Other Document Form

Number D1156.

Title TIMES BY DR BLACK RD LESLIE DEVINE, LAVENDER

Code A

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Themes from the Review of Cases
of
Elsie Devine, Elsie Lavender and Code A

Having reviewed three cases, I believe there are a number of themes that are coming through:

1. All these cases are complex cases involving and interaction of medical illness, psychiatric illness, social problems, old age and frailty. They represent a selection of some of the most complex cases managed in geriatric medicine.

2. The consultant assessment and supervision in the cases appears poor. Although a single clinical assessment is undertaken prior to transfer there is no care plan or statement of prognosis in any of the letters. It is not clear what direction or supervision, if any, are given to the clinical assistant (s) working at the Gosport War Memorial Hospital. The consultants though remain legally responsible for the ongoing medical care of the patients.

3. Medical assessment is very poor at the Gosport War Memorial. Patients do not appear to have been examined, or if they have been, it is not documented. No clear care plan is made in the notes; abnormal investigations are not considered or acted upon. There appears to be no attempt to ask for advice from more senior members of the team when faced with abnormal results, changing circumstances or difficult clinical problems. The medical note keeping is inadequate. It is clear from the nursing cardex the patients are seen on occasions and decisions made, without any documentation in the medical notes.

4. However I am clear that in all three patients, at the time a decision was made that they were for palliative care, they were indeed terminally ill and that their problems were irreversible by that stage. It does not mean that other interventions might not have helped earlier but they were certainly irreversible by the time terminal care management was initiated.

5. There appear to have been reasonable conversations with the family and the staff (along the lines of GMC Good Medical Practice) in making decisions about terminal care and indeed no where is there any apparent dissent from the care plan being suggested by the doctors.

6. The hardest part is deciding about the intent of the drugs used. Two patients were started on appropriate drugs and doses, particularly of Morphine like drugs, that would be in line with general clinical practice. However, in all three cases there was a large step up to a subcutaneous management containing significantly higher than expected (or in my view needed) doses of Diamorphine and Midazolam, in particular. There are two possible reasons for this, the first is that the doctor genuinely believed that these doses were

required to get immediate symptom relief and that the ideal palliative care patient was one that was quiet and sedated. Certainly this was the effect that was achieved and there was no distress in the process of dying of any of the three patients.

The other interpretation is that these were deliberately high doses to shorten the period of terminal care. I am unable to make this distinction from a review of the notes.

7. Despite this, none of the patients died within a very short period of time of the subcutaneous high doses starting and it is my belief that in all three cases any shortening of life is likely to have been more than a few days at most.

Code A

15/9/04

Dr. David A Black
September 2004