

**RESPONSE OF JAMES D WISHEART TO THE WRITTEN STATEMENT OF
PROF. G.D ANGELINI DATED, SEPTEMBER 1999.**

Reference No. WIT 0073 0001-0019

1. PROF ANGELINI'S CONVERSATION WITH MR DHASMANA.

Page 2, Para 5b.

Comment

I cannot comment as I was not present at this conversation and I do not know what was said. I expect that Mr Dhasmana will present his account of this conversation.

**2. THE APPOINTMENT OF A NEW PAEDIATRIC CARDIAC
SURGEON**

Page 2, Para 5d.

1. "...in my view, the solution to the problem was to appoint a new paediatric cardiac surgeon".
2. "...I was delighted when he (Ash Pawade) was successful at an interview for the position of a Paediatric Cardiac Surgeon...."

Comment

Although it would appear that there was some difference between Prof. Angelini's view and my own view of the issues involved in the future of paediatric cardiac surgery in Bristol, it

was common ground that a new paediatric cardiac surgeon should be appointed. Under my leadership we had sought in 1990-91 to appoint Mr Martin Elliott, a paediatric cardiac surgeon to the Chair of Cardiac Surgery which Prof Angelini now occupies; that attempt was unsuccessful. The reason I tried to recruit a new paediatric cardiac surgeon in 1990-91 is that in a rapidly developing speciality, I foresaw the need to bring the service forward for the future. At that time the creation of a new consultant appointment was a very major event, and I saw this as an opportunity which might not be repeated for five or ten years.

The advice of a Working Group which included Mr Dhasmana, Prof Angelini, Dr Bolsin, myself and others, which met mainly in the first half of 1994, was that a new surgeon should be appointed for the paediatric cardiac work and, as in 1990-91, it was my intention to withdraw from paediatric cardiac work when the new surgeon began. That is what happened. I have no doubt that that is what Prof Angelini wanted, but it would be wrong to think that it was his idea or that he alone sought and worked to this end.

3. ANNUAL STATISTICS

Page 3, Para 5e and Page 10, Para 34 (Topic 13).

“....but I never saw any comprehensive annual figures.”

Prof Angelini took up his appointment in Bristol in October 1992. I produced annual statistical summaries, which included both adult and paediatric figures for each year up to and including 1992. It is my belief that Prof. Angelini was given tables for earlier years, by me, when he was visiting us prior to his appointment. The tables for 1992 were prepared by me in early 1993 and I am in no doubt that they were circulated to Prof. Angelini as well as to other members of the team. Mr Dhasmana produced a table of figures for the financial year 1992-93, when he became the Associate Clinical Director for Cardiac Surgery. This included,

amongst other things, figures for the two paediatric cardiac surgeons individually. I would be most surprised if Prof. Angelini had not been given these tables at the time, as I believe they were circulated amongst the team. I am quite sure that he would have also have received subsequent figures, although I do not have quite such a clear recollection of when they were published.

In his statement to the Inquiry, Mr AJ Bryan says that during his time in Bristol within the remit of the Inquiry (1993-95) all the consultant surgeons received from Mr Dhasmana copies of the Bristol return to the UK Cardiac Surgical Register, including the paediatric figures (Paras 10 and 15).

In Paras 39 and 44 of his statement, Prof. Angelini comments "that the data collection was pretty good, and people agreed with the figures presented." (Para 44) He goes on to say that the main disagreement was about the interpretation of the data for paediatric cardiac surgery. Although he does not state clearly the time of the data which he is discussing in para 44, the inference must be, that it is in the time after Prof. Angelini came and before 1995. So here he appears to be commenting on data which in Para 5e he says he didn't see.

4. THE SURGERY

Page 3, Para 5e and Page 5, Para 20.

"It was my impression then...that the main problem was with the surgery, and the complications...were often the result the inaccurate surgery, prolonged cross clamp time, bypass time and overall length of operation."

