A medical error

In the dying days of the first half of the last century, when ward sisters wore starched veils and hospital walls were painted green, an intern 10 days out of medical school was summoned in the middle of the night to restart a clogged intravenous drip. This was done in those days by injecting 3.8% of sodium citrate, a procedure that doctors but not nurses were allowed to undertake.

Sleepily the intern made his way to the medical floor. A young nurse handed him the ampoule; the doctor pushed its contents into the plastic tube; the patient made an awful gurgling sound, turned blue, and stopped breathing, her head slumping on her chest.

By this time the nurse had left the floor. The young doctor stood transfixed, panic struck, uncertain what to do, then ran to the phone to get help, but found all lines were busy or not answering. He returned to the patient, who at that moment gave a deep snort, turned pink, and began to breath normally.

All this happened before the "error prevention movement," so ably covered in a recent issue (18 March). Since then potassium chloride ampoules have been mercifully removed from medical floors, and there has been much talk about developing systems to prevent the most blatant errors in the way it is done in aviation and other industries. There has also been much discussion about reporting errors, an idea that populist politicians have quickly seized on, leading to the suggestion of mandatory reporting by hospitals to central, government run agencies or accrediting bodies.

Although such reporting should ideally be voluntary and non-punitive, in practice this is unlikely to end up being so. Even today in many hospitals such an intern might have been fired or severely disciplined for his or her mistake, the nurse reprimanded, the hospital and the doctors sued for malpractice. Many ethicists, however, would contend that none the less the doctor has an obligation to disclose his or her mistakes, that this particular intern should have told everybody, or at least his superior.

It seems, however, that this particular intern was possessed of a highly developed sense of self preservation. I am told that he put the ampoule in question in his pocket and walked away from the ward. So the question arises, what would you have done under the same circumstances, and what would you do now?