Forgiveness has commissioned an annotated bibliography of social science research on forgiveness, which has been included in Worthington 1999. The Web site of A Campaign for Forgiveness Research includes descriptions of the 46 projects fully or partially funded as of 2001. Available online at: http://forgiving.org (accessed June 30, 2004).

20. See www.ukans.edu/7Elforgive/ (accessed December 8, 2001).


23. Bosk 1979. Subsequent quotations and references are cited internally.

24. See Bosk 1979, 127–46, for additional description and analysis of this ritual.


27. For a discussion of Austin’s taxonomy, see Grimes 1996, 285, 288.

28. The author is grateful to the anonymous reviewer of an earlier version of this chapter for this observation.

29. Albert Dreisbach, Department of Internal Medicine, Tulane University School of Medicine, New Orleans, Louisiana, personal communication.

30. Lyla Correoso, attending physician, Calvary Hospital, Bronx, New York, personal communication; staff chaplain, personal communication.

31. A. Dreisbach, personal communication.
32. A. Dreisbach, personal communication.
33. L. Correoso, personal communication; Donna Conroy, student chaplain, Calvary Hospital, Bronx, New York, personal communication. (n.b.: Conroy is also a former nurse.)
34. L. Correoso, personal communication; D. Conroy, personal communication.
35. A. Dreisbach, personal communication; Curtis Hart, Director of Pastoral Care, New York–Presbyterian Hospital and Lecturer, Division of Medical Ethics, Weill-Cornell Medical College, New York, New York, personal communication.
36. C. Hart, personal communication.
37. D. Conroy, personal communication.
38. D. Conroy, personal communication.

EIGHT: Ethical Action

2. Anonymous focus group participant, quoted in Gallagher et al. 2003, 1004.
3. See, for example, Wu et al. 1997, 770–75; and Wu 1999, 971.
5. Gilbert 1997, 37, 72, 337.
8. The author is grateful to Rev. Dean Weber for the observation that the notion of “systems error” or “collective guilt” may be unpalatable in principle to persons or groups who may conceptualize error or sin as actions that can be initiated only by individual moral agents.
11. Ibid., 1006.
14. The author is grateful to Jonathan Cohen for his observation concerning one possible legal problem with proposals that might describe hospital chaplains or other clergy as “confessors” for clinicians who have made mistakes. According to Cohen, the “priest-penitent privilege,” which protects clergy from being forced to reveal information that has been disclosed to them within the context of a religious “confession” (but not outside of this context), could arguably be invoked in such a way as to detract from the ability of an institution to fully investigate a clinician’s role in a mistake (personal communication). Sissela Bok also offers an important critique of institutional practices that ostensibly uphold “confidentiality,” but in fact work against the interests of patients and other vulnerable persons by ensuring that key information is kept secret; see Bok 1982, 133–35. As such, although professional chaplains may have the potential to serve as important resources in helping clinicians to address the emotional dimensions of medical mistakes, care should be taken to avoid any misunderstandings concerning the “confessional” nature of these activities. For much the same reason, the term “confessor,” with its connotations of secrecy, should perhaps be avoided as a way of characterizing any person or function involved in the resolution of medical mistakes.
19. The author is indebted to Rev. Curtis Hart for his observations concerning the “corrosive” effect on health care providers of withholding the truth about medical mistakes from patients. Personal communication.
24. For Kleinman’s critique of the word “noncompliance” as used by physicians, see Fadiman 1997, 261.
29. Hamm and Kraman 2001, 23. At the Lexington VAMC, the chief of staff is responsible for disclosing errors to patients on behalf of the institution.
30. For a summary of these critiques, see chapter 6, n24.
33. The author is indebted to Rev. Curtis Hart for his observations on these issues. Personal communication.
34. Donna Conroy, personal communication.
35. Donna Conroy, personal communication.
36. See Wu 1999, 971.
37. A curriculum on death and dying, developed by professional chaplains for medical students, describes the following scenarios in which a chaplain should be in the room when a clinician is breaking bad news to a patient: “[a] patient is going to be given a difficult or terminal diagnosis . . . especially when there is no family present”; “[a] patient’s prognosis is going to be changed from curable […] or in remission, to terminal.” Spencer 2000, 27. Quoted with permission.
38. This question has arisen in several states concerning the privacy of the counseling records of survivors of rape or sexual abuse, most notably with respect to the Roman Catholic Church’s sexual abuse crisis. In 2002, the Roman Catholic bishops pledged to provide “counseling” to survivors of sexual abuse by priests. In some dioceses, survivors and even counselors were not informed that defense attorneys might subpoena counseling records. In other dioceses, counseling was used as a pretext for obtaining information from survivors, or for persuading them not to sue.
40. Grillo 1991, 1545–1610. Citation refers to LexisNexis version of this article: 1–62, at 22–3.
41. Grillo also points out that transference and countertransference occur in doctor-patient relationships; see n225.
44. Description of Service of Remembrance provided by Rev. Paul Derrickson, Coordinator of Pastoral Services, Milton S. Hershey Medical Center, Hershey, Pa. Personal communication.