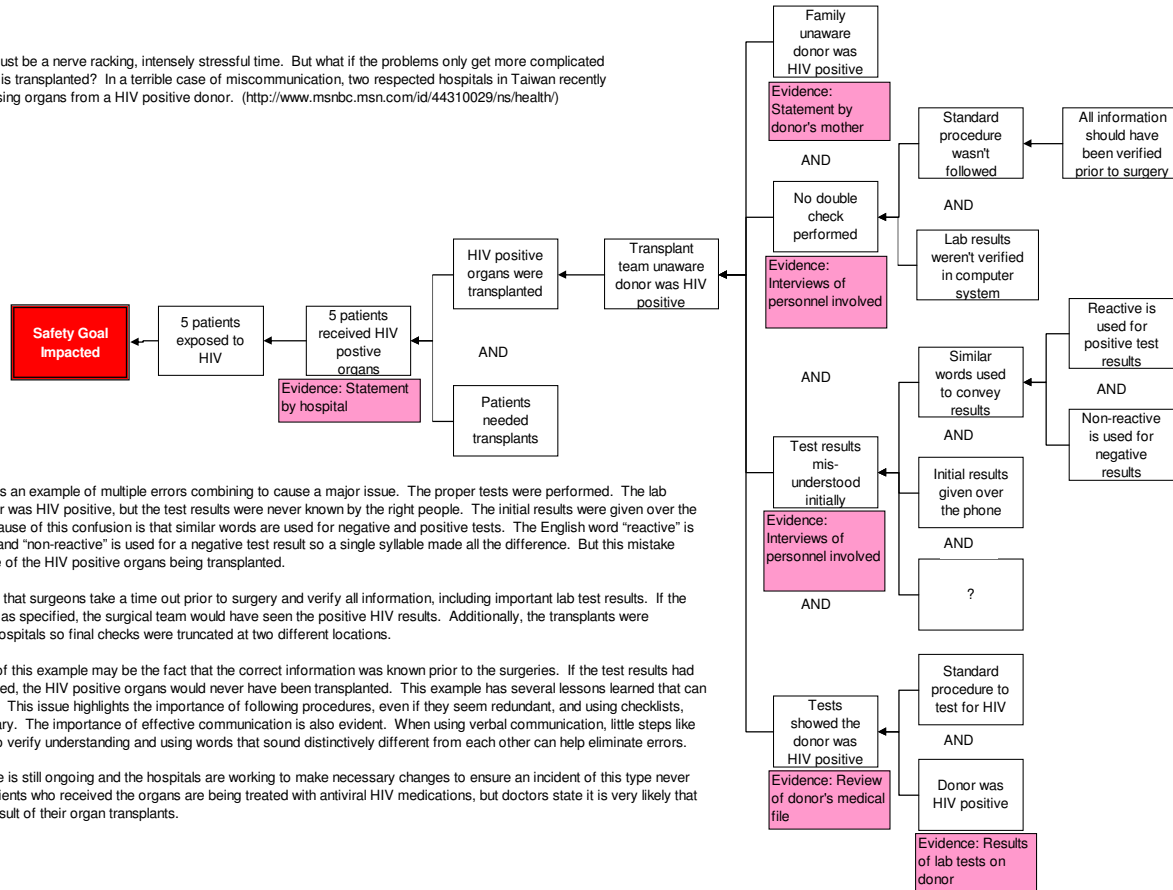


Five Receive HIV Positive Organs

Taipei, Taiwan
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Waiting on a transplant list must be a nerve racking, intensely stressful time. But what if the problems only get more complicated once the long awaited organ is transplanted? In a terrible case of miscommunication, two respected hospitals in Taiwan recently performed five transplants using organs from a HIV positive donor. (<http://www.msnbc.msn.com/id/44310029/ns/health>)

How did this happen?



As is typically the case, this is an example of multiple errors combining to cause a major issue. The proper tests were performed. The lab results showed that the donor was HIV positive, but the test results were never known by the right people. The initial results were given over the phone and misheard. One cause of this confusion is that similar words are used for negative and positive tests. The English word "reactive" is used for a positive HIV test and "non-reactive" is used for a negative test result so a single syllable made all the difference. But this mistake alone was not the sole cause of the HIV positive organs being transplanted.

Standard procedure requires that surgeons take a time out prior to surgery and verify all information, including important lab test results. If the final checks were performed as specified, the surgical team would have seen the positive HIV results. Additionally, the transplants were performed at two separate hospitals so final checks were truncated at two different locations.

The most poignant element of this example may be the fact that the correct information was known prior to the surgeries. If the test results had been effectively communicated, the HIV positive organs would never have been transplanted. This example has several lessons learned that can be applied across industries. This issue highlights the importance of following procedures, even if they seem redundant, and using checklists, even if they seem unnecessary. The importance of effective communication is also evident. When using verbal communication, little steps like repeating back information to verify understanding and using words that sound distinctively different from each other can help eliminate errors.

The investigation of this case is still ongoing and the hospitals are working to make necessary changes to ensure an incident of this type never happens again. The five patients who received the organs are being treated with antiviral HIV medications, but doctors state it is very likely that they will contract HIV as a result of their organ transplants.

Cause Map High Level



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