

The Ethical View
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Special Points of Interest:

- Reconceptualize the issue of medical error and understand an American stance towards error.
- Discover the recommendations of the IOM report *To Err is Human*, how they have failed and how they have succeeded.
- Sources to learn more about medical error.
- Summer experiences of Davidson students...from Charlotte to Los Angeles and Peru.
- Take a glimpse at the amazing work of Strong Tower Free Medical Clinic and the student behind it.
- And more...

Beyond Davidson: BRG In Review

By Sarah Thornton, Davidson College '02 and Virginia Nimick, Davidson College '04

On October 10, 2001, Davidson students Sarah Thornton, Kristin LeBlanc, Jen Higgins, Michelle Lim, and Virginia Nimick, along with Professor Lance K. Stell, attended the 9th Annual Bioethics Resource Group (BRG) conference in Charlotte, North Carolina. At the conference, physicians, nurses, ethicists, and social workers represented the majority of professionals from local hospitals. Students from Furman, UNC-Charlotte, Coastal Carolina, and UNC-Asheville also attended.

“Isn’t It Time We Talked” entitled the theme of this year’s event, with Keynote speaker Dr. Sean Morrison, head of the palliative care unit at Mount Sinai Medical Center, kicking off presentations. Dr. Morrison discussed end-of-life issues and “dying in America today.”

Dr. Morrison emphasized palliative care, which he believes relieves or soothes the symptoms of a disease or disorder without effecting a cure, as a better option than hospitalization for the terminally ill. Morrison discussed estimates that more than half of us will die in a hospital, even though 80% wish to die at home. He also emphasized that death in a hospital is very controlled and cannot be “natural” in any way. Patients’ and families’ wishes to enter hospice care often involve difficult decisions that often jeopardize other healthcare securities. Patients often relinquish Medicare benefits upon entry into hospice care. To make matters more difficult, only patients with a life expectancy of 6 months or less are eligible for entry into hospice care. And, Morrison reports, life expectancy determinations are often difficult estimations for physicians to make.

Morrison stressed that communication between doctors and patients about their palliative care wishes must improve. Specifically, Morrison emphasized the management of pain. He addressed the inevitability of pain at the end of life and stressed the need for physicians to do a better job of helping make patients as comfortable as possible for their last few days. He aspires for doctors to listen more to patients' and families' wishes, to bolster communication and understanding on all sides of end-of-life care.

After Dr. Morrison's speech, participants broke into smaller group discussions. The Davidson student group first attended a talk by J. Edward Spence, MD from Carolinas Medical Center regarding genetic diagnostic information. Dr. Spence utilized case study analysis to discuss testing children for genetic disorders, insurance coverage for genetic testing, and the complexities of patient versus physician autonomy.

Students from various institutions also participated in "A Call for Papers." The student-authors shared papers discussing bioethical issues ranging from terminal sedation and euthanasia to OxyContin, allowing students to exchange ideas and information.

Near the end of the day, Lance K. Stell, PhD moderated a debate concerning the new "portable" Do Not Resuscitate (DNR) order. Hospitals in the Charlotte area have collaborated to create a standard form to be used in each facility. Hopefully, Dr. Stell discussed, this new form will enable physicians to better respect the final wishes of their patients without fear of penalty of lawsuit.

This conference constituted a wonderful and unique opportunity for undergraduate students to learn about the field of bioethics and healthcare policy with the help of highly respected professionals. Students should take advantage of this opportunity to better understand the ethical issues facing modern medicine.

About the Authors...

Sarah Thornton is a senior psychology major with a concentration in medical humanities who participated in the Davidson in Mwandu program, working in the rural hospital. She plans on attending medical school after Davidson and is a member of the Davidson Lacrosse Team, the Davidson Premedical Society, and the Davidson Bioethics Society.

Virginia J. Nimick is a sophomore pursuing a CIS major in Ethics in Law and Medicine. She is a member of the Davidson Bioethics Society and a student intern for the Ethics Committee at Carolinas Medical Center. She will be interning in the bioethics department at Mt. Sinai Hospital this summer.

Setting the Scene: What Is Medical Error?

By McLean Jordan, Davidson College '01 and Kristin LeBlanc, Davidson College '02

It seems most people begin with an intuitive grasp of the definition of a “medical error.” If an error has occurred, some sort of mistake yields a “bad” or “undesirable” outcome. For instance, a slip of a knife leads to a patient injury that was not a planned or intended part of the medical care expected to be delivered.

While this definition seems clear, it does not extend to all real-world medical errors. Many deviations from standard, appropriate medical care do not lead to a “bad” outcome that a patient may discern. Since an error can occur without resulting in a bad outcome, medical errors are often unrecognizable to those patients who may have been true victims of substandard care.

This commonly accepted perception of medical errors encompasses a more complex problem than an incorrect definition. It showcases the way American culture perceives medical errors as human failures and departures from the standard of care. Other cultures see bad happenings entirely differently. The Azande culture of Zandeland, Africa views them as the engineerings of witches. Our own culture exhibits an inclination toward individual blame when unpleasanties occur. As a society, our freedoms and rights imbue Americans with the idea that we are all equal, that we all deserve medical care up to par, and that if something bad happens, *someone* should be held accountable. The litigiousness of our society speaks to this phenomenon.

The following articles reveal two opinions of medical error that emphasize and question our perception of medical errors themselves. There is no disputing that medical errors exist in modern healthcare. The real complexity arrives in choosing the most sound and appropriate theory to explain the occurrence of medical errors and the manner in which to handle them.

