

Joint Oireachtas Committee on Health

Meeting on Wednesday 16th May 2017

Opening Statement by Dr. Tony Holohan, Chief Medical Officer, Dept. of Health

I have been Chief Medical Officer for 10 years. In all those years, I cannot recall a time when patients were gripped by such widespread fear and concern. Yes of course, given the nature of the events that have unfolded in recent weeks, this fear and concern is entirely understandable; but it has been hugely difficult to get real facts, which people can trust, into the public domain and hence into public understanding.

Therefore, I would now like to take the opportunity to get those facts across and in some way allay public concerns. Yes, things went wrong that is true; lessons must be learnt that is also true; but it is important that we are clear about what actually came to light. Arising from the publicity following the Vicky Phelan court case, questions arose as to whether other patients might be in a similar situation. Had Vicky Phelan not highlighted her case, we might not have become aware that other women had not had the findings of the CervicalCheck clinical audit disclosed to them by their clinicians. We owe a debt of gratitude to Vicky. We have already expressed, and express again, our gratitude and thanks to her for creating the opportunity for us to learn and to improve our services. This will ultimately benefit all women in the country.

It has become clear that the non-disclosure of clinical audit findings was widespread. It has also become clear that the issue of disclosure was the subject of dispute among the relevant clinical community. I can provide assurance that the Department was not aware of these issues until this controversy arose. We have since had the opportunity to engage directly with a view to understanding, directing and investigating what happened.

So let me spell it out clearly; firstly, no Minister was advised. Secondly, the decision not to escalate was a fair and reasonable decision. It was reasonable because the information provided in the briefing notes provided by the HSE to the Department was evidence of ongoing improvement to how the service was being delivered, rather than the identification

of a problem which, of its nature, required escalation to Ministerial level. The HSE has and will confirm that within their systems no escalation of concern in relation to the implementation of this audit programme took place.

I think the characterisation of the Department, my colleagues and me in the media in recent days has been unfair. The Department is far from an organisation that is unwilling to seek proper disclosure to patients, that is unwilling to directly performance manage the HSE, and to escalate appropriately to Ministers. Any fair assessment of our work record will show that this is simply untrue.

Firstly, in relation to cancer, both I and the Assistant Secretary in Acute Hospitals have a long and very proud record of a hands-on involvement and achievement in major cancer developments. A key component of our work has been to drive extensions to cancer screening, starting with breast to cervical and to bowel screen. We were hands on in the establishment of these programmes.

In the case of cervical cancer particularly, it is important to point out just how much has been achieved. Before 2008 we had a disorganised arrangement of random screening where many women were getting too many smears and many others were not getting any smears at all. On an annual basis, we were doing more smears in the country at that time, than we are now. Smears were examined in a wide range of laboratories, many of which were too small and not fit for purpose. There were no quality assurance arrangements in place and there were very long turnaround times for reporting of smear results. In 2008 we introduced a population based programme which invites patients to come forward to their GPs for smears, those smears are sent to accredited laboratories and appropriate follow up colposcopy services were put in place.

Before 2008, cervical cancer incidents were rising and doctors working at the coal face in gynaecology spoke passionately about young women presenting symptomatically with very late advanced cancers that required radical surgical treatments and often had poor

prognosis. Since 2010 we can categorically demonstrate that the national programme is delivering on average a 7% reduction in incidents.

Much has been spoken of the fact that this issue was not escalated to the Minister. I, as Chief Medical Officer, and the Assistant Secretary, Acute Hospitals, have a long established practise of appropriate escalation of issues to Ministers, often in circumstances where the issues being escalated are difficult and challenging and may pose political challenges for the Ministers in question.

From our responses to individual incidents in the time of Minister Martin, to the establishment of the Patient Safety Commission by Minister Harney, through to the work on major challenging issues such as Portlaoise and other maternity services up to and including the Maternity Strategy, and the establishment of the National Patient Safety Office by Minister Varadkar, we have a long track record of not just escalating, but working hands on with a succession of Ministers and the senior leadership of the health system, and most importantly with patients and patient groups, to spearhead what has been an enormous programme of reform.

Let me now move on to open disclosure. Various theories have been reported around the advice I gave to the then Minister Varadkar and the Government in relation to open disclosure, so let me make some facts clear:

I do not regard open disclosure as optional. Open disclosure should happen in the right way, in every circumstance in which it is indicated. Patients simply must be informed. I know that this can be a challenge for the medical profession internationally, but professionals in this country are rising to that challenge. Our legislative approach is to encourage doctors to do the right thing in circumstances where disclosure is required. We know from the evidence internationally that one of the reasons that disclosure does not happen is that doctors fear the medico legal consequences. We have directly addressed this fear through the voluntary disclosure legislation which we have introduced. That legislation provides that if doctors disclose appropriately, they will not contribute further to any legal

risks they may have. That is intended to create a safe space and encourage people to do the right thing.

That is not to say that we do not see a role for mandatory open disclosure, so a stepped approach is required. Following many months of work, we have secured Government approval to introduce mandatory open disclosure for a specified list of serious reportable events. This is in line with the UK Duty of Candour. However, it goes further in that it places the duty directly on doctors, and not simply on organisations, to make those disclosures. Thus the commitment to open disclosure in this country exceeds that in the UK and is based on our assessment of what will work best to encourage and support disclosure in the right way and required disclosure where events are sufficiently serious. This has been the result of a huge amount of work by the Department over a long period of time.

It is really important that I am clear that we absolutely recognise that there are very tragic cases at the centre of the current controversy. We are fully sensitive to that. I want to engage directly with those people to better understand their perspectives and to ensure that their perspectives are directly fed into policy making and to policy oversight such that lessons for the health system are applied.

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