COMMENTS

regarding

STATEMENT OF DR JANE BARTON

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AT THE REQUEST OF: Hampshire Constabulary

CONTENTS

1. INSTRUCTIONS

To examine and comment upon the statement of Dr Jane Barton. In particular, if it raises issues that would impact upon any expert witness report prepared.

2. DOCUMENTATION

This Report is based on the following documents:

[1] Statement of Dr Jane Barton as provided to me by Hamsphire police (undated).

[2] Portsmouth and South East Hampshire Health Authority job description for the post of clinical assistant to the geriatric division in Gosport as provided to me by Hamsphire police (undated).

[3] Report regarding Elsie Devine (BJC/16) Dr A Wilcock, 10th December 2004.

3. COMMENTS

Dr Barton commenced the post of clinical assistant to the geriatric division in Gosport in 1988. As the job description is undated, it should be clarified that this relates to the post she applied for and was subsequently appointed to at this time. That said, some of the information in the job description does suggest that this is the case and I will proceed to make comments on this basis. For example, the job summary states that this is a new post and also puts the location of the beds on three separate sites (Gosport War Memorial, Northcott Annexe and Redcliffe Annexe), as Dr Barton reports in her statement.

There are some discrepancies between the job description and Dr Barton's statement:

i) Dr Barton states that the post was a training post. A clinical assistant post is not in my experience a training post and the job description does not describe it

as such. A clinical assistant is a 'career grade' post and intended for experienced physicians who can work autonomously and are most often filled by a general practitioner with a special interest in that area.

ii) Dr Barton states that the post was initially for four sessions a week and it was not until 1998 that it was increased to five. The job description states it is for five sessions.

iii) Dr Barton states that (in 1998) of the five sessions, one and a half were given to her partners in the practice for the out of hours aspect of the post. She goes on to state that she was therefore expected to carry out her day to day responsibilities within three and a half sessions. If I have understood her statement correctly she seems to be suggesting that her post was thus time limited to the equivalent of 20 hours per week in total (one session is usually equivalent to four hours), split into 14 hours for day to day work and 6 hours for out of hours work. The job description is however clear: The clinical assistant post was *to provide 24hour medical cover to the long stay patients in Gosport.* This is an important point of difference to clarify with the Medical Staffing Department, as it appears to me that the payment of five sessions a week (to be worked flexibly) was intended to be a nominal amount that would reflect the likely workload that the post would entail on average and was not intended to be a maximal time limit in which the work had to be done; how could it be if 24hour cover was required? The division of the sessions into day to day work and out of hours work is not part of the job description. It should be clarified if this division was made by Medical Staffing or Dr Barton.

The remaining comments are in no order of importance and generally reflect the order in which they arise in the statement.

Dr Barton describes how she would visit the hospital early every morning, return most lunchtimes and quite often, in particular if she was the duty doctor, return to the hospital after her evening surgery. She also states that she would make

herself available to staff 'even outside of these hours' and would receive calls from staff at home or at her surgery to discuss developments or problems with particular patients. As the job was to provide 24hour medical cover, these activities are all part of the duties of the post.

Dr Barton states that her role of clinical assistant was in addition to her full time role as a general practitioner. In my experience, general practitioners employed in clinical assistant posts, usually undertake the work in morning or afternoon sessions in place of their general practice duties rather than in addition to them. Although the job description says that the five sessions could be worked flexibly, I could see that trying to combine an increasingly busy clinical assistant post with a full time general practice commitment could become difficult as Dr Barton alludes to, e.g. arriving at the hospital at 7.30am every morning only to have to leave to start her general practice commitments at 9.00am, the increasing bed occupancy, dependency of the patients and medical input required. Dr Barton states that she raised the matter verbally with management in 1998 and thereafter, but not with whom or what options were discussed except 'there was no one else to do it [the post].' What I am left wondering is why Dr Barton did not feel it preferable to do what other general practitioners who are clinical assistants do - work some or all of the clinical assistant sessions instead of their general practice sessions to ease some of the time pressures. Did she discuss this as an option with the hospital management or her partners in her practice? The situation appeared to continue unchanged until her resignation in April 2000.

The two consultants, Dr Lord and Dr Tandy appear to have had a limited number of fixed sessions devoted to Gosport War Memorial Hospital. Dr Barton states that there was a general ward round on alternate Mondays, and a stroke ward round every Thursday (both Dr Lord) but does not state what Dr Tandy did. She does point out that from the end of April 1998 until February 1999 that

the consultant cover was reduced further due to Dr Tandy's absence. She states that she had no effective consultant support on one ward during this time and limited support on the other. A clinical assistant would be expected to have sufficient experience to operate autonomously and not to have to defer all decisions to the consultants. However, a clinical assistant should receive support from a consultant and Dr Lord and Dr Tandy should be asked for their view of the support that they gave. As the patients were under the consultants care, Dr Lord and Dr Tandy would have in effect delegated part of this care to Dr Barton. As such they would have had the responsibility as outlined in 'Good Medical Practice' (General Medical Council, page 12, 1998) to 'be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved.' Dr Barton states that by the time of her resignation in 2000, there were two consultants but does not name them, other than to state that one was also clinical director of the trust. These consultants should be identified and also asked for their views on the above.