Medical Error: A Student Opinion

By John Kenyon, Davidson College '01

Are hospitals safe? While this question may seem chock full of irony, it is a legitimate concern. According to the Boston Globe's Alice Dembner¹, the National Academy of Science's Institute of Medicine (IOM) released a study in 2000 strongly condemning the *status quo* of medical care in the United States. The study indicated that more than one million hospital patients each year are victims of medical errors and that as many as 98,000 patients die *per annum* from these errors. Clearly, action must be taken. Fortunately, the dilemma is being addressed, but in a piecemeal fashion: some of the report's recommendations on disclosure of errors have recently been enacted by the nation's hospitals.

While comprehensive, the IOM report probably overlooked some statistics that would have presented medical errors as an even bigger problem than is currently perceived. An article dated November 30, 1999² claims that the IOM report reveals that more people die each year in the U.S. from medical errors than from highway accidents, breast cancer, or AIDS. The article claims that these numbers are probably underestimates of the true extent of deaths due to medical errors because of the many incidents that go unreported.

Fortunately, reform has begun in disclosing medical errors more effectively. The IOM urged the enactment of rules requiring hospitals to report to state officials any deaths or serious injuries caused by such errors. It also urged information on errors of less serious consequences to be addressed along with a promise of confidentiality to encourage voluntary reporting.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which accredits 80% of the nation's hospitals, recently announced new standards similar to the IOM recommendations that would require hospitals to disclose medical errors to their patients. However, unlike the IOM recommendations, the JCAHO requirements do not require additional hospital bureaucracies-- something that could drive up the costs of medical care. Instead, hospitals must grapple with errors internally or risk losing accreditation.

These new standards are designed to promote open discussion and review of errors to find and apply solutions to the problem. Dennis O'Leary, president of JCAHO, said, "These standards are meant to create a culture of safety. Errors are not [currently] reported inside organizations because caregivers are fearful they will be punished."³ However, without reporting, these errors are rarely discovered, thus eliminating the ability to improve healthcare delivery.

While certain institutions such as the American Medical Association⁴ praise JCAHO's suggestions, opponents are concerned, believing that asking hospitals

to notify patients might scare administrators already fearful of a lawsuit into even more silence. JCAHO counters that hospitals not reporting errors to patients also run the risk of liability to patients even without error disclosure. Therefore, JCAHO claims, reporting not only helps patients but also caregivers and hospitals.

Thus, JCAHO requirements aim to begin the lengthy process of changing the culture of silence surrounding medical error disclosure. The key to reform is to avoid the blame game with the overall aim of delivering a better system of healthcare.

About the Author...

John Kenyon, '01 works with the Jacksonville Center for Clinical Research as a patient recruiter for eighty different clinical protocols and looks forward to medical school. In his article, Kenyon focuses on the particulars of the Institute of Medicine report To Err is Human. He reports the famous study's prescriptions for a change in the safety culture of our health care system with respect to medical error. Kenyon conveys his own thoughts on the failures of the IOM report, claiming that the study faces serious methodological weaknesses that ultimately stifle its credibility as a health care policy catalyst.

Medical Error: A Professional Opinion

By Talisman Ford, Ph.D., Davidson College Adjunct Lecturer, Medical Humanities

Asserting that one is in favor of the reduction of medical errors is about as unusual as a political candidate claiming to be "for education." Who isn't? So while the goal of reducing medical errors (and improving education, of course) may be widely shared, the issue of how to do so is much more contentious. As an historian of medicine, I am sorry to say that there are no clear or easy lessons from the past that may be brought to bear on the subject. Certainly health care providers committed medical errors in the past, but we do not have the kind of records that would allow for reliable quantification. So while we may not reap bountiful insight from direct parallels with the mistakes of the past, there are some useful questions that an historical perspective can lend to the debate. In particular, one can see many examples from the history of medicine of how non-medical factors like professional interests and ambitions have often played an important role in medical change. For example, though powerful chemical anesthetics had been available long before they began to be employed in the mid-nineteenth century, it is apparent that professional concerns contributed to their eventual acceptance. Not only concern for the suffering of patients, but also intense professional competition from medical sectarians such as hydropaths,

botanics, and homeopaths encouraged medical “regulars” to develop the chemical tools that sectarians shunned. Similarly, sanitarians of the late nineteenth century like Colonel George Waring were motivated by their altruistic concern for the health of city dwellers, but they also built impressive careers on their clean-up campaigns. Their crusades to swat flies, remove filth from streets, and stop spitters were often parlayed into powerful political offices. Certainly they believed they were working to improve the health of the citizenry, but their professional ambitions benefited from controlling large bureaucracies and the patronage opportunities that flowed from that control. As such, medical history suggests that we keep in mind the role of professional interest when considering calls for medical reform.

Many proponents of the campaign to reduce medical errors claim a groundswell of concern over the increasing number of medical errors. They cite 98,000 deaths per year which can be attributed to medical error, but it is interesting to note that activists in this field most often refer back to a single study, one overseen by the Institute of Medicine in 2000.⁵ The Agency for Healthcare Research and Quality (AHRQ) is a federal agency established in 1989 as a branch of the Department of Health and Human Services whose mission focuses on the reduction of medical errors. With a budget for the fiscal year of 2001 of almost 270 million and nearly 300 full-time staff, the AHRQ cites the study by the IOM as its principle source, in short, as its own reason for being.⁶ Numerous other experts joined the campaign to reduce errors including hospital administrators, HMO managers, and specialists in health care policy. An enormous cadre of experts have rallied to the cause and in almost every publication about the need for reform, they cite the same IOM study. However, few consider the methodological limitations of the study. First, the studies included by the IOM are all based on retrospective review of medical charts, which is problematic because the chart may not accurately reflect all the issues that led to a particular decision or the “adverse event” in question. Furthermore, when the study claims a medical error “led to” an injury or death, this implies that the error was SOLELY responsible for the death, which is seldom the case. Someone reviewing the chart of a patient with end stage cancer who died in the hospital may see that a patient’s morphine dosage was too high and conclude that the patient died of morphine overdose rather than cancer. It is ironic that the people best qualified to critique the IOM study, academic researchers specializing in medical errors, are the very people who stand to gain from the largesse of the AHRQ because it dispenses about 50 million dollars per year in grants to researchers.⁷

