Please be aware that this is an anonymised copy of what was a real report and litigation has ended. The names in this report are all false.

Medical Report by Dr Alastair H Bint FRCGP

To the IOP of the GMC

Dated
30th January 2012

Area of Expertise
General Practice

On behalf of
Dr XXXXXXX GMC number XXXXXXXX
XXXXXXXXXXX, Surrey, CR5 1NY

Instructing Solicitors
Mitchell and Co,
781 London Road, Thornton Heath, CR7 6AW
Re XXXXXXXXXX

Written by
Dr Alastair Bint, 25 Danesfield, Ripley, Surrey, GU23 6LS

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Report

1 Introduction

The Expert

I am Dr Alastair Halford Bint. My specialist field is General Medical Practice. Full details of my qualifications and experience entitling me to give expert opinion evidence in this case are summarised below.

Consulting room: St.Lukes Surgery,
Warren Road, Guildford,
GU1 3JH.

My experience and qualifications:

I am a full time NHS GP in a practice with a 10,000 patient population and I am a trainer of foundation doctors in General Practice. I am Provost (ex-Chairman) of the South West Thames faculty of the Royal College of General Practitioners and I sat on the executive committee for General Practice postgraduate training for Kent, Surrey and Sussex Deanery for 8 years.

I work as a clinical lead and have sat on the Guildford Practice Based Commissioning board, one of the roles of which is appraising clinical pathways and protocols. I currently sit on the joint GP revalidation board supporting GPs through the educational requirements of the revalidation process and I sit on the Fellowship committee overseeing Fellowship nominations, the highest award within the Royal College of GPs.

I am a commentator for the Royal College of GPs on professional regulatory and medico-legal issues. I have offered my expert opinion in over 400 alleged medical negligence cases and I am regularly appointed independent expert for the North London Coroner.

Qualifications:

MBChB, Bachelor of Medicine and Bachelor of Surgery, Edinburgh, 1998
Advanced life support; **ACLS** (1999), **ATLS** (2000), **PALS** and **APLS** (2001).
DGM, Diploma in Geriatric Medicine, Royal College of Physicians,
DRCOG, Diploma from Royal College of Obstetricians and Gynaecologists,
DFSRH, Diploma from Faculty of Sexual and Reproductive Healthcare,
FRCGP, Membership of Royal College of General Practitioners, Fellowship elected 2009.
MEWI, Membership of Expert Witness Institute,
PGCert, Postgraduate Certificate in Diabetes Care; Warwick Medical School

2 The instructions and issues addressed

I have been instructed by Solicitors acting fro Dr XXXX to comment on the standard of care provided by the Dr Naresh XXXX in relation to eleven episodes of clinical care which have formed the basis of the complaint made to the GMC.

3 Documents I have been provided with and have examined

Selected original hand written contemporaneous notes made on Doctors Direct headed paper and signed by Dr XXXX.

Various typed clinical audit meeting records between Dr XXX of Doctors Direct and Dr XXXX including 'interview with Dr XXXX 21.01/10'

I have assumed that the relevant authority and consent has been obtained for me to peruse these papers.

This report was originally written on the 23rd January 2012 however it has been amended on the 24th January and the 30th January following receipt of further clinical records.

4 Background

4.01 I am informed that Dr Naresh XXXX was working in the capacity of a private doctor for Doctors Direct from February 2008 and during his time with them, he consulted with approximately 4,000 patients ranging from detained prisoners to private paying members of the public to various medical assessments for public vehicle licences and the like.

4.02 I understand that Dr XXXX is not on the GP register but holds a medical degree from the University of Rajasthan (1982), a diploma in cardiology for the University of London (1985), a diploma in practical dermatology from the University of Wales (1998), the diploma from the Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists, London (2005) and amongst others, holds a certificate in substance misuse from the Royal College of General Practitioners (2008)

4.03 I am aware of my limited role in an IOP hearing however I offer my completely impartial expert opinion on the issues raised in these cases and have signed my compliance with my obligations as an expert to the Court at the end of this report.

5 My investigation of the facts of each of the 10 cases and my opinion relating to the care provided by the Dr XXXX.

5.01 Case of Mr Stephen Birks date of birth 15/10/57.

(a) Hand written contemporaneous records note that Dr XXXX attended Mr Birks in Custody on the 23rd July 2010.

