

Supplementary Inquiry Witness Statement of Dr Javed AKHTER

PERSONAL INFORMATION

1. My name is Dr Javed Akhter. My contact details are known to the Inquiry. I have previously given a witness statement to the Inquiry. I have been a locum consultant on ward 14 and ward F at the Vale of Leven Hospital ("VOLH") since 2007.

PRESCRIPTION OF ANTIBIOTICS

2. In relation to the prescription of antibiotics on the ward between January 2007 and June 2008 I used the "Argyll and Clyde Adult Drug Formulary 2006" which was given out to doctors by the hospital (**Production – GGC21790001**). Junior doctors used the same A5-sized booklet that I used when prescribing antibiotics on the ward in the period between January 2007 and June 2008.
3. I did not use "Greater Glasgow and Clyde Formulary (First Edition August 2007)" (**Production - GGC18270001**).
4. The British National Formulary, which is referred to in the Junior Doctors Handbooks (**Productions – GGC21720001 and GGC21730001**), can be used as a reference book rather than for first line prescribing. I do not think it was used in the treatment of *Clostridium difficile* ("C.diff") but it would be used for general antibiotic prescribing.

5. A junior doctor was not required to speak to a consultant before starting an antibiotic for things such as a simple chest infection or urinary tract infection ("UTI"). If it was a complex case or a more serious condition junior doctors would speak to the consultant before prescribing.
6. The threshold for starting antibiotics at that time was a clinical suspicion and evidence from 3 other sources which were the results of blood tests, information from x-rays and urine dipstick results. It was not just clinical suspicion that determined antibiotic prescribing. Clinical suspicion should be supported by the results of these other investigations which are very quickly available.
7. I would suggest that there was not over-prescribing of antibiotics for illnesses such as UTIs and chest infections in the period between January 2007 and June 2008 at the VOLH. Everyone follows guidelines and took advice so I do not think it was the case that over-prescribing was happening.
8. There have been changes in the practice of prescription of antibiotics since June 2008. NHS Greater Glasgow and Clyde have devised a new protocol for antibiotic prescribing. Some of the antibiotics have been graded as requiring to be discussed with, and consented to, by a microbiologist before prescribing.
9. I do not think there are fewer antibiotics prescribed now than in the period between January 2007 and June 2008. If everyone follows the guidelines then that should not be the case. Because of the intervention of the microbiologist, the prescribing of those antibiotics which are regarded as alert antibiotics has gone down. The microbiologist is now more involved and is there to give a second opinion or more informed advice on antibiotics.

10. There was a uniformity of approach throughout the various wards in the VOLH by all doctors in relation to the prescription of antibiotics in the period from January 2007 to June 2008.
11. I am not aware of any local guidelines or protocols in relation to antibiotic prescribing between January 2007 and June 2008. I am only aware of the Argyll and Clyde Adult Drug Formulary 2006 (**Production - GGC21790001**). The only information on prescribing that I am aware of, in terms of books, policies or guidance that was actually on the wards between January 2007 and June 2008, was that formulary.
12. The junior doctors start at VOLH at different times of the year. If a junior doctor is coming from a different hospital they may not need to be given the formulary as they may already have it. The junior doctors are given the formulary when the pharmacy distributes it.
13. I was aware that that certain antibiotics were more likely to disturb the flora in the gut and make the patient more liable to contract *C.diff*. This is a general teaching point. Every antibiotic has side-effects. I do not usually prescribe one group of antibiotics, called cephalosporins, without any definite indications. My knowledge of this issue has not changed since June 2008.
14. The prescribing policy between January 2007 and June 2008 was not so specific as to take account of the fact that certain antibiotics were more likely to precipitate *C.diff*. The guidelines just said that some antibiotics have side-effects. These guidelines are not in great detail, they just state dose and indications. They do not discuss the side-effects in detail.

15. However, it was general knowledge between January 2007 and June 2008 that third generation cephalosporins and clindamycin were thought to be causative agents for *C.diff*. Everyone should have been aware of that fact. It was also medical knowledge between January 2007 and June 2008 that penicillins, especially amoxicillin-clavulanate combinations and fluroquinolones, were implicated in causing *C.diff* I was aware of that fact.
16. The antibiotics I used for hospital acquired pneumonia between January 2007 and June 2008 depended upon the severity of the infection and the results of the relevant investigations. I would consult the guidelines and it would often be amoxicillin that I prescribed. My practice in relation to this has not changed. I follow my own understanding, training and teaching.
17. I cannot answer questions about the practice of other doctors and consultants at VOLH. It would be difficult for me to comment on the practice of other doctors but as a general rule they should all follow the guidelines.
18. It is a very open question to ask what antibiotics I used for UTIs between January 2007 and June 2008. I would wait until the laboratory reported back on the sensitivity of the organism and treat according to that. I would prescribe trimethoripim but only for a short time until I got more detailed results back from the investigations. My practice has not changed in relation to this. I cannot answer questions about the practice of other doctors and consultants at VOLH.
19. I do accept that first line therapy for a UTI should be trimethoripim and not augmentin as trimethoripim has low risk and augmentin high risk especially if given for longer periods such as 7 days.

20. I did not routinely use tazobactam pre-2008 because it is a broad-spectrum antibiotic and again it can predispose patients to *C.diff*. There are other antibiotics which can be given as first line medications that have fewer side effects.
21. In the period between January 2007 and June 2008 I would agree that antibiotics were only prescribed when there was good evidence of infection. I would not agree that treatment would only be given where there was a diagnosed infection or a patient was gravely ill, as treatment could be given if a patient had a mild infection.
22. I would agree that the practice was to use the smallest number of antibiotics with the narrowest spectrum possible. The practice was also to use the shortest course of antibiotics possible, for example 3 days for a simple UTI, 7 days for bronchitis and 10 days or longer only where to treat septicaemia or an abscess.

C.DIFF DIAGNOSIS

23. Between January 2007 and June 2008 a patient was isolated as soon as they had diarrhoea. The nurses did not wait until a positive result from a sample came back. To be on the safe side we would not distinguish between unexplained and explained diarrhoea.
24. As a guide to infection control between January 2007 and June 2008 I am aware that there was an infection control manual ("ICM") (**Production – GGC00780001**) on each ward. I cannot comment on what other people actually read or applied.

25. Between January 2007 and June 2008 when it was confirmed a patient had *C.diff* I would assess the severity of the *C.diff* in the patient. I would assess their observation chart, general condition, results of blood tests looking at renal function, C-reactive protein, white blood cell count and level of hydration.
26. I am not aware of any clinical guidance to enable a doctor to assess the severity of the *C.diff*.
27. The severity of the disease determined the treatment that a patient received for *C.diff*, along with advice from the microbiologist. Metronidazole is given usually at 400mg three times daily for 2 weeks. Vancomycin can also be given. If a patient is not responding to the initial metronidazole treatment then vancomycin would be started. The course of metronidazole can be stopped and the vancomycin commenced.
28. I was alert to the fact that I may have required a surgical input in some of my patients with severe *C.diff*. The surgeons were not readily available as they worked at the Royal Alexandra Hospital ("RAH"). I am aware that my junior doctor phoned the RAH surgeons in relation to one of my patients.
29. My approach between January 2007 and June 2008 when treating a patient with *C.diff* was to assess the severity of the *C.diff* and then determine the treatment appropriate. I cannot speak to what other consultants at VOLH did.
30. Between January 2007 and June 2008, after initial diagnosis with *C.diff*, I did reassess patients to see whether their *C.diff* was improving. I would reassess their observation chart, general condition, results of blood tests looking at renal function, C-reactive protein, white blood cell count and level of hydration.

31. I would reassess my patients on a daily basis if they were unwell, otherwise it would depend on the feedback I received from my junior doctors. I could reassess a patient more than once in the same day if they were very unwell.
32. I am not aware of any *C.diff* protocol at the VOLH.
33. I would phone the microbiologist for advice when managing patients with *C.diff*. I would speak to whichever microbiologist answered the phone. The contact was usually on the phone because the microbiologist was not based at the VOLH.
34. I cannot say how frequently the infection control nurse ("ICN") assessed my patients who had *C.diff* in the period between January 2007 and June 2008.
35. I do not recall the ICN coming to me for direction on the management of a patient with *C.diff*. I did get oral feedback from the ICN on the wards. In those days the ICN was not based at the VOLH or not coming to the hospital regularly. She was maybe at the VOLH 3 days a week.
36. Between January 2007 and June 2008 if a patient had *C.diff* infection I would order regular bloods to monitor the patient's condition. If I thought I needed to see the effect of certain antibiotics by monitoring the patient's progress I would order a repeat blood test. I would also check the patient's C-reactive protein, white blood cell count and renal function.
37. I have been asked about abdominal examinations. Between January 2007 and June 2008 I regularly examined the abdomens of my patients with *C.diff*. An abdomen examination is part of the clinical examination and I would do this each time I assessed a patient.

38. If there was an abdominal examination of a patient with *C.diff* I would expect this to be documented in the patient's notes together with the findings of the examination.
39. If the abdominal examination findings are not recorded in a patient's notes then the ideal practice has not been followed. The fact that an examination is not recorded, though, does not mean the abdominal examination was not carried out.
40. I accept that, as a doctor, I require to keep clear, concise and accurate notes properly detailing a patient's condition.
41. I consider that abdominal examination is an important part of the assessment of a patient with severe *C.diff*. A colonoscopy is an invasive procedure which cannot be carried out at short notice and is not standard practice. Colonoscopy is not part of bed side examination. I may also do a girth measurement of the abdomen and an abdominal X-ray which would provide me more information about the bowel.
42. Between January 2007 and June 2008 the VOLH did not have the facilities to examine the colon in patients with *C.diff*. The surgeons at the RAH would do this. I would consider this required to be done if we were unsure from the other examinations what the condition of the patient's colon was.
43. A definition of the severity of *C.diff* depends on the clinical condition of the patients. If the patient's inflammatory markers were impaired, renal functions impaired, blood pressure low and abdomen distended then I would say that the patient's condition was severe. I would also say that a severe case would involve a sepsis state in a patient.
44. I would consider changing to vancomycin if the patient was not responding to metromidazole, and if their inflammatory markers were

not down, renal function had not improved and the abdomen was distended. I would take advice from the microbiologist before changing the patient's antibiotic treatment.

45. In the period between January 2007 and June 2008 if a patient had a relapse my treatment would depend on whether it was the first, second or third relapse. It was not routine to use vancomycin in the first instance. I would use metronidazole first. I cannot comment on the practice of the other consultants.
46. I have been asked about pulsed vancomycin. I am not familiar with the term "pulsed vancomycin".
47. It is not a question of the patient being free of diarrhoea before being considered safe to remove from isolation. The patient still needs to be confirmed as *C.diff* negative by the laboratory before they are removed from isolation. I would consult the infection control team on this issue.
48. I think that, in the period between January 2007 and June 2008, 2 or more patients in the whole hospital had to be confirmed as *C.diff* positive to satisfy the criteria for an outbreak.
49. Pseudomembranous colitis is difficult to diagnose from the symptoms alone. A diagnosis would require a colonoscopy. I do not carry out such procedure.
50. I did not use probiotics such as yeast or lactobacillus for patients with *C.diff* I was not been issued with any guidance on the use of probiotics between January 2007 and June 2008. There is something now in the guidelines about the prescribing of probiotics after consultation with the microbiologist.

51. I did not use immunoglobulin therapy in the management of patients with severe colitis between January 2007 and June 2008. I cannot comment on what other consultants were aware of at this time.
52. I did not use adjuvant therapy with colestyramine.
53. I did not use steroid therapy in management of patients with *C.diff* because there is no evidence that it is effective. There is evidence that it is effective for inflammatory bowel disease but not for infectious bowel disease.
54. It is standard practice for nurses to keep a stool chart on every patient with diarrhoea so I would have expected the nurses to have kept a stool chart for the patients who had *C.diff*. I would check for a stool chart within the notes when assessing my patients.
55. It is difficult to say why there are no stool charts within many of the patients' notes with *C.diff*. I cannot comment on other people's practices. It is one of the nurses' responsibilities to keep charts but I cannot speak on the nurses' behalf.
56. I would involve a microbiologist in the care of a patient between January 2007 and June 2008 from the very start of a suspected *C.diff* cases. Even if we did not have the diagnosis I would ask the advice of the microbiologist. I would be particularly keen to seek the advice of the microbiologist if the patient was very unwell.
57. I could phone the microbiologist and one was available quickly. I could also get a sample analysed quickly by the laboratory if it is requested. However, I am not exactly sure what the fastest turn-around time was at the time.
58. There were no problems getting support from microbiology between January 2007 and June 2008, apart from them not being on-site.