While even one medical error is too many, it seems clear that many people may benefit from exaggerating the extent of the problem. Again, the example of Colonel Waring may be instructive here. Waring believed in the filth theory of disease which assumed that dirt caused disease. To improve public health, Waring hired enormous numbers of men to sweep the streets and pick up garbage and dead animals. When confronted with the growing evidence for

microbial causes for many diseases, Waring resisted its contagionist implications. He resisted a theory whose principle weapons in the fight against disease were vaccination, water treatment, and hand washing. As such, his professional ambitions discouraged his consideration of alternative explanations and new scientific data.

Despite the limitations of the evidence for medical errors, people continue to jump on the bandwagon for reform. After all, who could question the need to save lives? Of course, we all want to save lives but are we going about it the right way? With a large federal agency already devoted to reducing medical errors, do we need further oversight by state organizations or hospital associations, or is it possible that a non-medical factor such as professional interest is playing a role in their call for medical reform?

About the Author...

Dr. Talisman Ford is an adjunct professor of Medical Humanities at Davidson College teaching History of Medicine, 1750-present. Dr. Ford's research interests include sexuality in Brazil, childbirth in American medicine, and Latin American race relations. In her article, Ford offers us a unique insight into the theoretical thrust behind the current medical error movement. Questioning the motives behind those individuals who champion medical errors as problems, Ford offers her own thoughts concerning the misleading flavor that we Americans taste in the issue of medical error, claiming that the question should be not whether medical error is an issue but what the most responsible tactics to curb their occurrences are.

***To Err is Human: The Hustle & Bustle of Patient Safety Improvements* By Susan Vear, Davidson College '02**

Over a year and a half has passed since *To Err is Human* was published by the Institute of Medicine; what sorts of advancements in the field of patient safety have been made during that time?

As a direct response to the IOM's call for increased research and a national research agenda, the National Patient Safety Foundation (NPSF) published a study entitled *Current Research on Patient Safety in the United States*. The study was led by Jeffrey B. Cooper, PhD and was funded by the Agency for Health Care Quality and Research (AHRQ). The findings of the study were extremely positive –“despite the perception by many that research in patient safety has been ignored, this project has identified many organizations that consider patient safety to be a part of their mission.”⁸

The NPSF is also active in other areas of patient safety. In 2001 it hosted two national, multi-day conferences on patient safety as well as multiple regional, one-day conferences.⁹ At NPSF's 2001 Partnership Symposium in Dallas from October 10 to 12, the annual Solutions winners were announced. Each year the NPSF awards two individuals or institutions \$10,000 for abstracts of patient safety solutions that have been "tested, implemented, and proven to reduce error."¹⁰ This year's winners wrote abstracts on establishing a culture of safety in Intensive Care Units and on having Medicare patients "screened for or given pneumonia and flu vaccines."¹¹

The NPSF, however, is not the only organization working to improve patient safety in the medical world. The AHRQ has carried out studies, the most recent of which is an evidence report, *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*. The AHRQ was able to compile a list of the 11 most useful patient safety practices, among which are "giving patients antibiotics prior to surgery" and "using ultrasound to help guide the insertion of central intravenous lines."¹² However, researchers were surprised to see that some common safety practices, such as washing hands prior to patient contact, did not make the list. This, they claim, indicates that more research needs to be done in order to determine not only the most important means of establishing patient safety, but also the most efficient.¹³ In addition to conducting such studies, the AHRQ "will award nearly \$50 million . . . to support further research in patient safety."¹⁴

The Food and Drug Administration has been working to improve patient safety by minimizing medication errors. One of the major steps taken in achieving this goal is to change the way in which drugs are labelled.¹⁵ The new FDA labels will be more user-friendly, placing important and often referred-to information in a highlights section at the beginning of the package insert. The FDA claims the information will be "easier to find, read, and use, and it should also enhance the safe and effective use of prescription drugs."¹⁶

Thus, despite the perception given by the Institute of Medicine in *To Err is Human*, both companies and individuals give their time, energy, and finances to improve patient safety in the medical field.

About the Author...

Susan Vear is a senior biology major with a concentration in medical humanities. She is involved in the Davidson College Concert Choir and is vice-president of Alpha Epsilon Delta, the pre-medical honor society. She will be attending Wake Forest University School of Medicine in the fall of 2002.

To Err is Human: Prescriptions for Change
By Luke Grote, Davidson College '02

*To Err is Human*¹⁷, edited by Linda Kohn, Janet Corrigan, and Molla Donaldson, is a comprehensive report on the crisis of errors in health care by the Committee on Quality Health Care in America. The book makes a cogent argument that medical error is truly a national epidemic. More people die of medical error, it reports, than from automobile accidents. What's more, "preventable adverse events," defined as injuries caused by medical management (as opposed to an original condition of the patient), cost the country an unnecessary 17 to 29 billion dollars per year. Three major reasons are given for this breakdown in the healthcare system: the silence that shrouds medical error, the diffuse nature of the health care system itself, and the lack of incentive for safety.

The authors of this report warn that there is no single cause for this very complex situation. This health care crisis is essentially a failure of the system itself, the authors posit, and not a problem to be dealt with by affixing blame on the individuals who operate the system. The system breaks down, explains the book, because it is very complex and because it is a "tightly coupled" system, one that cannot tolerate delays and is limited in the ways it can reach its objectives. The intrinsic system failures that are the result of poor design, the committee warns, are the most dangerous. They contend that these breakdowns have been ignored and need to be addressed.