Comment

- Prof. Angelini had worked for a short time in the Thoraxcenter, Rotterdam, with Dr Jan Quaegebeur, one of the world's leading paediatric cardiac surgeons; Dr Quaegebeur's performance is indeed a formidable comparator.
- Inaccurate surgery: I do not know on what basis Prof. Angelini is able to make this statement. He did not observe the operations. He did not attend any post-mortems, clinico-pathological conferences, or any post-operative catheter conferences, where such information might be gleaned. At the GMC, the charge of operating beyond my technical competence was dismissed (as was the similar charge against Mr Dhasmana). The autopsies which would identify "inaccurate surgery", did not make such a finding. I believe that the frequency of re-operation (which would be needed if surgery had been inaccurate) was low in my hands.
- Long operating times. I was not a fast surgeon, I was probably slower than average, but I believe that I was not excessively slow. The only data available on operation times, is in Dr Bolsin's audit, where he drew together the operation times given in the operation notes dictated by the surgeon; there are no comparators for this data against which to make a judgement. At the GMC, Mr Brawn, expert for the GMC, knowing the times taken by me to do the complete AVSD corrections in 1990-95, did not consider that to be a major issue.

5. RAISING CONCERNS

Page 5, Para 9.

"In 1992...there were no formal mechanisms to raise concerns..."

Comment

This statement is incorrect. The channels which existed before and after 1992 included, in addition to the Associate Clinical Director of Cardiac Surgery, the Clinical Director of Surgery, the Clinical Director of Cardiac Services, the Chairman of the Division of Surgery, any of the Three Wise Men, the Chairman of HMC, (which post I only occupied from 1992-94) or the Medical Director. There were all the General Management lines up to the Chief Executive, who himself was a doctor: there were the University lines of communication through the Clinical Professors, to the Dean to the Vice Chancellor. Outside the Trust and University, there were lines to the British Medical Association, the Society of Cardio-Thoracic Surgeons, the Royal College of Surgeons, the Department of Health etc.

6. POLARISATION OF THE ISSUE

Page 6, Paras.14 and 17, and Page 16, Para. 64.

“...quite soon it became a very polarised issue”.

“...the loyalty of the Staff people who had been in Bristol for a long time was what made the resolution of the problem more difficult.”

Comment

- I disagree with this description of the situation.
- ‘Polarisation’ implies two groups of people consciously opposing each other. At the time the reality was very different and it evolved gradually. It seems that Dr Bolsin was talking to a great many people in the Trust, the University and the DOH, including both Doctors and Nurses. My awareness of this activity is still growing in 1999. What I heard or knew at the time was both incomplete and late. Dr Bolsin’s viewpoints were not in the open and

were not at all clearly known, so in a sense there was nothing to be polarised against prior to 1995.

They did act openly at the time of the proposed switch operation in January 1995 and I would agree that after that, there was polarisation of viewpoint.

- Prof. Angelini names Dr Ian Davies, Dr S Prynne, Mr AJ Bryan and Mr Richard Downs as being part of the polarised scenario.

Dr Davies never ever spoke to me on this subject.

Dr Prynne did discuss paediatric cardiac surgical results with me; sometimes this was challenging, but it was always enquiring and constructive.

Mr Downs never ever spoke to me on this subject.

Mr Bryan only spoke to me after January 1995 in terms regretting the difficult relationships which appeared to exist at that time.

7. PARA 17

See my response to Para. 14.

8. HOPING THINGS WOULD GET BETTER

Page 7, Para 18.

“The culture was one of hoping that things would get better by themselves”.

Comment

- The first attempt to have a new paediatric cardiac surgeon and to move the work to the Children's Hospital was in 1990-91, which was unsuccessful.
- In 1992 a proposal to Region to develop the Unit further failed as Region chose to establish a second centre in Plymouth instead. Our goal to move to the Children's Hospital remained unchanged and might have been achieved, if that proposal had been successful.
- In 1992 draft proposals were submitted to the Supra-Regional Services Advisory Group of the DOH, to fund a move to the Children's Hospital. This failed, amongst other things, because the Supra-Regional system was de-designated.
- We persisted, and the Working Group set up in December 1993, which completed its work in the Summer of 1994, eventually achieved the two objectives of the new surgeon and moving the work to the Children's Hospital.
- I would not prescribe this persistent activity as "hoping that things would get better by themselves".