59. I do not recall whether microbiologists came to the ward to review patients between January 2007 and June 2008. I did not see them on the ward.
60. I think the pharmacy reviewed the drug kardex. They may have made comments on the dose of the medication required, the length of time it was to be prescribed for and any interactions the medication might have with other medications that the patient was taking. The pharmacists were available to talk to and were visible on the wards carrying out the activities I have mentioned.
61. I would have stopped the prescribing of lactulose and senna when patients had been diagnosed with *C. diff*. This change would be communicated verbally to the nurses and also written on the kardex. I cannot comment on the practice of other doctors.
62. If patients clearly had *C. diff* diarrhoea and continued to be prescribed and receive lactulose and senna, this would have been inappropriate. These medications are given to treat constipation and the patient with *C. diff* diarrhoea has the reverse. I am not aware of this happening and do not recall ever having to query this.
63. The practice in relation to reviewing the antibiotics for UTI or chest infection when a patient was diagnosed with *C. diff* diagnosis depended on the antibiotics the patient was on. The antibiotics would be reviewed. Where the antibiotics had no link with *C. diff* they would be continued and any antibiotics with a link to *C. diff* would be stopped. If a patient required to be continued on an antibiotic for an infection then an alternative antibiotic, that had no link with *C. diff*, would be prescribed.
64. It is part of general medical training to know that drugs can interact with each other and therefore I was aware of the fact that proton pump

inhibitors could be a factor in *C. diff*. I cannot comment on the general practice, but I would avoid prescribing a protein pump inhibitor in the case of a patient with a *C. diff* diagnosis.

65. There was awareness between January 2007 and June 2008 that fluid management was important in relation to patients with *C. diff*. It depends on the patient's clinical condition whether or not aggressive rehydration is required. If someone is severely dehydrated then the doctor can give a course of aggressive intravenous ("IV") fluids for a short period of time and see what the response of the kidneys is.
66. I do accept that a patient can become hypovolaemic even before they start to get diarrhoea.
67. I have been asked about when IV fluids should be commenced. The thinking at that time was that it all depended on the circumstances. If the patient was clinically dehydrated and the blood tests were indicating that they were dehydrated then they would be started on IV fluids. On top of that, if a patient could not take anything by mouth or was vomiting then IV fluids would be the main choice of treatment. Also if someone had lost fluids very rapidly that would be an indication that IV fluids were appropriate.
68. If IV fluids were commenced I would have expected nursing staff to keep accurate and complete fluid balance charts.
69. I think the fluid management of patients is part of the general training for nurses. There are specific guidelines about fluid management in relation to some illnesses but not *C. diff*.

70. I would always review the fluid management charts of my own patients and the patients on the ward as part of my assessment of the patients. I cannot explain why many of the patients do not have properly completed and accurate fluid management charts.

71. I think the general principle for the management of someone with diarrhoea is to give them IV fluids first, then to involve the dietician and consider feeding by line or tube if the illness continues.

NOT FOR ACTIVE TREATMENT

72. I understand the term "not for active treatment" to mean someone who has a terminal illness and they are not considered for pulmonary cardiovascular resuscitation. Basically this means people who are dying. My understanding of "active treatment" is antibiotic treatment or oxygen therapy. Pain control medications are not considered to be active treatment.

73. To decide whether a patient is not for active treatment would be a consultant's decision. This is my practice to discuss such a decision with the patient's family and document that such a decision has been made and would inform the nurses of my decision verbally.

74. There have not been any changes in the procedures at VOLH for not for active treatment since June 2008.

75. I was not aware of a policy document or protocol used pre-June 2008.

76. I cannot comment on whether there was a uniformity of approach, in relation to decisions about not for active treatment, within the VOLH.

77. I was first made aware that there appeared to be a number of patients with *C.diff* at the VOLH when this was disclosed to us by the health board. I did have concerns over the numbers of patients affected and I discussed the situation with consultant colleagues, junior doctors and nurses. I did not discuss anything with health board management.

DO NOT ATTEMPT RESCUSITATION (“DNAR”) ORDERS

78. I am not sure if there was a policy document pre-2008 in relation to DNAR orders but there was a general consensus surrounding what was the appropriate procedure. This was a part of general medical training.

