Dr Lord.

DAY 26

A Q You talk about stool cultures and, in the third paragraph you refer to the ulcers that she has, and you say:

"... overall she is frail and quite unwell at present."

A Yes.

B Q Clearly a number of medical concerns about her?
A Yes.

Q I am going to move on, if I may, to a patient whom I think you may recall, Arthur Cunningham. We have him as Patient G. We have a letter written by you in March 1998 at page 140.
A Yes.

C

Q I do not think I need take you through it. It speaks for itself. On the second page of that letter, page 142, you talk about the dose of Levadopa for his Parkinson's disease that he was then on?
A Yes.

Q And it appears that you and the patient had a disagreement about what was the proper
D level?
A Yes.

Q How as he getting more than you thought was appropriate?
A There had been occasions, as I recall, where he would have a house call, usually at a week-end, and would be seen by a GP who did not know him and would say that his Parkinson's disease was quite severe. And so that is how he obtained a supply of doubles of
E stronger Sinemet than we prescribed. Although we checked medication at the day hospital, he on a few occasions had the stronger strength in his pocket. If it happens ---

Q Sorry?
A The Parkinson's --- Sorry?

Q How as he seeing doctors that he did not know?
F A If it is an out of hours house call, it could be someone from the deputising service, they would not necessarily have access to notes when they visited him.

Q I understand. So it was Mr Cunningham's decision to call an out of hours doctor?
A Yes.

Q I understand.
G A He was quite disabled. He had a war injury in addition to his Parkinson's.

Q We have another letter from you three months later on page 134.
A Yes.

Q Again, the content of the letter really speaks for itself but you do make a comment at the start of the second paragraph in relation to the amount of weight that he seems to have
H lost since you last saw him on the 10 March?

A A Yes.

Q Are you able to tell us why that might have been?
A Further on in the letter I said there might have been a degree of depression.

Q Yes.
A Sometimes people with Parkinson's do lose weight quite rapidly for no reasons but
B you do not know that until some time has lapsed. At that point it was not certain. As I recall it, it was quite a striking difference in his appearance and that is why I put it in.

Q Can I just ask you? I am sure the Panel know, but you make reference at the beginning of the third paragraph to a "monkey pole"?
A That is the pole above the bed and ends up with a sling, and then a triangle, that actually helps people move in bed.

C

Q So it is to help him to ---
A It is a form of a bed lever but it is above the bed.

Q If we look over to the second page of that letter on page 136, we see on the third paragraph, you say you have reduced his Levadopa further. You had said at the top of the previous paragraph, you felt he was on too much of that medication?
D A Yes.

Q And you say, towards the end, at the bottom of the page:

> "We will need to ascertain as to whether Mr Cunningham is going to remain at Merlin Park…"

E That was the home that he was in?
A Yes. That was the rest home.

Q And I think you saw him again, certainly in September 1998. We have a letter at page 458 of this bundle.
A Yes.

F Q And we have a clinical note for the occasion when you saw him, starting at page 644.
A Yes.

Q Just dealing with the letter, if I may, at page 458, you indicate that he was reviewed in the Dolphin Day Hospital. You refer to a large necrotic sacral ulcer which was extremely offensive?
A Yes.

G

Q You talk about his Parkinson's disease. You say:

> "… mentally he was less depressed but continues to be very frail."

A Yes.

H

A

Q And you say you have taken the liberty of admitting him to Dryad Ward with a view to more aggressive treatment of the sacral ulcer. What were the options for you at that stage given the ulcer that he had and his other conditions?

A The options were that he was returned to the nursing home where was and we asked them to deal with it. The fact that he had developed a pressure sore in a nursing home meant that he needed something that was more specialised and we must have had a bed on Dryad Ward available that day, because we did not admit people from the community direct to Gosport War Memorial Hospital. They usually came through our acute wards. So we must have had a bed vacant and it was either we sent him back to the nursing home he came from and asked them to deal with it, because that was the highest level of care he could have in the community, or we could have sent him to the emergency department at QA, where probably he would have waited a long time on a trolley to be seen and it would not have been an appropriate choice for him. So he was admitted direct to Dryad Ward from the day hospital on the same day.