9. PARA. 20

See my response to Para 5e.

10. MR PAWADE'S EARLY RESULTS IN THE BRI

Page 7, Para 22 and Page 121, Para46.

“...in exactly the same set-up... he (Mr Pawade) was able to achieve excellent results.”

Comment

Mr Pawade is an excellent surgeon who has made an enormous contribution to the development of Paediatric Cardiac Surgery in Bristol.

- In May to October 1995 he operated in the Bristol Royal Infirmary, in the circumstances described by Prof Angelini. It is fair to point out that during this time he carried out no switch operations and a relatively small number of complex procedures.
- Subsequently, at the Children's Hospital, he has carried out a full range of operations with excellent results. However, this is in a very different setting, with dramatically improved facilities and staff, compared to that which Mr Dhasmana and I experienced previously in the BRI.

11. PARA 23

Please see my responses to Paras. 5d and 18.

12. THE PATS COMPUTER SYSTEM

Page 10, Para 34.

I expect Mr Hutter will comment on this

13. COMPREHENSIVE DATA

Page 10, Para 34.

“The first time I saw comprehensive data ...”

See my comments on Paragraphs 5e (Topic 3), 39 and 44.

14. THE EFFECT OF THE PRIVATE EYE PUBLICATION

Page 10, Para 34.

“Because of the previous articles which had appeared in “Private Eye”, there was a general reluctance from the two paediatric cardiac surgeons to make the data available within the unit”

Comment

Unfortunately material presented to a Paediatric Cardiological Audit meeting was published in Private Eye in July 1992. Following this confidence was undermined and paediatric cardiological audit lapsed for a time. However, all the other audit activities continued and figures continued to be compiled and to be available. (see also Paras 5e (Topic 3), 39 and 44).

As Chairman of the Hospital Medical Committee I exhorted the members, including the cardiac surgeons, not to allow this incident to inhibit the audit process, the measurement of outcome or the development of openness. I believe that I said this to the Committee in the autumn of 1992.

15. INDIVIDUAL SURGEON'S RESULTS

Page 10, Para 35

“I never received from Mr Dhasmana or Mr Wisheart specific data relating to their individual performance”.

Comment

- In my annual statistical summaries up to and including 1992, I had not presented information for individual surgeons.
- In his first publication of the Unit's results, Mr Dhasmana presented the statistical summaries for the financial year 1992-93. This included details of individual surgeon's results for paediatric cardiac surgery.
- I do not believe that this was general practice at that time, and this is borne out by the fact that two years later in 1995, Mr Marc de Leval and Dr Stewart Hunter did not ask us to prepare figures for individual surgeons, although in fact we did so anyway.
- I cannot think of any reason why Prof. Angelini would not have received these figures.

16. THE TABLES PREPARED FOR DE LEVAL AND HUNTER

Page 10, Para 35.

"The first time that I was provided with a full picture of the results was literally half an hour before I was invited to speak to Prof de Leval and Dr Hunter."

Comment

- As I have set out in my comments of Para.5e (Topic 3), 35(Topic 15), 39 and 44 I believe that Prof. Angelini did have the annual statistical summaries.
- The pressure that Mr Dhasmana and I were under to prepare the figures for Mr de Leval and Dr Hunter was immense. In less than two weeks and in addition to our regular commitments, we had to (1) prepare the summarised results for 1992-95 and (2) complete a data sheet for each of 450 Open Heart procedures carried out during those years.

Despite receiving assistance from Dr RP Martin and Dr AM Hayes in doing this work, it was only completed the evening before the visitors came.

17. FIGURES FOR THE SWITCH OPERATION

Page 10, Para 36

“In January 1995... I was also provided with comprehensive figures for the switch operation”.

Comment

- This is probably quite correct for the following reasons:
- In preparing our summaries I initially, and later Mr Dhasmana had generally adhered to the same categories as used by the UKCSR, so that comparisons could be made. The UKCSR did not distinguish between the different operations for Transposition of the Great Arteries.
- The results of the switch operation had been discussed in detail in a number of meetings of the paediatric cardiological group, of which Prof. Angelini was not a member- not being a paediatric cardiac surgeon. He would not have known of the information which was shared at those meetings.

18. ACCURACY AND SIGNIFICANCE OF AUDIT FIGURES

Page 11, Para 39 and Page 12, 44

“...whatever was presented corresponded to the truth,” but were these figures “regarded as acceptable practise...”

Comment

- These figures were regarded as accurate.
- The Inquiry will be considering their appropriate interpretation.
- These two paragraphs do not seem to agree with the statement in para.5E. "I never saw any comprehensive annual figures...", or a similar statement in para.34.

19. PARA 46

See my response to Para 22.

20. THE DATA PRESENTED TO DE LEVAL**Page 13, Para 47**

"The results of the audit conducted by Dr Bolsin were , with small exceptions, very much in line with the data that was analysed by Mr de Leval, and indeed with the comprehensive data which was subsequently provided by the UBHT in 1995, in the final version of Mr de Leval's report."

Comment

- In February 1995 Mr de Leval and Dr Hunter requested from the two surgeons the data for 1992 -95 and this was provided. In February 1995, Dr Bolsin brought to Mr de Leval and Dr Hunter his own audit, covering the period October 1990- July 1992. It was on that day that I first learnt of the existence of this audit.

- The data contained in the UBHT publication of January 1996 (not in 1995), to which Mr de Leval added a commentary, was the in-house data of the cardiac surgical department, namely the data of Mr Dhasmana and myself.
- In his commentary Mr Marc de Leval states, in his first paragraph that, in February he had been provided with data, "some of which proved to be incomplete and inaccurate." I believe he was referring to the errors for the results of VSD surgery in Dr Bolsin's audit. This stated that for 47 operations to close a VSD there were *six* deaths; infact there was *one*. All of the incorrect additional 5 deaths were attributed to me. I believe that this was a major factor leading to the description of myself as a "high risk surgeon" in the draft report.
- In the penultimate paragraph of his commentary Mr de Leval states, "in conclusion, I believe that the Bristol performance over the last 3 years in terms of mortality, matches the average UK results as published by the UKCSR, including Open-Heart surgery in infancy, with the exception of the results of AVSDs (my patients) and the Arterial Switch procedures (Mr Dhasmana's patients). This informed and considered conclusion appears to be largely in contrast to the views of Dr Bolsin and Prof. Angelini.

21. MORBIDITY

Page 13, Para 48

"Although these data are an insufficient basis on which to draw any definite conclusions, the fact that these children were subjected to very long operations and very long periods of ventilation, automatically means that morbidity was very high"

Comment

- I believe that there are no comparators against which to judge Dr Bolsin's collected figures for operative times, ventilation times, or morbidity. This assumes that Dr Bolsin's figures can be verified.
- Prof Angelini is correct to say that these data are an insufficient basis on which to draw any definite conclusion.
- I believe that Prof Angelini is incorrect to assert (speculatively) that long operations *automatically means* morbidity "was very high."

22. ERRORS IN DR BOLSIN'S AUDIT

Page 13, Para 50

"...even given the errors that were subsequently recognised, this did not change the overall picture at all."

Comment

- The errors which were identified in Dr Bolsin's audit concerned mortality following VSD surgery.
- Closure of a VSD is a relatively common operation which carries a relatively low risk within the framework of paediatric cardiac surgical practise.
- Dr Bolsin's audit stated that there were 6 deaths out of 47 VSD Closure operations. There was actually 1 death.
- The extra 5 deaths were all attributed to me.