The authors of *To Err Is Human* venture to overcome the inertia of a health care system that is currently in a state of inaction regarding patient safety. They propose a four-tiered approach to overcoming this stagnancy. The first stage of this plan is the establishment of a national focus to create leadership, research, tools, and protocols to engender an extensive knowledge base about patient safety. Second, they recommend recognizing and preventing errors by making immediate reporting of errors mandatory.

The committee aims to raise safety standards by encouraging oversight organizations, group purchasers, and professional groups to create a safer environment for safety. The final facet of this plan is to create safety systems inside health care organizations by employing safety measures at the delivery level.

The bulk of *To Err is Human* is comprised of recommendations for reducing medical error. The first recommendation is that Congress establish a Center for Patient Safety. This institution would perform two main tasks, proposes the committee: 1) it would set the national goals for patient safety, monitor progression toward these goals, and issue an annual report on the state of patient safety to Congress and the president, and, 2) it would foster awareness of errors in health care through research and education.

To stop the silence that currently shrouds the issue of patient safety, the committee suggests launching a nationwide mandatory reporting system and promoting voluntary reporting. In order to safeguard these initiatives, the authors deem it essential to protect this reporting from legal discovery.

Another recommendation is setting performance standards and expectations for patient safety. The purposes would be to establish minimum levels of performance or consistency across multiple individuals and organizations and to set a base level of expectations for consumers and purchasers as well as providers. This study recognizes that setting these standards would necessitate a change in current accreditation and licensing protocol. The authors also emphasize that licensing should be a recurring process. Professional groups focusing more on safety and group purchasers providing safety information to employees and beneficiaries are also considered by the committee to be integral components in the establishment of new standards and expectations.

The committee believes that health care organizations have five main responsibilities in improving patient safety: 1) providing strong leadership, 2) revamping the system with an appreciation of human limitation, 3) promoting efficient teamwork, 4) anticipating the unexpected, and 5) promoting learning. They believe that continually improved patient safety should be a primary objective. This can be achieved, the authors contend, with the establishment of patient safety programs with defined executive responsibilities. They stress principles such as teamwork, standardization and simplification of equipment, supplies and processes, and the implementation of nonpunitive means of reporting errors. I am convinced that the health care system can dramatically improve patient safety if it adheres to these precepts.

About the Author...

Luke Grote is a senior English major. He is captain of the rugby team. During his time at Davidson, he has volunteered with the Big Buddy program and the Davidson College Presbyterian Church youth group. Luke plans to teach high school English next year.

Medical Error: Resources

By Michelle Lim, Davidson College '02

Michelle Lim is a senior at Davidson College, majoring in Medical Humanities. She is the founder and current President of the Davidson Bioethics Society..

Listed below are various resources to read more about medical error.

References from Medical Error Articles/Journals:

- 1) Dembner, Alice. "Hospitals facing new safety rules." Boston Globe July 2, 2001.
- 2) "Medical errors kill tens of thousands annually, panel says" Cnn.com November 30, 1999.
- 3) "Medical Errors: The Scope of the Problem." Cnn.com November 30, 1999.
- 4) "Medical errors kill tens of thousands annually, panel says" Cnn.com November 30, 1999.
- 5) Kohn, Linda T. et al. *To Err is Human: Building a Safer Health System*: Institute of Medicine, National Academy Press, 2000.
<http://books.nap.edu/books/0309068371/html/index.html>
- 6) Agency for Healthcare Research and Quality,
<http://www.ahrq.gov/qual/errorsix.htm>
- 7) Ibid
- 8) Cooper, Jeffrey, PhD. *Current Research on Patient Safety in the United States*. Conducted by the
National Patient Safety Foundation.
- 9) <http://www.npsf.org/html/events.html>
- 10) <http://www.npsf.org/html/3mjanssen.html>
- 11) Ibid
- 12) *AHRQ Releases New Evidence on Proven Patient Safety Practices*. Press Release, July 17, 2001. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/news/press/pr2001/ptsafpr.htm>
- 13) Ibid
- 14) Ibid
- 15) <http://www.fda.gov/bbs/topics/NEWS/NEW00745.html>
- 16) Ibid
- 17) Kohn, Linda T, et al. *To Err is Human: Building a Safer Health System*. Institute of Medicine, National Academy Press, 2000.

Case Law:

- 1) *Schueler v. Strelinger*. 43 N.J. 330 (1964).
- 2) *Carbone v. Warburton*. 11 N.J. 418 (1953).
- 3) *Clark v. Wichman*. 72 N.J. Super. 486 (1962).
- 4) *Stottlemire v. Cawood*. 213 F. Supp. 897 (1963).
- 5) *Snyder v. St. Louis Southwestern Ry. Co.* 228 Mo. App. 626, S.W. 2d 504 (1934).
- 6) *McPeak v. Vanderbilt University Hospital*. 33 Tenn. App. 76, 229 S.W. 2d 150 (1950).
- 7) *Hathaway v. Coughlin*. 99 F.3d 550 (1996)

8) *Wray v. Gregory*. 61 F.3d 1414 (1995).

Websites:

1) *Agency for Healthcare Research and Quality*

<http://www.ahrq.gov/qual/errorsix.htm>

*Provides an extensive list of audio and press releases as well as Congressional hearings and other documents pertaining to medical errors.

2) *National Patient Safety Foundation*

<http://www.npsf.org>

*Seeks to improve measurably patient safety in the delivery of health care; site provides extensive information on patient safety, accountability, and medical errors.

3) *Institute of Medicine*

<http://www.iom.edu>

*Aims to advance and disseminate scientific knowledge to improve human health; provides objective, timely, and authoritative information and advice concerning health and science policy to the government, the corporate sector, the professions, and the public.

