RESPONSE OF JAMES D WISHEART TO THE WRITTEN STATEMENT OF DR S J PRYN,

DATED 7 OCTOBER 1999

WIT 034100001-0057

1. CARDIAC SURGICAL AUDIT MEETINGS

Ref Page 4, para 2

i) 'Children who had died were not often presented at these monthly audit meetings.'

ii) '..I was not .. informed of when and where these meetings were to take place..' (Clinico-Pathological Conferences).

Comment

i) Dr Pryn was one of the first consultant anaesthetists to attend the Cardiac Surgical Unit Audit meetings and he did so on a number of occasions after his appointment in 1993. However, I disagree with the above statement. It is my recollection that the deaths of children were presented to the Cardiac Surgical Audit.

ii) I regret that Dr Pryn did not know about the Clinico-Pathological conferences. His Clinical Director knew (see Dr Monk's statement, Para 84, Wit: 0105 0043), and Dr Masey attended when she was able to do so

2. 'THE RED BOOK' - GUIDELINES FOR THE CARE OF THE CARDIAC SURGICAL PATIENT

Ref Pages 7-8 para 10

'....a number of features were out of date'

Comment

This book had been written in 1988 with contributions by Mr M K Bhatnagar (Cardiac Surgical Senior Registrar,) Mr Kevin Wattersön (Cardiac Surgical Register) and Dr A Jarvis (Anaesthetic Senior Registrar) as well as myself

This was the last of a number of revisions of a book I first compiled in the Spring of 1976 in my first year in Bristol These guidelines were comprehensive, covering the whole range of care required by each patient, and each edition was prepared in full consultation with all the disciplines who made up the Team. I considered this consultation to be important if all members of the Team were to use the book even though it caused delay in preparation and was time consuming experience

I felt it important that the authorship of these Guidelines should pass to new hands No one took up this opportunity When Doctors Pryn and Davies were appointed with Intensivist sessions in mid 1993 it naturally fell to them to do so. Over the subsequent years Dr Pryn has written protocols for some topics as he has outlined in his statement (page 8 para. 11).

3. THE INTRODUCTION OF INTENSIVISTS

Ref page 10, par.14

'. the consultant cardiac surgeons felt that they would lose control of clinical decisions relating to their patients.'

'Mr Bryan and Professor Angelini openly criticised the concept of Intensivist sessions. . .'

'our uncertain role was compounded by the fact that we were only available on CICU for three morning sessions a week '

'Change of supervisory roles. ... is always difficult, and to some extent the nurses were caught in the middle '

Comment

The introduction of intensivists was made particularly difficult as they were only present on three mornings a week, leaving three and a half week-days, the nights and the weekends without their presence. This is why it continued to be necessary at this stage for the surgeons to continue to a play a continuing and active role in the care of their patients

4 INTENSIVE CARE WARD ROUNDS

Ref. Pages 11-12, Para 15

(i) 'It was not possible to have discussions with the surgical registrars about the management of the sickest patients....as they were required in theatre....'

(ii) 'The consultant cardiac surgeons did not attend either of the morning CICU rounds, but popped in to see their patients at variable times during the day'

(iii) 'Frequently changes in treatment were made. .without discussion . '

Ref. also Pages 29-30, Para 2

(iv) ' conflicts with medical management initiated by the surgical registrar . '

(v) 'Mr Wisheart and Mr Dhasmana who did not attend the morning ward rounds but usually saw their patients at other more variable times during the day'

Ref. Page 31, Para 3

(vi) 'The same courtesy of communication could not always be said to have occurred when the surgeons wished to change the clinical management.'

Comment

The surgical registrars and SHOs usually began their ward round at 0745-0800, and many of them had to go to theatre before 0900. This was known. The Intensivists and Anaesthetists chose to have their ward rounds later, and not to accompany the surgical registrars in

Intensive care.I f they disagreed with a decision taken earlier they could discuss it with a member of the surgical team. At Para 3 on Pages 30-31, Dr Pryn describes how he discusses proposed changes of care with the surgeon concerned and as a result an agreement is achieved. This is my recollection too.

Re quotes (i) and (iv)

I do not understand or agree with his use of the word 'conflict' (Page 30, line 9) To describe the holding of a different view about the management of a patient, as conflict rather than as a matter for discussion, I do not understand. I do not know whether Dr Pryn considered joining the earlier ward round or instructing his Registrar to do so, as this would have eased the decision making and communication problems which he perceives.

Re quotes (ii) and (v)

I have set out my routine in ICU in my evidence on Issue G 4 and on Page 17 through to G5 lines 25-27. I usually attended ICU between 8 and 9 a.m. and at intervals through the day as my other commitments permitted

Re quotes (iii) and (vi)

On page 30 of my evidence under Issue G6 I have described the liaison between surgeons and anaesthetists in Intensive Care and the methods of communication which generally worked well.

Dr Pryn mentions unilateral actions by surgeons. We did not discuss every decision as in addition to each having a good understanding of the way the other would work, we also each had some ideas of our own sphere of responsibility and what constituted on the one hand a low level decision or on the other hand a high level decision needing discussion. It is possible that our ideas or expectations in this area may not have been identical. If Dr Pryn feels that I did not consult with him (he does not specify me) then I do apologise, although I have no recollection of such incidents. I do know that there were examples of such incidents in both directions.

5 **THE PATIENT OF AUGUST 1994**

Ref: Page 14, para 2

Comment

Dr Pryn expresses a general concern about the age of patients being operated for complete Atrio Ventricular Septal Defect (AVSD) and refers to a particular patient.

(i) **His general concern.** From about 1990 we had implemented a policy of operating on complete AVSD in the first year of life. For the period 90-95, 70% of complete AVSDs in our practice were operated in the first year of life, compared with just under 70% in the UK CSR for the country as a whole. In retrospect there was a case to be made for operating earlier in the first year of life than we were doing; there is no single reason for the fact that we did not do so.

(ii) **The patient of August 1994** Dr Pryn is probably correct to comment as he does with the benefit of hindsight, although we can also say with hindsight that an earlier operation would probably not have made any difference to the outcome for reasons set out below:

This child was first seen by a cardiologist at 3 months of age, was catheterised at 4 months of age. The findings did not indicate any reason to be anxious about rising Pulmonary Vascular Resistance.

She was discussed first with the surgeons at 5 months of age, seen at the Outpatients at 6 months of age and operated at 9 months of age, when she sadly died. Post mortem showed the most extreme of the forms of Pulmonary Vascular Disease and, in addition, a previously undiagnosed left ventricular outflow tract obstruction (LVOTO). This alone would have increased the risk of the operation very significantly. Immediately before operation the clinical findings were of a large heart and wet lungs and did not suggest the presence of advanced Pulmonary Vascular Disease. Mr WJ Brawn giving evidence to the GMC for the Council stated on Day 19

page 72 para G that with those preoperative measurements he would not have expected the histopathological findings of the most severe form of Pulmonary Vascular Disease.

So while Dr Pryn's advice to operate earlier is sound there was nothing known about the patient in question prior to surgery to indicate any particular urgency for her.

6. BYPASS AND CROSS CLAMP TIME

Ref: Page 23, para 10, 11

'It was my impression that, for both Mr Wisheart and Mr Dhasmana, bypass time and cross clamp times were significantly longer ...'

'...had more problems post-operatively ... I suspected as a consequence of the prolonged ischaemia and bypass times.'

Comment

I sought always to balance the need for speed with the need for careful meticulous surgery. I recognise that I was a slower surgeon than average, but did not regard myself as excessively slow. I am not aware of any data to confirm or refute Dr Pryn's suspicions about the consequences of possibly longer operation times in Bristol.

7. INTENSIVE CARE

Page 29-30 para.2

(i) I believe that I was always contactable when on call,

(ii) 'They were not always available during the day.'

Comment

1. I have always found Dr Pryn to be immediately contactable and available when on call

2. Neither the anaesthetist nor surgeon who were on call for ITU were always immediately available because of their other proper commitments, I have described this in my evidence under Issue G4 at page 17.

8. LATE OCTOBER 1995 AT THE BRI

Ref: Page 32, para.8

'With the same... Staff ...(Mr Pawade) had only one death in this series of 53...'

Comment

This comment illustrates the danger of making statements about aggregate groups of patients without knowledge of the detail, including case mix etc. The case mix of patients in this specific period has been brought to the Inquiry's attention in evidence at Day70 on page 26, para. 63 Lines 10-13 (the Internet Version), and does not include many high risk patients.