- It now appears that Dr Bolsin's audit findings were widely circulated before the de Leval and Hunter visit, as well as appearing in the press and media, after the visit, but before the error was identified.
- This erroneous finding was a major contributor to the initial view, which I believe to be false, that I was a "high risk surgeon", for paediatric cases.
- The remainder of Dr Bolsin's audit has not been checked, so it is not known whether it contains errors or not. Prof Angelini's remarks quoted above, appear to recognise the possibility that there may be further errors.
- Prof. Angelini states that it is not surprising that Dr Bolsin made "some errors". However, given that he was a specialist paediatric cardiac anaesthetist and an audit expert, I believe that these elementary errors were extremely surprising. His work would have been quite unacceptable material for publication in any scientific or peer review journal.
- To suggest that errors of this magnitude do not change the overall picture, is an attempt to minimise the importance of the errors. The errors have been of the utmost importance generally, of the utmost importance to me personally, in that they have been a major factor in creating a public perception of me, which I believe to be incorrect.
- As I was unaware of Dr Bolsin's audit until 1995 I cannot comment on the final sentence of this paragraph.

23. DEATHS DURING THE SUMMER OF 1994

Page 14, para 52.

Comment

- I was not present at the consultants meeting Prof Angelini is describing, and therefore I cannot comment on what took place.

24. PARA 53

As I was not present at this meeting I am unable to comment.

25. PARA 55

I have no knowledge of a meeting between Prof Angelini and Mr McKinley and therefore cannot comment.

26. DINNER IN APRIL 1994**Page 15, Para 56**

“In April 1994 a dinner was organised by Dr C Monk”.

Comment

- The dinner was organised by myself in discussion with Dr C Monk.
- At the dinner I asked Dr Bolsin and Prof Angelini if they would share their concerns with me.
- Prof Angelini is correct to say that they did not do so.

- As they had not expected to be presented with this question so I did say that if they wished not to respond over dinner then would they please do so within the next few days.
- They did not do so.

27 MEETING WITH PROF JR FARNDON

Page 16, para 62

“I ...contacted Prof Farndon and ...a meeting took place...with Mr Wisheart...”.

Comment

This meeting took place on 23rd December 1993 for a short time at lunch time..

- The point of the meeting, as I recall it, was that Prof Angelini wished to create an appointment of a consultant paediatric cardiac surgeon, and to do so as a Consultant Senior Lecturer within his department. Although I too, wished to appoint a new paediatric cardiac surgeon, and we did so during the next year, I did not feel that this was the best way to go about it.
- There was no reference to any specific figure or to Dr Bolsin's audit; there was no presentation of any figures.

28 **CONVERSATIONS BETWEEN PROF ANGELINI, MR DHASMANA
AND MR WISHEART**

Page 16, para 63

“I had conversations, most of them informal, with Mr Wisheart and Mr Dhasmana, but I realised that effectively that I was getting nowhere, since their perception of the situation was completely different from mine.

Comment

- I cannot comment upon what Prof Angelini thought.
- Mr Dhasmana, Prof Angelini and myself with others, worked together in a number of fora, notably the Working Group of 1994, and I understood that we had reached a conclusion and made recommendations supported by everyone. I was not aware that Prof Angelini preferred any other course.
- Prof Angelini did make his position clear in January 1995 when he objected to the proposed switch operation. I responded to this by openly arranging a complete review of that decision.
- Prof Angelini never drew our attention in any way to the fact that Dr Bolsin had shown him his audit and its findings.
- Even when asked to do so, in a relaxed and convivial atmosphere in April 1994, Prof Angelini did not say what his concerns were.
- I do not know what actual events Prof Angelini is seeking to describe.

29 AUDIT MEETINGS IN 1993**Page 16, para 59**

“During 1993 there were fairly regular audit meetings...and I had questioned Mr Wisheart and Mr Dhasmana on specific cases related to paediatric cardiac surgical practise.”

Comment

I have no recollection of Prof Angelini making any particular contribution to the discussion of paediatric cases at the cardiac surgical audit meetings, in 1993 or indeed in 1994.

30. POLARISATION**Page 16, para 64**

See my response to Para 14.

31. PROF ANGELINI TALKS TO COLLEAGUES**Page 17,para 66, 67 and 68**

“...I raised the issue with ...”.

