Medical Aftermath and Update

In 2007 we settled a wrongful death suit that we had brought against the hospital and the doctors. It was a painful process for us, but we felt that we needed an independent assessment of what happened and the legal system provides for this. At every turn in this protracted process, we encountered nothing but respect and compassion from all parties.

Prior to our legal action, we had been discussing with hospital officials the circumstances surrounding Julia's death, and the changes in procedures and practices that they adopted as a response to our tragedy.

For years, we were told that a day rarely went by at the hospital without a reference to Julia or a recollection of her case. Every hospital knows tragedy, but Julia's case was special. Her death demanded significant changes, and her case is being used to promote patient safety reforms well beyond our community.

Most significant, perhaps, was the introduction of a “Rapid Response” program. As the name implies, there is a team of doctors and nurses available to intervene in a case immediately when anyone—anyone—believes that a patient's condition is deteriorating and the team at hand is not responding with sufficient urgency. The practice had been implemented in other hospitals over the previous several years and was already under consideration here. But Julia's case was the catalyst for putting it in place in the fall of 2005. The admissions process for new patients includes specific instructions (printed in multiple languages) to parents about this program and how to initiate a request in regard to the condition of their child.

The Rapid Response Team story was published in a national journal on hospital quality and patient safety. In actions more directly related to Julia's case, we were told about the following:

- "Chain of command” protocols were refined and reinforced for accessing qualified medical attention in situations when a patient is deteriorating or when family concerns need a physician's timely response. A nurse or care provider must move up the chain of command if an attending physician does not respond within a set period of time. (This applies in situations short of a “crisis” when a Rapid Response Team would be called.)

- Clinical standards for determining that a patient is ready for discharge from a post-surgical care unit were revised.

- Training of personnel around issues of patient safety has focused on communication between and among care givers. New emphasis has been given to the responsibility of anyone involved in the care of a patient to "stop the line," if they have a personal concern that is being overlooked by the team. The team is obligated to stop and reassess the patient's safety.

- Before any surgical procedure begins, the surgical team is required to "pause for the cause," as a final confirmation of the surgical orders and the patient's condition.

We were told that Julia's death was intensely traumatic for her care team. We know from other sources that shock rippled beyond the hospital to the broader medical community. We take some comfort in learning of the changes in policy and practice that were adopted by the hospital. We hope that the story of Julia's death remains in the hospital's institutional memory and continues to inform and strengthen their culture of patient safety.

We have also worked with the University of Minnesota Foundation and the Pediatrics Program of the Medical School to identify pediatric residency training and continuing education programs that we can support. We are in awe of the creativity and enthusiasm of Drs. Andrew Olson, Abe Jacob, among others, who are working with us to find ways to improve the training of new doctors, and change the culture of the medical community in ways that will enhance the care and safety of children—especially adolescents—in the system.