Managing a Medical Error
School of Medicine – Transition to Residency – Professionalism, Ethics & Law

Mr. Davidson is a 40-year-old man with newly-diagnosed diffuse large cell lymphoma. He is hospitalized for potential tumor lysis syndrome as he receives his first cycle of rituximab-CHOP chemotherapy. You write an order for vincristine 2.0 mg IV push; the order is co-signed by the attending and faxed to the pharmacy. The pharmacy mixes the medication in a syringe per protocol and sends it to the floor. The oncology nurse takes the vincristine syringe, inserts it into Mr. Davidson’s heparin lock, and—just before administering the drug—reads 20 mg on the label rather than 2.0 mg. She removes the syringe from the hepar lock and returns, very shaken, to the nursing station. Her reaction is obvious to Mr. Davidson. The event results in a two-hour delay in his starting treatment.

This is a “near miss,” an error caught before it can harm the patient.

1. What are the relevant details of the case so far?
2. How do you explain the delay to the patient?
3. What are the factors that influence the physician’s feelings occurring as a result of a medical error?

Assume for a moment that the dosing error was not identified by the nurse, and that Mr. Davidson receives the entire 20 mg of vincristine. Over the next 48 hours he develops severe neurotoxicity. His family (wife, two teenage children, and brother) is at the bedside during this admission and is shocked at his reaction to the chemotherapy. He rapidly becomes sicker, and dies four days after receiving the drug. In carefully reviewing the records the following day, you see that the decimal point is not visible on the fax printout from pharmacy, but clearly visible on the written chart order. Pharmacy records confirm that 20 mg was dispensed.

4. What are the possible sources of this error?
5. What are the reasons to disclose, and not to disclose, this error to the family? What should they be told? When, and by whom?
6. How should this error be reported to the hospital?