

Case Study I: (Reporting Medical Errors: Inappropriate Transfusion)

A 62 year old man with colon cancer was undergoing surgery to remove the cancer from his sphincter and have a colostomy placed. Although the patient has had a colonoscopy every year for the previous ten years the cancer was never found until two months ago. The surgeon told the healthcare team the cancer had been growing for six to eight years.

The night prior to surgery all labs were completed, consent was signed and anesthesia had finished their pre-op. The surgery went fairly smoothly; however, the patient required a great deal of A+ blood. The blood for all three OR rooms was stored together in one refrigerator. The refrigerator held three containers, one for each OR, and each container was labeled with the patient's name. The OR nurse who was the runner for that surgery was sent to get an additional pint of blood. Inadvertently, he grabbed the wrong patient's blood, which was B-.

Due to the emergent nature of trying to get the blood into the patient, the safety precautions usually followed when hanging blood were not followed. The anesthesiologist, along with the nurse, did not match the information on the label to the patient's chart. Both co-signed the label without reading it.

As the nurse went to remove the empty bag, she noted that name on the label was not the patient's name and immediately notified the healthcare team. A large dose of diphenhydramine was given and the patient was monitored for a transfusion reaction. Fortunately, he only had a slightly increased fever. He went on to recover fully.

Questions for Discussion:

1. As the patient has had colonoscopies for the last ten years, should he be told that the cancer was missed each time?
2. Is it more important to discover *who* caused the blood error or *how* the error occurred? Is there a difference in this case?
3. Should either the nurse or the anesthesiologist (or both) be punished for this error?
4. Aside from following the correct procedures for hanging blood, are there any other measures that could be taken to prevent this mistake from happening again?
5. Following the surgery, from the hospital's perspective, who should be notified? Risk Management? Legal? The patient? JCAHO?
6. As the patient did not experience any adverse effects, should he be told about the mistake? Who should tell him? What should be said?

Case Study II: What does she really want? Who knows?

Mrs. L is a 50-year-old woman who was transferred to this tertiary care facility from a primary care hospital. She has a husband who visited frequently, if not daily. She also has several brothers and sisters but no children. Mrs. L is currently suffering from multiple external lacerations on her hands, chest, and groin area as well as kidney failure. These health problems are related to her long-term insulin dependent diabetes. She has suffered from diabetes since childhood but the complications and consequences of this illness have increased recently with a leg amputation being necessary about a year ago. She began dialysis shortly thereafter.

Mrs. L was transferred to this tertiary care facility to have the lesions biopsied for diagnostic purposes. The lesions were open, draining, and very painful to the patient. Initial work-up ruled out vasculitis as the causal agent. Finding the source of the lesions proved difficult and the hospitalization became prolonged as other complications developed. Mrs. L was in great pain and was placed on a sand bed and given a patient-controlled analgesia machine (PCA) to help provide relief. Despite these measures, pain continued to be a factor in the slow process of diagnostic testing.

After three weeks of hospitalization that included a variety of diagnostic tests and treatment of many complications including adjustment disorders and depressive moods, Mrs. L required surgery for perforation of gastric ulcers. She was placed in the Intensive Care Unit (ICU) post-operatively due to atrial fibrillation and she remained intubated. After six days in the ICU, she was extubated. The patient, however, refused to be suctioned by the nursing staff after extubation. She was transferred out of the ICU ten days after her admission to that unit.

Mrs. L began to ask the nurses to stop dialysis. These requests began about two weeks into this hospitalization and continued at intervals. Each time a request was made, a discussion would be held with Mrs. L, her husband, and the attending physician. In these meetings, Mr. L would often ask Mrs. L to change her mind regarding the dialysis or other tests she was resisting "for him." Each time, the request was granted by the patient after some resistance. On a couple of occasions, the patient agreed to further diagnostic work if her husband would be able to be with her through the test. The nursing staff became increasingly unnerved by the situation as Mrs. L would often continue to tell the nurses that she "really" wished to stop and "just wanted to die in peace." This particular wish was always superseded by the results of the patient-husband-physician conferences.

The patient and her husband grew tired of the long hospital stay. However, neither discharge to their home nor transfer back to the primary care facility near their home was ever seriously considered as a treatment option. At one conference, it was explained to the patient that transfer to another facility might entail some of the painful diagnostic tests being repeated. This information ended all further requests for transfer.

Several questions are clearly on the mind of the nursing staff:

1. Which of Mrs. L's wishes are her "real" ones, e.g., what she tells the nurses or those she agrees to in conference with husband and physician?
2. Is the patient being coerced by the pressures implicit in the conference discussions or are the wishes she expresses to the nurses "off the cuff" comments that should not be taken seriously?
3. How might the health care team work to resolve this case?
4. Are physician and nurse roles in such a case different? Or are both in some sense the "advocate" for the patient?