The Doolin Lecture 2015: 5th December 2015; â The Patient Experience as a Catalyst for Changeâ

Abstract:

The 2015 Doolin Lecture was given by Ms Margaret Murphy, a leading advocate for patient safety. This yearâ s talk dealt with error from the patientâ s perspective, while last yearâ s Doolin Lecture delivered by the late Professor Aidan Halligan had dealt with error from the doctorâ s viewpoint. When introducing Ms. Murphy, Dr. Ray Walley IMO President, said that she had championed patient safety following the death of her son from a medical oversight.

Ms. Murphy opened by stating that the good doctor treats the disease, but the great doctor treats the patient with the disease. She emphasised the importance of the patientâ s experience of the healthcare system. Close co-operation between the patient and the healthcare worker should be encouraged. She quoted the patient safety framework suggested by the Irish Commission on Patient Safety and Quality Assurance. This supports safe and effective care from skilled professionals in an appropriate environment. It was established in 2007 following the Lourdes Inquiry and produced its report in July 2008. Its objective is to develop clear, and practical recommendations in order to ensure patient safety. The foreword to the Report begins with a quote from Atul Gwande â we look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the lineâ .

One of the tenets of the safety culture is to make the status quo uncomfortable, while making the future attractive. She serves as the External Lead Advisor of the WHO Patients for Safety which has a network of 500 champions from 52 countries. One of its aspirations is to harness untapped resources and utilize them for patient safety.

The core values for patient safety are openness, collaborative partnerships, meaningful engagement, and reduction in harm. Ms Murphy recalled Helen Kellerâ s statement â the one thing worse than being blind is having sight but no visionâ . The future should find ways of separating disclosure and blame. Disclosure is about integrity and professionalism. No one should be hesitant to speak up on behalf of patients.

Ms. Murphy illustrated many of the previous points by discussing the death of her 21 year old son Kevin. It took both composure and fortitude to describe such personal, painful, and distressing events in public. She added that in the case of her deceased son, the healthcare system failed him at every point of contact. He had presented in 1997 with back pain. He was referred for hospital investigations. Blood tests were performed, but a raised serum calcium, and creatinine were not acted on. Ms Murphy had increasing concerns about Kevin. He was staying in bed more than usual, he had failed his exams. The family consulted a psychiatrist because of changed behavior. In response to her call, her sonâ s blood test results were to the GP, but no verbal contact was made with her. The GP referred Kevin to the hospital medical department, and he attached a post-it with the blood test results to the back of the letter. These results, which showed the raised calcium and creatinine were misplaced and not seen by the hospital medical staff. He was admitted to hospital in 1999. A provisional diagnosis of nephritis was made. His condition deteriorated in hospital and he died. The postmortem revealed a solitary parathyroid adenoma, which in retrospect had been the cause of the hypercalcaemia.

Ms. Murphy and her husband sought an explanation for the events and circumstances leading up to their sonâ s death. They found the interactions and communications with the hospital insufficient. They felt that they did not receive a satisfactory explanation about why the raised serum calcium level was not acted on and why the results were subsequently misplaced. Following a period of communication with the hospital, the family decided to take legal action in order to get answers. Ms. Murphy found the litigation process unsatisfactory. She said that substantial efforts went into the defense of the lawsuit, rather than on improving the hospitalâ s services. It needs to be appreciated, however, that this cannot change unless the current adversarial medico-legal system is reviewed.

In May 2004, the High Court found in favour of the action brought by the family against the hospital. The family subsequently donated the settlement to charity.

Ms Murphy explained to the audience that she had gone into such detail about her sonâ s illness during her presentation because it helps to emphasise the core message. â Tell me a fact and I will learn, tell me a truth and I will believe, tell me a story and it will live in my heart foreverâ . She thinks that the lessons that need to be learned are; simple measures save lives, and you ignore at your peril the concerns of a mother.

Ms. Murphyâ s concluding remarks are in common with other safety advocates who are involved with patient safety and the avoidance of error. â It could not happen hereâ are the five most dangerous words in the practice of medicine. Everybody in healthcare should resolve to make patient care as safe as possible as soon as possible.

The safety issues raised in this lecture were about diagnosis, which is a critical step for all patients. Diagnosis can be very challenging for doctors. There are 13,000 diseases. Many have a straightforward pattern but a substantial number have a complex, multi symptom, multi system presentation. We all need to be frequently reminded about diagnostic vigilance. When things donâ t fit, ask the question â what else could it be.â

The second issue raised was that of missing investigation results. This possibility makes all doctors uneasy, because we are aware that it can happen to any one of us. One promising development is the introduction of the electronic patient record, which will facilitate all laboratory and radiology results being entered as soon as they become available. The other potential is that abnormal results can be automatically flagged. The pilot programme is due to be rolled out next year in a number of Irish hospitals.

The third issue is how a hospital and its staff should best interact with relatives when a patient is perceived to have suffered an adverse, avoidable outcome. This is an area that doctors and other healthcare staff have struggled with for a long time. Neither the undergraduate or postgraduate training programme prepares one for these scenarios. The introduction of open disclosure policies and their structured governance offer the potential to bridge this communication deficit.

Ms Murphyâ s lecture was both thought provoking and challenging. It was a reminder of the importance of paying attention to the patientâ s details including history, examination, and investigations. Communication is of paramount importance. However when moving from individual cases to the global provision of healthcare, we need to accept, as recently pointed by Mr. Tony Oâ Brien HSE, that harm occurs and we must address the resulting needs in a sensible and pragmatic way.

JFA Murphy

Editor

1. Building a culture of safety. Report of the Commission on Patient Safety and Quality Assurance. Department of Health and Children. July 2008.

Comments: