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Practitioner's blog

Patient misidentification and its ramifications

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A North African man in his forties was brought to the Emergency Department by ambulance. He had given his name and details to the paramedics by showing them his driving licence. The hospital receptionist copied his details from the ambulance documentation, but in the process an 'e' was changed to an 'a' due to the characteristics of the paramedic's handwriting. This went unnoticed and the patient was admitted to a ward. Unfortunately, during the night he deteriorated and needed to be transferred to a tertiary specialist centre, where he later died without a relative present. His details were copied from the notes compiled in the first hospital, and the misspelling of his name was also copied. When his wife came to see his body she noticed that the spelling of his surname on the identity bracelet was incorrect. She pointed this out to staff, but was apparently informed that it could not be changed as the mortuary staff had used the name on the identity band and on the patient's notes. As his wife had little understanding of the system she did not argue her point, and indeed it is not unusual for people from minority groups to defer to authority in such situations, as they may feel disadvantaged and marginalised by language and a poor knowledge of the system. Thus the death certificate was also issued with the wrong spelling of the patient's name.

The extent of what may seem like a minor error became only too evident when the family wanted to repatriate the man's body for burial in his native country. At a time when they least needed it, they encountered major bureaucratic complications about transporting his body because the name on the death certificate did not match that on the passport, and his eligibility for funeral rites and burial in his native land was therefore questioned. Returning her husband to the land of his birth for burial was the last gesture his wife could make, and having her efforts thwarted by bureaucracy greatly exacerbated her grief and created feelings of mistrust in a system she believed was there to care for patients and ensure their safety.

It is very sad that one transposed letter in a person's name could be the cause of so much grief and pain, but this would be to understate and oversimplify a complex range of issues and the high risk of error. All healthcare staff are expected to check patients' identities for every procedure, in order to ensure safety and minimise risk. Clearly this did not happen, and an initial error was perpetuated. One might argue that this error could have occurred with any patient, and this is undoubtedly true. However, the risk and potential for such an occurrence is far greater where the name is not familiar, where there are language barriers and where advocacy for that person is either weak or absent.

What is perhaps of greater concern in this situation is the subtle nature of cultural ambivalence and the juxtaposition of an inflexible and unwilling attitude in responding to the woman's observation that her husband's name was spelt incorrectly. We need to question and challenge such attitudes where they prevail, especially if they are directed at those who, by virtue of being different in some way and unable to assert their own sense of agency, become the recipients of substandard care. It is not enough merely to tick the boxes of 'cultural competence.' Patient-centred care demands that we spell and pronounce our patients' names correctly, not only for safety reasons, but most of all because it is important to them.

Genuine cultural competence requires a patient-centred approach to identifying the cultural and communication needs of all patients, but becoming culturally competent is not an endpoint in itself. In clinical practice we have become more aware of the importance of language and interpreting, but we have yet to attach the same importance to accurately spelling and pronouncing unfamiliar names, even though we ourselves may well be offended by (or laugh at) those

who mispronounce our own names! Despite numerous interventions, many ethnic minority patients continue to be at a disadvantage in our healthcare system (Lakhani, 2008) for various reasons, and the potential for misidentifying patients continues to be a risk.

A person's name is intricately linked both to their personal identity and, in many societies, to their family, ethnic and cultural identities. Most importantly, names confer belonging and being valued, which is important not only to the individual but also to their family and the wider social sphere. Remembering, using and speaking a name correctly will enhance communication. Conversely, mispronunciation can have the opposite effect. Mispronunciation by accident is annoying but may initially be excused, as names with unfamiliar sounds or which are composed of many consonants can be difficult to pronounce at first. However, continued mispronunciation may be perceived as a deliberate distortion of identity or a complete lack of respect for that person. Misspelling a name can have much more serious ramifications, as we have shown here. Making assumptions about how names are spelt and not checking their spelling is unacceptable and can even endanger patients. Interfering with someone's name is therefore an affront to their sense of self, and potentially to their safety.

Accurately spelling, pronouncing and remembering a person's name are key to effective human interaction. Doing this engages on a personal level and conveys recognition and respect. Good communication is essential in healthcare, yet often the first and most obvious difficulty that many ethnic minority patients face when accessing health services is communication and being understood, particularly with regard to the spelling and pronunciation of their name. These difficulties are accentuated further if the individual does not speak English or speaks with a strong accent, and if there is a cultural gap and lack of knowledge in the host culture about the significance of names in different cultures and how they are spelt.

REFERENCES

Lakhani M (2008) *No Patient Left Behind: how can we ensure world class primary care for black and minority ethnic people?* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084971 (accessed February 2014).

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