79. Between January 2007 and June 2008 a DNAR order would be completed if someone had a terminal illness and a severe infection or had concurrent illnesses which were not responding to treatment. If it was thought that the process of cardio-pulmonary resuscitation would not be successful then a DNAR order could be put in place. A DNAR order could also be put in place at the request of the patient if the consultant was in agreement with the patient's wishes.

80. I am only aware of one form that was used for a DNAR order between January 2007 and June 2008.

81. I am not familiar with the policy of Argyll and Clyde Health Board in relation to DNAR orders or of any other special policy. However, as part of good clinical practice a doctor should be aware of the limitations of treatment and proper care to be given to dying patients.

82. Between January 2007 and June 2008 the decision to proceed with a DNAR order required to be made by a consultant. The expectation was that the decision to complete a DNAR order would be discussed with the family members and/or the patient. It is normally the consultant who discussed a DNAR order with the family members and/or the patient.
83. I cannot explain why many of the DNAR forms do not appear to have any reference to discussions with family members, or why many family members say in their statements that the decision was not discussed with them, because it is my practice to make arrangements to discuss a DNAR order with a patient's relatives.
84. It is my practice to write that a decision had been made to put a DNAR order in place in the medical notes. I did not consider the order itself to be sufficient. I would expect that there should be a clinical note in the patients' notes referring to the fact a decision had been made. The decision to put a DNAR order in place was communicated by the consultant to nursing staff verbally and a nurse would sit in with the consultant during discussions with the family most of the time.
85. I cannot explain why there is no reference in many of the patients' clinical notes to the DNAR decision being made as it is my usual practice to write this in the medical notes.
86. There has not been any change since June 2008 in relation to DNAR orders. I do know that the Liverpool protocol in regards to the care of dying patients was going to be introduced 2 or 3 months ago and that has some guidelines on DNAR orders.

INTERACTION WITH RAH

87. As the VOLH does not have an intensive care unit patients would be transferred to the RAH for intensive care. We have a scoring system on the severity of the illness which is the basis on which decisions to transfer are made. The scoring system was a guideline; it was not a rule and clinical judgement would be applied.
88. If the patient's score is more than 25 then they will be transferred. If the medical team thinks that a patient might require intensive care then the patient should be transferred. That was the working practice at the time. If the patient scored less than 25 but then their clinical condition worsened then transfer would be discussed.
89. In relation to patients being transferred from the RAH to the VOLH this would be a clinical decision for the staff at the RAH and I cannot comment on that.

DEATH CERTIFICATION

90. Junior doctors could certify death without reference to a patient's consultant.
91. My own practice in relation to *C.diff* would be to decide whether it had been the main cause of death or a contributory factor. I would consider *C.diff* to be a contributory factor if the patient had another illness that they would have died from anyway.

92. Where *C.diff* goes in the death certificate depends on how much of a contribution it played in the patient's death. A patient might have *C.diff* for months but it did not cause their death. If the other illness did not have enough severity but *C.diff* was severe then *C.diff* would be put as the main cause of death.

HEALTH BOARD PUBLICATIONS

93. I am not aware of the NHSGGC antimicrobial prescribing policy
(**Production - GGC0084001**).

94. I am aware of the NHSGGC Infection Control Manual
(**Production - GGC0078001**).

95. I am not aware of the "Scottish Medicines Consortium
Recommendation 2005" (**Production - GGC15970001**).

96. I am aware of the "NHSGGC Formulary 2007"
(**Production - GGC18270001**) and the "NHSGGC Formulary 2008"
(**Production - GGC18280001**) but these are not the documents I used
on a day-to-day basis to prescribe on the wards.

97. I am not aware of the "NHS Scotland Code of Practice for HAI"
(**Production - GOV00090001**).

98. I have seen the "NHSGGC Control of Infection Committee Policy on
CDAD" before (**Production - GGC01010001**).

99. I am aware of the contents of the VOLH Resuscitation Policy
(**Production - GGC04470001**).

100. I am aware of the existence of the "Junior Doctor Handbook - August 2007" (**Production - GGC21720001**) and the "Junior Doctor Handbook – August 2008" (**Production - GGC21730001**) but would not have any cause to refer to these.

101. I have no objection to my supplementary witness statement being published as part of the evidence to the inquiry. I believe the facts stated in this witness statement to be true.

Signed.

Dated.....

19-01-2011