4) *American Medical Association*

<http://www.ama-assn.org>

*Provides information on the history and mission of the AMA, E&M Guidelines, legislative initiatives, new scientific discoveries, and medical ethics knowledge; provides research from JAMA and specialty journals; provides information on litigation affecting medicine, AMA membership and other products and services.

5) *Medical Errors: The Scope of the Problem. Fact Sheet, Publication No. AHRQ 00-P037. Agency for Healthcare Research and Quality.*

<http://www.ahrq.gov/qual/errback.htm>

*Illuminates fundamental concerns surrounding medical error, including the relative antiquity of the problem, the related issue of public fears, types of errors, and a systems approach to prevent medical error.

6) *“Doing What Counts for Patient Safety: Federal Actions to Reduce Medical Errors and Their Impact.” Report to the Quality \Interagency Coordination Task Force (QuIC) to the President, February 2000.*

<http://www.quic.gov/report/toc.htm>

*Provides a complete version of the report to the President on medical error, including the federal response the IOM report, identifying and implementing error reduction strategies, and working alongside the private sector and state governments to reduce error commission.

Books:

- 1) *To Err Is Human: Building a Safer Health System.* Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors; Committee on Quality of Health Care in America, Institute of Medicine. National Academy Press, 2000.
*An eye-opening book exposing the tragic dangers of the medical health care system in the United States while providing general solutions for the system as a whole. To read online go to:
<http://www.nap.edu/books/0309068371/html>
- 2) *Human Error.* James T. Reason. Cambridge: Cambridge University Press, 1990.
*A broad introductory overview of medical error with clear definitions, classifications, and explanations on the different types of error; a quick run-through of other relevant literature and scientific studies.
- 3) *Medication Errors: Causes, Prevention and Risk Management.* Neil M. Davis and Michael R. Cohen. Philadelphia: George F. Stickley Co., 1981.
*Emphasizes that systems are at the heart of medical error prevention: medication errors are not typically made or prevented by one person alone; recommended for health care professionals.
- 4) *Crossing the Quality Chasm : A New Health System for the 21st Century by the Institute of Medicine.* National Academy Press, 2001.
*Identifies and analyzes with great insight and clarity deficiencies in the quality of our present medical care delivery system; outlines how medical care delivery and error prevention systems should work.
- 5) *Demanding Medical Excellence : Doctors and Accountability in the Information Age.* Michael L. Millenson. University of Chicago Press, 2000.
*An engaging account of the development of information science and quality assurance in medicine, enlivened by clinical vignettes and brief biographies.
- 6) *Margin of Error: The Ethics Of Mistakes in the Practice of Medicine.* Susan B. Rubin and Laurie Zoloth, Eds. Hagerstown: Univ.Pub.Group, 2000.
*Offers an original, important, and deeply personal contribution to the literature on mistakes in medicine and ethics consultation.

Errors, Economics, & the Importance of Collaboration

By Jen Higgins, Davidson College '02

Dr. Kelly Chaston, Associate Professor of Economics, is currently teaching her second semester of Health Economics this year at Davidson College. Chaston became the adjunct health economist on campus as the result of her specialization in public finance. As health care began to overwhelm policy decisions at all levels, her curiosity peaked toward a desire to understand health care's pivotal role in the American economy. This course teaches the application of basic tools of economic analysis towards the markets of medical care and health insurance in the United States.

When asked to discuss medical error, Chaston's thoughts demonstrate a need for both professional collaboration and careful economic analysis. "It is never going to be in society's best interest to ensure that there are no medical errors," Chaston says. "We need to use resources in such a way as to stop the most egregious errors--those that result in long-standing illnesses and even death. It is important that we set up cost-effective protocols that minimize non-egregious medical errors."

"We clearly need a system that has sort of an understanding for the reality of human error. The challenge is in maintaining a responsible system compatible with this fact. Because if you make the penalty so substantial that cohorts are unwilling to report one of their own, you are not helping the cause of reducing the number of errors."

Tort law reform is an issue often raised in the ethical debate. Chaston comments that medical errors must be addressed carefully, citing the reality of human error for all professionals, including physicians. "Tort law must be viewed extremely carefully," Chaston points out, "so as not to minimize the value of avoided errors. Constructing protocols to eliminate human error will always be something at risk. The only way to reduce it is to impose protocols which ultimately become cost-prohibitive from an economic standpoint."

Like most scholars engaged in the debate over medical error, Chaston agrees that there is no easy solution to this growing problem. "We should institute a system where physicians take responsibility for the process itself. How *do* we develop a system of checks and balances that ensures a neurosurgeon (or any physician) does not make mistakes? As we become consumed by routine, mistakes become even more frequent."

The penalties for medical errors are stiff. But should they be? Shouldn't we be more aware of a so-called "gray area" that exists when it comes to medical error? Is there an alternative to taking away a person's livelihood because of an inadvertent error? And furthermore, does that automatically make that physician a "bad" doctor? As health care becomes a critical issue in the U.S. economy, it

is imperative that society devote substantial resources to examine the roles each member of the health care industry plays respective to medical error. For there to be progress in health care policy, physicians, policy makers, administrators, and economists must collaborate to create a safer and economically sound health care environment.

About the Author...

Jen Higgins is a senior Medical Economics and Ethics major and is President of the Davidson Women's Club Soccer team. After graduation from Davidson, Jen plans to pursue a master's degree in hospital administration.

**Summer Experiences: Following the Yellow Brick Road
When I Grow Up By Jen Higgins, Davidson College '02**

This summer, I figured out what I want to be 'when I grow up.' It only took 21 years to find that perfect job, the one that when I close my eyes, it becomes clear and in focus without having to squint so hard. A hospital CEO. This is the title that I fill in now on all of those questionnaires and surveys that prompt the question: Career goals? To find a career that you can be passionate about is a landmark in any young adult's life; finding mine so soon has been a blessing in disguise.

