JB/PS/1

STATEMENT OF DR JANE BARTON

I am Dr Jane Barton of the Forton Medical Centre, White's Place, Gosport Hampshire.

I am a Registered Medical Practitioner and qualified in 1972 at Oxford University with the degrees MA, BM BCh. I joined my present GP practice in January 1980, initially as an assistant for three months and then as a minimum full time partner.

As a General Practitioner I had a minimum full time commitment. I had approximately 1500 patients on my list. I worked eight general practice surgery sessions weekly and carried out house calls on my own patients and I conducted half of the out of hours on call responsibilities of my partners with one night in ten and one weekend quarterly on duty for the whole practice.

In addition to my general practice duties, I took up the post of the sole Clinical Assistant in elderly medicine at the Gosport War Memorial Hospital in 1988. The GWMH was a cottage hospital. It had 48 long stay beds and was originally on three separate sites, and was resourced, designed and staffed to provide continuing care for long stay elderly patients.

The position of Clinical Assistant is a training post, and for me it was a part-time appointment. Initially the position was for 4 sessions each week, one of which was allocated

to my partners to provide out of hours cover. This was later increased, so that by 1998 the Health Care Trust had allocated me 5 clinical assistant sessions, of which 1½ were now given to my partners in the GP practice for the out of hours aspects of the post. I was therefore expected to carry out my day to day responsibilities in this post in effect within 3½ sessions each week. This was of course in additionto my GP responsibilities.

By 1998, I was working on two of the wards at the Hospital, Daedalus, and Dryad Wards. The two wards had a total of 48 beds. About 8 of the beds on Daedalus Ward were for 'slow stream' stroke patients. The remaining beds were otherwise designated to provide continuing care for elderly patients.

Two Consultants in elderly medicine were responsible for each of the wards. Dr Althea Lord was responsible for Daedalus Ward and Dr Jane Tandy for Dryad Ward. Both Consultants, however, had considerable responsibilities elsewhere and thus their actual time at the Gosport War Memorial Hospital was significantly limited. Dr Lord for example was responsible for an acute ward and a continuing care ward at the Queen Alexandra Hospital in Portsmouth, and had responsibilities at a third site, St Mary's Hospital, also in Portsmouth. As a result, Dr Lord's presence at the hospital was limited to conducting a continuing care ward round on Daedalus Ward every other Monday. She would also be in the hospital, conducting outpatients on Thursday when she would carry out a further ward round in relation to the stroke patients.

Dr Tandy took annual leave towards the end of April 1998 followed immediately thereafter by maternity leave, so that she did not return to work until February 1999. In spite of the considerable workload, the Trust took the decision that her post should not be filled by a locum. Dr Lord kindly volunteered to make herself available to cover, but the reality was that given her own position as a very busy consultant, she could not carry out a ward round on Dryad Ward. For much of 1998 therefore, I had no effective consultant support on one of the two wards for which I had responsibilities, with the consultant role on the other ward already being limited.

At the time of my resignation from the GWMH in April 2000 there were 2 Elderly Medicine consultants covering the wards and providing a weekly ward round. The consultant nominally in charge of Dryad was also Clinical Director for the Trust as well as his other extensive clinical commitments in two other hospitals and was not always available to provide the weekly service.

In carrying out my duties as Clinical Assistant I would arrive at the Hospital each morning when it opened about 7.30am. I would visit both Daedalus and Dryad wards, reviewing patients and liasing with staff, before I then commenced my General Practitioner responsibilities at 9am. I would return to the Hospital virtually every lunchtime. New patients, of whom there were about 5 each week, would usually arrive before lunchtime and I

would admit patients, write up charts and see relatives. Quite often, in particular if I was the duty doctor, I would return to the Hospital after GP surgery hours at about 7pm. I was concerned to make myself available to relatives who were not usually able to see me in the course of their working day. This became a very important time commitment in the job. I would also attend the Daedalus ward round on Mondays with Dr Lord, but was unable to attend the round for stroke patients on Thursdays.

I was also concerned to make myself available even outside those hours when I was in attendance at the hospital. The nursing staff would therefore ring me either at home or at my GP surgery to discuss developments or problems with particular patients. In the event that medication was to be increased, even within a range of medication already prescribed by me, it would be usual for the nursing staff either to inform me of the fact that they considered it necessary to make such a change, or they would inform me shortly thereafter of the fact that the increase had been made.

When I first took up the post, the level of dependency of patients was relatively low. In general the patients did not have major medical needs. An analogy now would be to a nursing home. However, over time that position changed very considerably. Patients who were increasingly dependent would be admitted to the wards, so that in time, and certainly by 1998, many of the patients were profoundly dependent with minimal Bartell scores. There

was in consequence a considerable increase in the medical and nursing input required to care for such patients.