(b) The notes record, '*says took 8 paracetamol tablets 500mg each, has been sick (vomiting) x 5*.' Oxygen saturations, temperature, pulse and blood pressure were recorded as normal. Dr XXXX gave a single oral dose of 10mg stemetil anti-emetic medication and advised custody staff to monitor him regularly.

(c) On the reverse side of the clinical record Dr XXXX has detailed that Mr Birks was on no other medications, that there were no known allergies, that the Prison Officer is certain that only 8 paracetamol had been taken, with some salient and normal examination findings as well as Dr XXXX's advice that the patient go to the Prison Medical Wing and that the Prison Medical Officer be informed regarding the situation and for them to manage further.

(d) Clinical audit meeting notes dated 16th November 2010 have identified some possible deficiencies in the care in this case.

(e) My opinion here is that a dose of 8 paracetamol tablets, although technically an overdose, is not a significantly toxic dose. 24 tablets (12g) is considered significantly toxic [1] and I can understand the argument that this patient, having vomited several times after taking the dosage, may well have already emitted several of the paracetamol.

(f) However, in my opinion, in this case, because there were too many unknown variables, such as whether he may still have taken more than 8 tablets or indeed any other tablets obtained illicitly, whether he may have an undeclared pre-existing liver dysfunction (for example alcoholic hepatitis) that would have made the 8 paracetamol more toxic, and considering that vomiting can be the first sign of paracetamol poisoning, on balance in my opinion this patient required liver function monitoring and blood paracetamol levels to be taken, timed against when he had taken the overdose and if this was not possible within the custody suit, that he should have been referred straight to hospital.

(g) What I am unaware of is whether urgent conveyance to the Prison Medical Wing was possible and whether the Prison Medical Officer then had the facilities to test for paracetamol levels and liver function on an urgent basis. If there were facilities for rapid conveyance to the Prison Medical Wing and urgent access to blood tests, then Dr XXXX's management with regards deferring to the Prison Medical Officer was entirely reasonable.

Reference 1. Oxford Handbook of Accident and Emergency Medicine 1999 page 190 re Paracetamol poisoning.

(h) If there were not the facilities for urgent transference to a Prison Medical Wing or the facilities for urgent blood testing, then on balance I am of the view that the safe decision here would have been for Dr XXXX to refer Mr Birks to hospital and to not do so was, in my view and on balance, a mistake. I will say however that I suspect that Dr XXXX would not be alone in making a mistake like this and in my opinion and experience there is likely to be a range of opinion here with a body of responsible General Practitioners who may have done the same and not considered 8 paracetamol to be a particularly toxic dose worthy of hospital admission.

5.02 Case of Romeria Andre date of birth 14/11/1980

(a) The original hand written contemporaneous records note that Dr XXXX attended this patient on the 24th April 2011 and that the complaint was of a right shoulder injury one day ago. Examination findings were of globally reduced movement of the shoulder and Dr XXXX dispensed a voltarol (diclofenac injection 75mgs and further 42x voltarol oral tablets 50mg. Dr XXXX advised that the patient attend St Marks Hospital for an x-ray and further management.

(b) Clinical audit meeting records note that Dr XXXX was challenged over his dispensing of these medications. My opinion is that I consider this to be reasonable and safe clinical care. It was reasonable to offer an injection of pain relief and some oral medications with appropriate clinical decision making with regards the need for further management from the hospital.

5.03 Case of XXXXX date of birth 07/07/1997

(a) The original hand written contemporaneous records note that Dr XXXX attended this patient on the 20th April 2011. The reason for attendance was stated as sore throat, green mucus, cough and fever. Salient examination findings noted a fever of 37.7 degrees, pulse of 99, 'throat inflamed, glands enlarged in neck, chest crepitations both bases audible.' Amoxicillin antibiotics were dispensed along with paracetamol and ibuprofen.

(b) Clinical audit meeting records note that Dr XXXX was challenged over the prescription for amoxicillin in case this patient had Epstein Bar Virus (EBV, the cause of Glandular Fever) which would have provoked an itchy rash when treated with amoxicillin. Glandular fever is normally fairly evident on clinical examination of the tonsils because exudative tonsils are normally very clearly visible. I would therefore expect that Dr XXXX would have seen this had the patient been suffering from glandular fever. EBV also does not cause chest signs. In my opinion EBV does not sound like a significant possibility and amoxicillin is a very reasonable choice of antibiotic for a patient who is feverish with a green mucus cough and abnormal chest sounds (crepitations). This was reasonable medical care.