I took the opportunity to do an internship during the Summer of 2001 with Durham Regional Hospital in Durham, NC. My time spent at this hospital was invaluable for a number of reasons: 1) I was enlisted to complete several major projects as an Administrative Intern, which gave me a sense of investment and accountability despite my youth; 2) I was given complete access to my boss--the CEO, Mr. Rich Liekweg--and his schedule. It was a privilege to be able to sit in on any meeting I wanted and interact with some of the most highly influential people within the Health System; 3) I worked harder than I have ever worked in my professional life. All twelve weeks. And the punch line—I enjoyed every minute of it.

I decided to keep a journal as a way for me to keep track of my experiences and observations for future reference. Here are a few excerpts:

May 31, 2001

....With the right people and the right resources, running a hospital doesn't seem to be so stressful. But I also think that on the flip side of things, it could be even more stressful because you have to maintain success, as basketball coaches say who have won national championships: "It's a lot easier to win your first championship than it is to win a second, and a third, and so on."

....Standards of excellence are difficult to maintain. In sports. In healthcare. There are plenty of parallels. In one presentation, I compared your typical management structure to a soccer team. As a goalkeeper, the ball has to get through 10 other people before it can be dropped. Last line of defense, first line of offense. Hospitals have a critical role in the community that cannot be overlooked. Management must capitalize on this image and constantly remind its employees of their responsibilities.More and more, running a hospital is equivalent to running a Fortune 500 company. Sure, health care is a unique market, but these days its operational motives are one and the same: gotta turn a profit. If it's breaking even or costing us money, gotta cut it loose. Gotta reinvest that capital into programs that will make us even more next year. Because that's what we want as entrepreneurs, right? Yes, but not as health care administrators.

June 22, 2001

....I came across a quip that read "So you want to be a rural CEO? Why?" It was interesting because it pointed out how health care in the urban setting is filled with politics and less with accountability. CEOs can fire 200 people or make the wrong decision, and sleep easily at night because they have no connection. While your rural CEO--maybe he makes less money--but he's accountable. He goes to the grocery store after work to run into someone who gives him an earful about how he's doing more harm than good with his initiatives. The community is vocal because they can be. The CEO subsequently is more careful and open with what he does and says because he knows the whole world will tell him if it's the tiniest bit wrong.

July 25, 2001

....A Wall Street Journal piece on the \$5.2 million patient--absolutely incredible to spend that much on one patient. Is this the epitome of medical professionalism at its finest? I wonder why we read about this patient on the front page of the WSJ and not the uninsured patient who dies in the ED waiting room?

....I was reminded of how invaluable an experience like this is for me as I decide what to do with my life. And to recognize how rare an opportunity like it is, even when you finally do get to be worthy of the Red Zone. They treated me with utmost confidence and I should be flattered that they allowed me to be there. They did not feel the need to censor themselves in any way. A taste of what's to come. And definitely a better glimpse into what hospital administration is all about.

August 10, 2001

....A quick recap. The past two days have been insane. And now...it's over. I've seen so much over the past twelve weeks. It has been an amazing experience. So what did I take away from it all? I learned that being a CEO requires the ability to jump with both feet forward. To be innovative and visionary. To be firm

and deliberate. To be confident and receptive. To be a motivator and a catalyst. And to be okay with being the bad guy. To know that your decisions affect people's lives (often throughout an entire community) and not be too bothered by that (because you can admit when you are right and concede when you are wrong). To be a gamer. To be a player 'for the greater good' of the organization, because it takes careful execution to become the best administrator.

I also saw that there are plenty of additional roles that probably aren't a part of the job description for a hospital CEO. You are forced to act as a businessman, a politician, a visionary/motivator, *and* a persuasive salesman. There are times when your employees need you to be their coach in CEO's clothing. Times you have to motivate and inspire. Times when just have to improvise and do your best not to make promises that you can't or won't or don't intend to keep.

As I finish my senior year and move on to bigger and better things, I look back on my twelve week administrative internship as a wonderful learning experience and a test of my dedication to pursuing this career. Despite many warnings, I was not dissuaded but even more encouraged to continue this course. I took away some valuable lessons that I will carry with me throughout my career. It was a rare privilege to witness this chapter in the life of my community hospital.

Peru By Carolina Hartridge, Davidson College '05

"Carolina, venga aquí. Necesitamos su cartera de mágico. ¡Rápidamente!" This translates to "Caroline, come quickly. We need your magic kit." I heard the statement frequently last July.

Spending the summer volunteering at a primitive health clinic in the Peruvian mountains, I anticipated learning just a bit about health; never did I anticipate questioning the clinic's methods to which I would be exposed.

The entire staff of eight, including a dentist, an OB/GYN, a lab technician and several nurses piled into the dentist's office and pulled a guitar off the wall. Traditional Peruvian music with some Eagles thrown in drifted into the waiting room. I asked if we needed to tend to the patients and they all nodded a reply of "yes" and continued to sing. I drew the conclusion that none of the patients were in a critical state of health and any preconceived ideals I had of western medicine meant nothing here.

The first day of work I watched the dentist with amazement. He spent the entire day pulling teeth. I was intrigued and allowed to watch the intricate movements of his hands in children's mouths. The dentist offered me the opportunity to pull one of the patient's teeth. Passing, I offered up the possibility of tomorrow. All I

could think of was bearing the responsibility of doing something wrong. The supplies of my magical medical kit (basic first aid kit) would suffice as the extent of my service for the moment.