B

C

Q By admitting him from the Dolphin Day Hospital, you are just taking him on to a bed within the same physical site at the War Memorial Hospital, are you not?
A It was in the same building, yes. On the same floor as well.

Q "DDH" in your note is obviously Dolphin Day Hospital. That is where you saw him.
A Dolphin Day Hospital.

D

Q "Very frail. Tablets found in mouth some hours after they are given." Is that what your note says?
A Yes. That is how it should read. It is badly written, but that is how it should read.

Q Would that be of concern?
A Yes. It meant that he had not swallowed them, had not been able to swallow them for whatever reason. It is important that medication for his Parkinson's and certainly his depression that the tablets are taken. So it indicated his frailty, it could have indicated a reluctance to have medication, it could have indicated a poor swallow, which can happen.

E

Q You then deal with the ulcer and you have drawn a diagram.
A Yes.

F

Q Just remind us where the lateral malleolus is?
A That would be the outer aspect of the left ankle.

Q "PD" means Parkinson's disease. "No worse", you said.
A Yes.

G

Q You then go on to list a number of problems. The fourth one is depression and an element of dementia. Is that right?
A Yes. That is from previous assessments at the time. He spent some time with the psychiatric team as an inpatient and there were concerns that there was significant depression, but a degree of dementia as well.

Q You have written as point 5 "Diabetes mellitus - diet". Does that mean controlled by diet? He was not insulin dependent.

H

A Yes. No, he was not.

Q Point 6. Is it "Catheterised for retention"?
A Yes, it is. He had already been catheterised. I think that was some time ago.

Q If we go over the page to page 645, your note continues. You say, "Stop codanthramer + metronidazole + Amlodipine."
A Yes.

Q What types of medication are they?
A Co-danthramer is a laxative, which is predominantly a softener. The amlodipine is blood pressure and metronidazole is an antibiotic.

Q Are those all in tablet form?
A I need to look at the chart. Sometimes metronidazole can be used topically as well to the ulcers.

Q Page 757
A Yes. The metronidazole was being given orally. The reason that I do not usually use oral antibiotics unless someone really has a bad infection is that the tissue in the sacral ulcer is often dead and for antibiotics to penetrate that is extremely difficult. So that would have been why the metronidazole and amlodipine, because it was not really required for blood pressure control at that stage.

Q We have seen you cross through the amlodipline, the co-danthramer and the metronidazole and you have signed it each time.
A Yes. The magnesium hydroxide on that is also a softener. He had one laxative that was a stool softener.

Q Coming back to your note at page 645, the fact that tablets had been found in his mouth some hours after he had been given them, was that in your mind when you decided to stop some of those tablets, or not?
A Partly that, but also partly, were they really indicated? So a combination of reasons.

Q The next entry in your plan is "TCI". Is that "to come in"?
A To come in, yes.

Q "Dryad today. Aserbine for sacral ulcer." Tell us, how bad was that ulcer?
A That would be probably among the severest of the sacral ulcers, because there is a black scar on top. When that scar lifts, the ulcer would have been several centimetres in depth, because the tissue on top has died, but the tissue underneath that is degrading and that is why the ulcer is so offensive. The Aserbine was to try and lift the lid off it, if you like, and then allow the ulcer to heal from the bottom up, in the hope that it would.

Q At the bottom of your note, you have written, "Prognosis poor". What are you referring to there?
A Again, the outlook for him was not good. He had sustained a pressure sore in a nursing home, which really has qualified nurses and a high degree of nursing expertise. He had a long-term condition in the form of Parkinson's disease, which he had had for quite a while, and nutritionally he was not good. Mentally he had declined as well and the outlook

A for him – at best, he would return to a nursing home, but to heal that ulcer, as I remember it, would have taken several months

Q What you say is that he should be nursed on site, given a high protein diet and "Oramorph prn if pain".
A Yes. So Oramorph if required for pain.