Comment

- Although I was in regular contact with each individual named in these paragraphs, only Professors Dieppe and Farndon, spoke to me about this issue. I approached Prof John

Vann Jones to present him with an accurate summary of the paediatric cardiac surgical results.

- In my conversations with these individuals there was no mention of an audit having been carried out by Dr Bolsin, or of any audit figures.

32. HOW SOME SAW DR BOLSIN

Page 18, Para 72

“...some saw Dr Bolsin as a traitor of the profession on a personal crusade.”

Comment

I had no such clear view of Dr Bolsin, before the events of early 1995. In retrospect, the problem was that I was unaware of most of his activities in relation to paediatric cardiac surgery. what I did learn of his activities was always incomplete and long after the event.

33. CONTROL CULTURE AND OTHER CHARGES.

Page 18, para 75

“...this culture of keeping everything under control, remained, and Mr Wisheart was, I believe, put in charge of organising the external enquiry on his own practice. Mr Wisheart and Mr Dhasmana were responsible for collecting their data, and none of us had any means of verifying whether the data were accurate or not. When the report became available there was a deliberate attempt to prevent people from seeing it, and a series of revisions of the report were carried out”.

Comment

- Control culture. Having been Chairman of the HMC and being Medical Director at the time, makes it rather easy for others to make the charge of “control culture” against me. From my perspective there was no control culture and there was no intention that there should be one. I did not suppress any expression of concern either within cardiac surgery, the paediatric cardiological group or at the level of the wider Trust. We all had our own views about the future of paediatric cardiac surgery in Bristol and mine was openly expressed in the recommendations of the Working Group of 1994. which led to the appointment of Mr Pawade and the move to the Children’s Hospital.

When Prof Angelini openly raised an issue with me in January 1995 I responded openly, and in my view properly.

- Organising the External Enquiry
 1. Dr Roylance asked me as Medical Director to take the initial steps in setting up the enquiry. I sought the advice of Mr John Parker, who is now deceased, but was then President of the British Cardiac Society. He advised me to approach Mr de Leval and Dr Hunter.
 2. I did this and they agreed to act and to visit us very quickly.
 3. Otherwise, the arrangements for the visits were organised by Dr Roylance, Rachel Ferris and others.
- Mr Wisheart and Mr Dhasmana collected their own data
 1. We were asked by Mr de Leval to present them with our data for 1992 to January 1995. This part of the task was not onerous, as these figures were available.

2. We were subsequently asked to complete a data sheet for each of the approximately 450 paediatric open heart operations carried out on children in those years. This was a mammoth task, which required access to the medical records. Drs RP Martin and Alison Hayes assisted us, and we managed to complete this immediately prior to the visit, which was on 10th February, 1995.

3 Elsewhere in his statement, Prof Angelini has accepted the accuracy and truthfulness of the data we presented at various times (Paras 39 and 44.). This was the same data. It is unrealistic for him to suggest that he could have verified it in a short period of time.

- Deliberate attempts to prevent people seeing it (the report).

1 This is quite an incorrect statement.

2 Opportunities were provided for people to see the draft report as individuals, and for all the members of the cardiac team, the Chairman arranged meetings for two whole evenings which were devoted to going through the report in detail. Prof Angelini participated in that process.

3 People were not able to have possession of the draft report or to make copies of it.

4 Early on the Chairman asked Dr Laszlo to deal with issues relating to the report and the Media and withdrew me from any responsibilities in that area. He organised, or asked others to organise, all the proceedings relating to the draft report.

- A series of revisions to the report

1 There was one draft report, one final report and no intermediate reports; there was not a series of revisions.

- 2 When Dr Roylance returned from leave he asked me to inform Mr de Leval that the report would be made public.
- 3 Mr Marc de Leval was anxious to alter the report before it entered the public arena

34. ADULT CARDIAC SURGERY

Pages 18 and 19, Paras 77-81.

Comment

The subject of these paragraphs is outside the terms of reference of this Inquiry and I have no comment to make.