Rather than sit, watch, translate, file, and offer antiseptic spray, antibiotic cream, and waterproof wrappings, I began to ask why I turned down medical care opportunities U.S. medical students are not even allowed to perform. If the clinicians needed my help and were willing to accept that I had little or no knowledge of the field, why not jump right in?

After the first week of work, I was checking vitals and administering vaccinations. The second week brought typhoid blood work and testing fecal samples for parasites. Week three: pap smears, pulling teeth, administering Novocain or Lidocaine, and prescription consultations. By the end of the summer, each Friday brought a meeting with the head doctor who would ask how he could improve his practice. Everything that seemed basic to me was a revelation and a brilliant suggestion to him. It was difficult to express the dire importance of seemingly simple ideas such as birth control and disease prevention. It takes years for the locals to understand not only the methods but also the reasons behind them and how such preventions will benefit their lives. My suggestions began with wearing gloves and changing the gloves with each new patient, using antibacterial soap, cleaning instruments between patients, making sure patients continue with antibiotics, basic STD prevention, and prenatal care.

While my magical first aid kit offered relief and my suggestions offered a bit of direction towards improvement, these were temporary attempts to aid. As a volunteer, was it my ethical duty to assist wherever needed no matter what qualification was required, or only to offer help, which would allow the clinic to see a broader goal of increased funding, improved facilities, and properly qualified personnel?

Over four months later I still think about my experience this past summer and wonder if my actions were ethical and if the clinicians' actions were ethical as well. Friends involved in U.S. health care cringe at the prospect of liability when considering my experiences. I have realized, though, that I am comforted by my own ethics, beliefs, and the actions to which those led. Ethically, there was a feeling that I had to help in all ways possible. I was able to decide what tasks I could and could not perform each day and I could see that the suggestions at the weekly meetings offered a more general and perhaps more lasting impression. If the magical kit's help was required more often than the methods, facilities, and funding advice, then the needed focus of my volunteerism was obvious.

***Intron-A: A Promising Prophylaxis?* By Christin Raimondo, Davidson College '01**

This past summer I was fortunate enough to work at Carolinas Medical Center under Dr. Richard White, a surgical oncologist who sees a variety of cancer patients whom he is able to treat both in the surgical as well as the clinical setting. It was Dr. White's interest in the melanoma-fighting drug Intron-A that prompted him to further investigate clinical effects, both biological and social. Intron-A, or interferon, is a drug used to treat patients who have been diagnosed with melanoma and have a high risk of recurrence. The longer melanoma goes without treatment, the greater the chances of it spreading to other parts of the body, both external and internal. Melanoma can affect various organs in the body including the lymph nodes, the liver, the reproductive system, and even the brain.

The best defense against this deadly disease is early detection and removal. Surgically removing the cutaneous melanoma before it spreads internally essentially renders the patient disease-free. However, because melanoma has such a high rate of recurrence it is important to follow surgery with some sort of adjuvant therapy; Intron-A is one of the few options.

Intron-A is a type of treatment in which patients who have been diagnosed with melanoma and have been rendered free of disease by surgical methods are placed on the drug as a prophylactic method to reduce the risk of recurrence. The treatment lasts for 12 months and consists of multiple injections, as many as 5 per week for the first month and 3 per week for the remaining 11 months. It is a strenuous regimen requiring frequent blood tests to regulate liver function levels and many blood and nutrient concentration levels. Monthly office visits are also required and side effects are closely monitored to assure that the patient is not suffering from any severe toxicities. For many patients, experiencing a year on interferon is like experiencing the flu for a year with symptoms like headache, fever, nausea, hair loss, depression, and extreme fatigue.

Because of these intense side effects, many patients are unable to finish therapy and are faced with fighting melanoma alone. By studying the effects of interferon more closely, Dr. White hopes to understand how to treat better his patients. Yet for some, the treatment is simply not worth the negative side effects.

With my summer research help, Dr. White will be able to collectively analyze each of his melanoma patients in a database. Every side effect was accounted for and each toxicity noted. In the end, we have a more comprehensive understanding of the effects of the melanoma-fighting drug interferon, and will be able to treat and help patients.

Anesthesiology: Not a Numbing Experience By Ryan Owens, Davidson College '02

Despite the fact that my summer opportunity was designed primarily for Brown University students, I contacted the director of the program and applied. The program consisted of 6 weeks in Los Angeles interning with the Anesthesiology Department at Cedars-Sinai Medical Center. The goal of the program was to allow pre-med students to experience what it is like to be a doctor in order to make a more informed decision about going to medical school. At orientation, the director explained, "I want you to see the good, the bad, and the ugly."

Each day I woke up at 6 a.m. and went to the hospital to see which surgical floor I was assigned to for the day. I would select the surgeries I wanted to observe and then ask the anesthesiologist for permission to "tag along." It was like having a free pass to any surgery in the hospital from brain tumor removals to hip replacements to Cesarean Sections. We were only expected to work from 7 a.m. to 4 p.m. although I would often find myself at the hospital as late as 9 p.m.!

The students in the program were also given an Anesthesiology handbook to learn about what they were observing. I would take the book with me each day and reference it every time I saw something new. The combination of having the text and seeing the anesthesiologist in action allowed me to soak up the information at a rate that surprised even myself.

After completing the program, I realize that I did see the good, the bad, and the ugly. I still believe that the good associated with being a doctor outweighs the bad and the ugly. I have also learned that the ideas I have about medicine from basic pre-medical undergraduate classes resemble little the actual exciting world of medicine.

A Vision for a Community in Need
By Susanne Francis, Davidson College '03

It is 6:20 on a Thursday night, and fourteen patients have already signed in. No doctors have arrived yet at the Strong Tower Free Medical Clinic, which opens its doors from 6:00-9:00 pm, two nights a week. There is a frenzy of opening duties. Behind the search for charts, translated greetings, and struggles with laboratories is a college senior, who has just spent the past eight hours managing a full Davidson workload.