9. REVIEW OF ANNUAL RESULTS

Ref: Page 36, para 4

'...by the time I arrived at the BRI (July 1993), the process of regular review of the annual results of paediatric cardiac surgery in open forum...had lapsed.'

Ref.. Page 43, Para 11

'By mid-1994 (we) were asking the surgeons, via Dr Monk, to present the figures for the year ending March 1994 as soon as possible ... it never materialised.'

Comment

I do not agree that the presentation of annual results of paediatric cardiac surgery had lapsed.

(i) Mr A J Bryan recalls Mr Dhasmana's presentation of the annual results, including paediatric cardiac surgery in 1994 and subsequently (evidence to the Inquiry on Day 63, page 11, para.24 lines 5-10) I believe this was at a cardiac surgery audit meeting

(ii) There were four meetings of the multi-disciplinary group in the evening in various homes between July 1993 and before the meeting on 8 December 1994 to which Dr Pryn refers. I presume that Dr Pryn was unable to attend any of these It is likely that the annual results were on the Agenda of some or a number of these meetings although I have no recollection Please also see Dr Pryn's statement page 43, para12 and my comment on it at number 17

(iii) Dr Pryn himself has referred to a meeting in January 1994 when it was planned that the results would be presented by Mr Dhasmana. This is at page 41, para.5 of his statement I therefore believe that it is not correct to say that the review of annual figures in open forum had lapsed.

10 DR BOLSIN'S AUDIT

Ref page 39 para 1 (continued from page 38)

'One piece of data which particularly surprised me...' 'I assumed that .. my colleagues were all familiar with it'

Comment

1. Did Dr Pryn express his surprise or scepticism to Dr Bolsin about his alleged VSD results?

2. It is entirely reasonable for Dr Pryn to have assumed that all members of the Team knew about Dr Bolsin's audit. Unfortunately neither Mr Dhasmana nor myself knew of its existence or its content.

11 DR PRYN'S AUDIT

Ref page 39, para.2

'...Dr Chris Monk asked me if I would collect data...'

Comment

Sadly this is yet another audit which is 'secret' in the sense that the surgeons whose work was being audited were unaware of it.

12 DIFFICULTIES OF CLASSIFICATION

Ref Page 40, para 4

'The most difficult aspect of compiling this data for me was to divide it into diagnostic groups,'

Comment

This paragraph underlines the unsatisfactory nature of a secret or undisclosed audit. Had Dr Pryn asked the surgeons, or requested access to the filed copies of the operation notes, or the surgeons' logs, this difficulty would have been resolved straight away.

13 AUDIT MEETING IN JANUARY 1994

Ref. Page 41, para 5.

Comment

It had been planned that Mr Dhasmana would present the paediatric data for the year 92-93 at this meeting. He and I had compiled the data together in preparation for the meeting. In the event, he was detained in theatre, but because I was familiar with the data I was able to present it to the meeting

14 ANNUAL RESULTS

Page 42, para9

Comment

See my comment No 9

15 MEETING AT DR JOFFE'S HOME IN LATE 1994

Page 43, para 12

'In late 1994 I attended a meeting at Dr Joffe's house; this was the first multi-disciplinary consultant meeting to discuss paediatric cardiac issues, since I joined the BRI, it marked the resumption of a previous series of regular meetings...'

Comment

Dr Pryn came to Bristol in July 1993. The meeting he describes was on 8 December 1994. There were meetings of the multi-disciplinary group on the following dates: 12 July 1993, in

my house, 30th November 1993 in Dr Joffe's home, and on 25 October 1994 in my home. These dates are taken from my (personal) appointment diary and I believe them to be reliable.

16 CARDIAC ANAESTHETISTS' VIEWS

Ref. page 46, para.18

'I believe Dr Chris Monk faithfully presented. . the collective concerns . .to discuss the latest annual outcome figures ' ' .I believe that Dr Monk discussed with Mr Wisheart and Mr Dhasmana the content of the letter...(of 21st June 1994).'

Comment

Dr Monk did raise with me the question of discussing annual results. I believe that this was in the Spring of 1994 although I cannot be certain of the date. I found the request curious because I believe the results had been openly presented (see my comments above at comments No.9, 13 and 15).

I was not aware of the existence of the letter, nor had I seen it, or its contents until I saw it on a television programme in 1995 or 1996.