Further, in 1998 as an example, the bed occupancy was about 80%. However, the Trust was concerned to increase that still further and it then rose to approximately 90%. There would therefore be as many as 40 or more patients to be seen and/or reviewed by me when I attended each day. There was no increase in nursing staff, support staff, occupational therapy, and physiotherapy, and no support from social services to assist with the increase in patients, and the increase in dependency and medical needs. On a day by day basis mine was the only medical input.

Part of the list of duties laid down for me, as Clinical Assistant was to be responsible for the day-to-day medical management of patients. My work involved looking after a large number of elderly patients approaching the end of their lives and requiring continuing care from the Health Service. The vast majority had undergone treatment in the acute sector and were transferred to our care for rehabilitation, continuing care or palliative care after their acute management was completed. A major group of these patients were suffering from end stage dementia as well as major organ failure such as renal failure. A lot of my time would be spent attempting for forge a relationship with families and helping them come to terms with the approaching death of a loved one. This aspect of the job was often not helped by unrealistic expectations of the level of rehabilitation available at our cottage hospital or possible in

these individual patients and difficult dynamics within the families. The act of transferring such frail patients also further compromised their condition, sometimes irreversibly.

In carrying out my work I relied on a team of nurses both trained and untrained to support the work I did. Between us all we tried to offer a level of freedom from pain, physical discomfort, unpleasant symptoms and mental distress, which is difficult to offer in an acute setting and is more allied to palliative care.

Over the 12 years in which I was in post, I believe I was able to establish a very good working relationship with the nursing staff at the hospital. I found them to be responsible and caring. They were experienced, as I think I myself became, in caring for elderly dependent patients. I felt able to place a significant measure of trust in the nursing staff.

Over the period in which I was in post there was only a marginal increase in the number of nursing staff. With the significant number of patients and the considerable increase in dependency over the period, the nurses too were faced with an excessive workload.

The picture therefore that was emerging, at least by 1998 at the hospital was one in which there had been a marked increase in the dependency of the patients, and indeed an increase in their numbers. There was limited consultant input, reduced still further by the fact that no locum was appointed to cover Dr Tandy's position. By this time the demands on me were

very considerable given that I was expected to deliver this significant volume of care within a mere 3½ sessions each week. I raised this matter with management, albeit verbally, saying that I could not manage this level of care for the number of patients, but the reality was that there was no one else to do it. In due course I felt unable to continue. I resigned from my post in 2000.

It may be of some significance that my position was then replaced, not with another part-time clinical assistant, but a full-time staff grade. Indeed, my present understanding is that this post may be increased to two full-time positions, and is a clear reflection of the very considerable demands upon me at the relevant time when I was struggling to cope with the care of patients. In addition, the Consultant cover to the two wards was increased to ten sessions per week in 2000.

In 1998, I had tried to raise the issue with Trust management, but there was no one else to do the job. I could have said that I couldn't do the job any more and walked away, resigning my position at that time. However, I felt obliged to remain, to support my colleagues, and more particularly, to care for my patients. I felt that if I left I would be letting down the nursing staff with whom I had worked for 12 years, and letting down the patients, many of whom were in my practice and part of my own community. In reality I was trying to do my best in the most trying of circumstances. I continued to express my concern to Trust management, but to no avail, and eventually I felt compelled to resign in April 2000.

In caring for patients on a day by day basis therefore I was left with the choice of attending to my patients and making notes as best I could, or making more detailed notes about those I did see, but potentially neglecting others. In the circumstances, I attended to my patients and I readily accept that my note keeping suffered in consequence. The medical records therefore do not set out each and every review with a full assessment of a condition of a patient at any given point. Of necessity they were sparse. The constraints on the caring experienced nursing staff meant that they too had the same problem - to tend to the patients, keeping them clean, feeding them, and attending to their other nursing needs, or to write detailed notes.

Similarly, in relation to prescribing I felt obliged to adopt a policy of pro-active prescribing, giving nurses a degree of discretion and administering within a range of medication. As a result, if the patient's condition deteriorated such that they required further medication to ease pain and suffering, that medication could be given even though the staffing arrangements at the hospital were such that no medical staff could attend to see the patient. This was of assistance in particular out of hours. It was a practice adopted out of necessity, but one in which I had trust and confidence in the nurses who would be acting on my prescripts, and indeed in which the nurses would routinely liase with me as and when increases in medication were made even within the authority of the prescription. I accept that this would not be necessary in a teaching hospital or even big district general hospital

where a professor or consultant in geriatrics will have a plethora of junior staff. Somebody will either be on the end of a bleep or be available on the ward to write up/review a prescription for opiates.

It may also be of some significance that prescriptions of this nature by me 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.

Lest this observation, and indeed others, in relation to the degree of consultant support appear in any way to be critical of Dr Lord, I am very anxious to emphasise that Dr Lord was caring, thoughtful and considerate. The reality is that Dr Lord too had a considerable workload, and she did what she could, given the constraints upon her.