J.T. Tolentino is the Volunteer Coordinator for Strong Tower. Yet to an observer, he is the lifeblood of the clinic. In October of 1998, Strong Tower Free Medical

Clinic officially opened its doors in Huntersville, NC. Ever since then, a growing list of student volunteers, doctors, and nurses have given their time to meet the needs of approximately 1,500 patients. With the majority of patients being Hispanic, volunteer student translators are necessary from the initial assessment to the diagnosis and treatment. Tolentino fell right into the role his freshman year. He has experience of many varieties, from his certification to draw blood to his efforts in grant writing. This past summer, he and his Co-Chair, Ashley Crimmins, stayed in North Carolina so that they could maintain the vitality of the clinic once Davidson students had left for vacation. Strong Tower has seen a vast turnaround in its organization and function under Tolentino's leadership.

Strong Tower operates on a first-come, first-serve basis, with the aid of twenty active doctors. There are three treatment rooms and a chiropractic room in use. A Women's Clinic is held the third Tuesday of every month. Private doctors and corporations donate all supplies and medications. Tolentino has plans for a Wellness Care Program, consisting of diabetic and hypertension maintenance services. In addition, he would like to begin a dental program and expand women's care to include a pre-natal focus, yet plans are currently stalled due to a lack of funding. Tolentino says that his primary wish is to "have enough resources to serve more patients, more quickly." This can only come through enhanced community awareness and support. Strong Tower will always remain a non-profit organization and free to the indigent.

J.T. Tolentino has recognized a great need for care in our community. Through his strong leadership and the gracious spirit of doctors, nurses and other volunteers, over a thousand people are receiving the medical treatment that they deserve but cannot afford. Additionally, Hispanics are being given opportunities to adapt to the local culture with "English as a Second Language" courses. The invaluable experiences Tolentino has gained in his work with Strong Tower Free Medical Clinic will prepare him for a compassionate future career in medicine.

About the Author...

Susanne Francis is a junior biology and Spanish double major at Davidson College. Upon graduation, she plans to enter medical school and pursue a career as a surgeon in the Navy.

Emory Conference

By Megan Shafer, Davidson College '03 and Mark Pustay, Davidson College '03

From October 4th to 7th, Aditi Sethi, Caroline Hartridge, Sarah Henry, Mark Pustay and Megan Shafer attended The Undergraduate Conference of Bioethics at Emory University. We were privy to active discussion groups, informative field studies, and intriguing lectures, exhausting a plethora of different topics including genetic engineering, male pregnancies, public policy, and euthanasia.

The intimacy of the conference gave the participants an opportunity to meet with the speakers on a more personal level. In addition, we were lucky enough to meet many leading bioethics scholars; for example, Dr. Gregor Wolbring, PhD, who led an interesting discussion on the ethics of peace, noted that even in times of war, ethical issues cannot be ignored.

The conference opened with a rousing address given by University of Pennsylvania professor Dr. Glenn McGee, who called the upcoming bioethical debates the twentieth-century version of “the just war.” He challenged what he called a “stagnant” Congress to push ahead medical research and technology, all the while allowing for an active discussion on potentially volatile issues.

During the two days in Atlanta, each student was invited to attend discussions that provided a chance to sound off. In one precept, a philosophy professor challenged a student on what the professor termed “medical imperialism.” In terms of international conflict, many students advocated a position that medical personnel in different countries were obligated to improve political conflict abroad. Other students insisted that such actions were not within the ethical expectations of a doctor or a nurse.

A highlight for many came when the attendees were invited to a number of Atlanta-area institutions that help shape bioethics policy on a national level.

One group visited the Center for Disease Control while another trip offered the opportunity to see Grady Medical Center, the largest hospital in the Southeast. Yet another trip featured a care house for young children who have been abandoned by their parents. The trips offered a sobering reality in contrast to the theoretical specifics that we had been debating over the course of the two days.

The final speaker of the conference was Dr. Ursula Goodenough, professor of philosophy at Washington University in St. Louis, MS, who urged each student to be aware of what is going on around him and her, to be “mindful” of the future and what it holds. Dr. Goodenough’s mantra of “mindfulness” became a treatise on the treatment of patient-doctor relationships. In a way, Dr. Goodenough’s address left the group with a feeling of altruism and a sense of the humanism of the medical profession.

About the Authors...

Megan Shafer is the Social Chair of Turner House. In addition, she plays an active role in the Davidson Ambassador program as a tour guide and panelist. She also serves as treasurer of RRAD (Reproductive Rights Alliance of Davidson) as well as a member of four honor societies.

Mark Pustay is a junior Political Science major from Columbus, Ohio. Mark serves on the Pre-Law Executive Board and is a defense advisor on the Davidson College Honor Council. He is also member of the Davidson Bioethics Society and the Reproductive Rights Alliance of Davidson.

Bioethics Society News, Spring, 2002

The Davidson College Bioethics Society hosted the Students Pre-Conference Workshops of the 15th Annual Speas Symposium on March 13, 2002. The topic was "Responsibility for Health Status" and Keynote Speaker was Dr. Carl Cohen, Professor of Philosophy at the University of Michigan. Dr. Cohen presented a talk on "Reflections on Responsibility for Health." Student breakout sessions highlighted issues such as patient versus physician responsibility for health care, fetal rights, social stigma of illness, genetic testing boundaries, and the use of animals in biomedical research. Next year's Speas Symposium will focus on access to medical care.

THE ETHICAL VIEW

Dr. Kelly Chaston
J. T. Tolentino
Dr. Talisman Ford
John Kenyon
Dr. Carl Cohen
Student Breakout Session
Student Breakout Session