Dr Barton states that she attended the ward round on (alternate) Mondays with Dr Lord but was unable to attend the round for stroke patients on a Thursday. She does not explain why. Given that she has underscored the relatively small input from the consultant staff, I would have thought it important for her to attend. The job description states that one of the duties of the post was 'to attend the weekly consultant rounds.'

Dr Barton states that because of the busy nature of the job her note keeping suffered in consequence. She states that the medical records she kept 'do not set out each and every review with a full assessment of a condition of a patient at any given point.' As such she has failed to fulfil one of the stated duties of the post 'to be responsible for the writing up of the initial case notes and to ensure that follow up notes are kept up to date and reviewed regularly' and to provide good clinical care that includes 'keeping clear, accurate and contemporaneous

patient records which report the clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed' as defined by the General Medical Council, 1998. Being busy is probably not a good enough reason on its own to fail to keep good records. After all, general practitioners may see approximately 20 patients in a morning or evening surgery at 6–10minute intervals and they are expected to keep clear and accurate records. Being busy may mean the notes are concise, but nevertheless, when there were significant changes in the patients condition or medication prescribed, an entry however brief should have appeared in the medical notes.

Dr Barton also states that she 'felt obliged to adopt a policy of pro-active prescribing.' This does not appear to have been part of any trust policy. It appears to relate to the prescribing of drugs within a range to 'give the nurses a degree of discretion to administer within a range of medication.' Dr Barton states that this was to allow patients to receive medication 'even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient.' If I have understood the job description properly, this statement can not be correct: Dr Barton's (and her partners) job was *to provide 24hour medical cover to the long stay patients in Gosport.* As such, there should have always been access to medical cover 24hours, seven days a week and I do not think it can be argued that it had to arise 'out of necessity'. As the out of hours medical cover was provided by general practitioners, possibly also on call for patients elsewhere (this should be clarified) it is possible that there could be a delay in them attending the patients at Gosport and that for some patients, depending on the circumstances, this delay could be unacceptable. In this regard, ensuring that patients with symptoms such as pain had additional pain relief prescribed 'as required' would be seen as appropriate to avoid unnecessary delay in a patient obtaining pain relief. This does not however, in my experience, extend to the prescribing of wide dose ranges of diamorphine

and/or sedatives by a syringe driver, for patients for whom they may not be indicated or excessive in dose 'just in case'. At worst, this practice could be seen as a way of reducing the need for the general practitioners having to visit patients at Gosport out of hours. I do not understand why appropriate doses of analgesics or other symptom relieving medication was not always prescribed as stat doses on the 'as required' section of the drug chart. This would have allowed patients easy access to additional medication they required at any time and removed the need for the medication in the syringe drivers to be written as large dose ranges.

Dr Barton states 'it may be of some significance that the prescriptions of this nature by her were inevitably reviewed on a regular basis by consultants when carrying out their ward rounds. At no time was I ever informed that my practice in this regard was inappropriate.' Dr Lord, Dr Tandy and the other consultants should be asked for their view on this statement.

4. CONCLUSION

It seems clear from the job description that the post of clinical assistant to the geriatric division in Gosport to which Dr Barton was appointed to in 1988, was to provide 24hour medical cover to the patients in Gosport, and that this was remunerated at a nominal number of sessions to reflect the likely workload. Dr Barton appears to view the sessions as the maximal number of hours the job entailed however. It was not a training post. It would seem that initially, the workload was such that Dr Barton was able to take on the post in addition to her full time general practice commitments without apparent difficulty. Over the years and by 1998 at least, it seems that the workload had increased due to greater bed occupancy and increasing patient dependency. This appears to have made undertaking the post together with a full time general practice

commitment increasingly difficult. As a result, there were increasing time pressures and corners were cut - notes were not kept up to date and pro-active prescribing used, at best as a way of addressing the patients needs in a situation where medical cover was not always immediately available, but at worst to limit the out of hours medical work load. Dr Barton raised her concerns to hospital management but put nothing in writing. No details are given of any options discussed. The consultant's view of the support they provided Dr Barton should be explored, together with their knowledge of her 'pro-active' prescribing. The consultants do have a responsibility when delegating care of their patients to others as described above.

In short, Dr Barton's statement provides insight into the increasing workload in the post and her response to that. She admits to failing in the duties of the post and good clinical practice, with particular reference to keeping medical notes up to date. At odds with the job description, Dr Barton's statement appears to suggest that 24hour medical cover was not part of the duties of the post, that full 24hour medical cover did not exist, and that this was a factor that influenced her prescribing practice.

Having read Dr Barton's statement, I do not believe that it materially alters my report regarding Elsie Devine (BJC/16), dated 10th December 2004.