B Q Oramorph. Is that a linctus, a syrup?
A That is a morphine elixir, morphine liquid.

Q It is not a tablet?
A No. It will be liquid and it will be short-acting.

Q Again, was it your view that it would be appropriate to go to that level of analgesia,
C given the condition you saw him in?
A Yes. From what I recall – and it was a long time ago – he was really quite distressed and I feel it was an appropriate decision.

Q We know that this man was subsequently put on a syringe driver with diamorphine and other medication. We have heard that a request was made by his stepson that the syringe driver be stopped at some point. What would your view have been if you had been asked? Is
D it appropriate to stop a syringe driver once a patient has been started?
A I did not see Mr Cunningham after he was admitted, so I do not know exactly. I do not have a picture of how distressed he was at that stage. In practice, in general, it would be really unusual for us to stop a syringe driver. Sometimes patients decline medication, but that could be for a reason of wanting to settle their affairs because they know they are terminal. Recently I have had occasion when someone has asked for morphine to be delayed until a relative came from overseas, because there were things they wanted to say and settle. It is
E always a balance, a balance as to whether you feel pain control is the most important thing or whether you feel that it is reasonable to withhold pain control to grant that request by the patient. By and large, once you make a decision to start a syringe driver, you really have worked through the other options and you have had the discussion that this person is at the end of their life and really needs this for symptom control. In my practice I cannot remember that we have actually stopped a syringe driver, but sometimes, as I said recently, we have not started strong medication. That was just a one-off.

F

Q You have told us that was for someone coming from abroad to see the patient.
A Yes. New Zealand is far away from most places!

Q I am going to take you to one more patient, if I may, and this is the last patient I want to ask you about. It is Patient L, Jean Stevens. The page I want to take you to, please, is 224. Again, I think you have had a chance to look at these notes recently, but you do not recall this
G patient.
A Not at all.

Q Page 224 is the request, I think of you:

"Please could you give your opinion as to the best path for rehabilitation of this 73 year old [female] who suffered a [right] CVE."

H

A

That is neck of femur?
A No, no. It probably was a stroke. It probably means cerebrovascular event.

Q "... leading to a dense [left] hemiparesis".
A Yes. Hemiparesis meaning the left side of the body was weak. So a stroke affecting the left side of the body, but it was dense, quite a dense weakness.

B

Q It says:

> "She is improving slowly and there is nothing more we can do for her on the acute medical side of things."

Was this an acute ward that you were being invited to see her on?
A Yes. The ward – that is a Haslar record I think – all the patients we saw at Haslar,

C

certainly then, the wards were all acute medical, surgical or acute orthopaedics.

Q I think if we go on to page 228, we have your clinical note. People may want to put a finger in there and also find page 734, which is your letter. In your note you say of this patient:

> "Extremely unwell 73 year old with

D

> 1. Dense [right] hemiplagia due to [right] parietal infarction."

The parietal region is the side of the brain above the ear, I think.
A It is. Hemiplegia means that there was no movement at all. So I would use the word hemiplegia when there was complete paralysis and not just partial paralysis.

E

Q "Ant MI". Is that an anterior myocardial infarction?
A It should be anterior myocardial infarct and left ventricular failure.

Q Atrial fibrillation we recognise. What would you say about the level of cardiac problem that this lady had?
A If I recall correctly, I think she was actually admitted with a myocardial infarct and then went on to develop a stroke.

F

Q You have written "Aspiration pneumonia". Aspiration means inhalation of stomach contents, leading to pneumonia?
A Yes. A poor swallow, probably associated mostly with the stroke and then inhalation of whatever the stomach contents into the lungs and pneumonia following that.

Q How serious a condition can that be in a patient of this sort of age and in this sort of

G

condition?
A I do not recall the patient, but certainly from my letter I was not keen to take her because I thought she was probably not going to survive even the short journey from Haslar to Gosport.

Q You say at point 5 in your note "Previous sigmoid colectomy". That is surgery on part of the bowel?

H

A Yes. On the lower part of the large bowel.