

The Doolin Memorial Lecture 2025

J.F.A. Murphy

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Lecture Title: The Power of Story Telling in Healthcare

Speaker: Dr Suzanne Crowe, President of the Irish Medical Council

Consultant in Paediatric Intensive Care, Crumlin Hospital, Children's Health Ireland

Dr Suzanne Crowe opened her lecture by stating that we humans have always been story tellers. Storytelling is a biological necessity. It is the vehicle used to transmit knowledge, express empathy, and to determine the best course of action. Stories capture who we are and they help to shape us.

Stories predate science and writing. Every community had a storytelling process. The ability to recount our day-to-day experiences is what gave us our biological advantage. It provides us with the platform to warn, teach and enquire. Any one of us, using the story format, can in a matter of minutes compress our life experiences. When a patient tells their medical story, it lights up different parts of the listener's brain. It is well recognized that an individual patient's story can transform a doctor's thinking and approach to the delivery of medical care. Data shifts one's mind and stories shift one's heart. The story leads and drives the commitment to the provision of holistic care.

Dr Crowe gives the example of an 8-year-old child who was admitted to the ICU from a peripheral hospital with a history of tachycardia and abdominal pain. His mother was extremely concerned that he may have sepsis. Fortunately, the investigations were normal and ultimately the diagnosis was severe constipation which was readily treated. Following further discussions with his mother, the true story was unlocked. The child had autism and a severely restricted diet and would only eat bread and butter, the cause of his constipation. The mother's only other child had died from neonatal sepsis which explains her deep concerns that infection was the cause of her son's symptoms. The case illustrates that one needs both knowledge and understanding in order to give the delivery of clinical care its proper shape.

There are fundamental principles that all doctors know and apply in their daily practice. Consent is a story based on trust and the recognition of patient's dignity and self-determination. Hand-washing in the prevention of patient cross-infection, one of the cornerstones of good healthcare, is based on the hard lessons that have been learned from previous hospital outbreaks. We teach medicine in this way. The medical story arc is the narrative

journey of a patient's illness using the sequence of presentation, the key issues, the treatment and the resolution. It is not only what happened but also what mattered. Stories blend the details into a recognizable shape.

Our brains love stories. Memory scaffolds are important. They are the structures on which we can lay other stories. Students will remember the patient, and they will remember the patient's story. The storyteller in Irish culture knew that the lesson would not be forgotten. Mountpellier, the world's oldest practicing medical school, was established in the 12th century. The sharing of medical wisdom, however, is much older and is based on stories and storytelling. Every good story captures the consequences of the actions that were taken. We like things demonstrated rather than dictated. When information is assimilated into a story, it can be applied more readily to the individual patient's case. A frequent scenario in the workplace is when colleagues stop one and say, 'let me tell you what happened last night, why it matters, and what the consequences were'. This sharing of a recent clinical experience is very important because working with patients can be very hard in terms of witnessing their distress during acute illness. One is also sustained by their bravery in the face of adversity. Their adherence to hope is inspiring.

Dr Crowe gives the example of the dynamics frequently at play in the narrative between the patient and the doctor. When undertaking pre-operative assessments of adult patients admitted for elective orthopaedic surgery, she found that it was informative to reflect on their verbal interactions. Some would discuss their plans after the surgery including going on a holiday or being able to actively mind their grandchild again. On the other hand, there were others who would express fears about how they would cope with post-operative pain and their ability to recover. This latter group were often the ones that struggled the most after the surgery. Patients don't tell us any details accidentally. They are not accidental communications. Expressions like 'I'm not yet back to my normal self' are very meaningful.

Medical adverse incident reviews are structured investigations into what happened, why and how to prevent a recurrence. The format may currently be incomplete. While the facts and the timelines are documented, the story has been removed. The narrative that connects the objective data is not available. The staff do not give their background personal accounts. The family's circumstances are not transmitted. We are ignoring how people learn when we remove the details of the story. The learning and the important messages are not clearly identified. In these circumstances, the accident is likely to be repeated.

Sharing an office with colleagues is very beneficial. They assimilate each other's stories about on-call experiences and they listen without judgement. Dr Crowe provides a personal example. When on call in the ICU, an ill child rapidly deteriorated and died. Very shortly, a

matter of minutes before her demise, an E. coli positive blood culture was communicated by the laboratory to the ICU. The staff found the child's sudden demise and the events around it upsetting. Her colleagues sat down, listened and concluded that the additional information was not available in a meaningful time-frame and nothing else could have been done to change the outcome. This was very reassuring. In situations like this, stories are able to connect things up in a meaningful way.

In hospitals, there are many different story telling sources including doctors, nurses, patients and the local culture. There are many other cultural differences in society. The commonly encountered ones are deprivation, homelessness and drug addiction. The stories of these patient groups need to be listened to if we are going to provide them with the care that they need.

In current paediatric practice, it is recognised that the parent brings profound knowledge about their child. This has been highlighted by the introduction of Martha's rule, now in place in many UK hospitals, which supports the right of parents to get a rapid review if they feel that their child's condition is deteriorating. The healthcare systems now in place are based on teamwork. The patient stories must go across the team. The handover from shift to shift and the inciteful comments about the patient's progress are at the centre of good care.

The WHO surgical checklist, introduced by Atul Gawande, has proven to be an important worldwide safety tool. However, the theatre remains an impersonal environment. Most of the staff have not met and do not know the patient who is about to undergo surgery. In Crumlin Children's Hospital, in an attempt to add a human touch, a personal note is added such as 'the patient has asked Santa for a bike'.

The purpose of intensive care is to keep the patient physiologically stable until recovery takes place. There is a constant need to ask what we are doing. If the patient is not going to recover, it is important to meet the family at an early stage and discuss the alternative options. If there is a relative travelling back from abroad, the decision may be to continue ICU care for a period of time. Otherwise, it is advisable to redirect care and allow the patient to have a natural death.

Finally, Dr Crowe mentioned the late Dr John Pritchard at St. James's Hospital and his excellent teaching skills. Dr Prichard constantly told the students that the patient is telling you what is wrong with them. The human body is the story that the spirit is trying to tell. Stories are the telling pathway. When we tell stories, we are doing what is clinically important even in the era of technology. Medicine, at its core, remains an oral art.

The audience, which consisted mainly of clinical doctors, listened to Suzanne Crowe with rapt attention. Her message resonated with what they encounter every day in their interactions with patients. The lecture was timely. In an era of rapidly developing technology, it provides a blueprint on how the patient's story is kept at the centre of their clinical journey.

J.F.A. Murphy
Editor