5.04 Case of Victoria XXXXXX

(a) The original hand written contemporaneous records note that Dr XXXX attended this patient on the 19th May 2011. The presenting complaint was of a lump in the vaginal vault. The clinical audit meeting records note that the Chaperone box was not ticked and is critical of this, however I see that the box is ticked and I am informed by Dr XXXX that in fact the patients husband was present. I can only assume that a mistake was made by Direct Doctors and perhaps their photocopy of the records did not show the tick.

(b) It would appear that a suitable chaperone was present, this visit occurred at the patient's home and Dr XXXX was not accompanied by a nurse therefore the presence of the husband, subject to the patient's consent, was in my opinion a reasonable option. Dr XXXX noted the lump and advised referral to Gynaecology for marsupilisation, without prescribing any medications, which was in my view very reasonable.

5.05 Case of XXXXXXx date of birth 21/06/1992

(a) The original hand written contemporaneous records note that Dr XXXX attended this patient on the 26th May 2011. The patient was in custody and was known to suffer from Schizophrenia and was taking the anti-psychotic medication Aripiprazole 10mg. The clinical records are sparse but they note that the patient was hearing voices. Single stat doses of diazepam 10mg and dihydrocodeine 60 were issued with the advice that the social worker hold on to and issue the aripiprazole. The boxes were ticked to say that Mr XXXXX was fit to appear in Court and was fit to be transported by cellular vehicle.

(b) The clinical audit meeting records note two criticisms, firstly relating to the 'large doses' of medication and secondly to the assessment that he was fit to appear in Court.

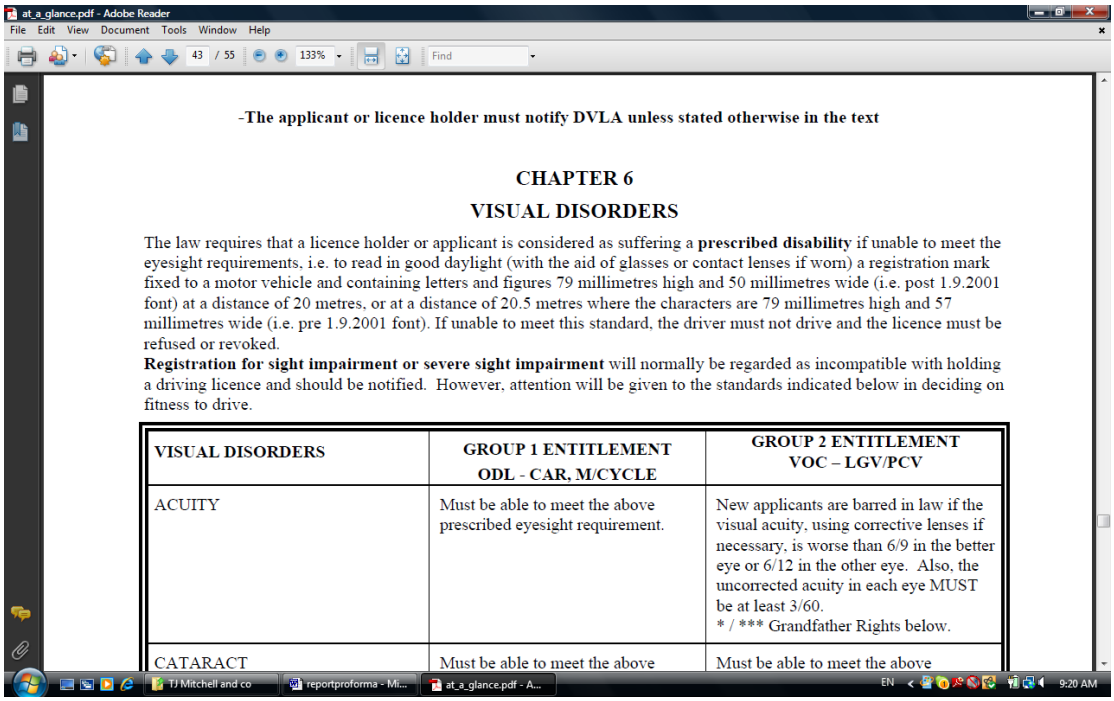
(c) As one off doses, I do not consider 10mg diazepam nor 60 mg dihydrocodeine to be excessive at all. To give dihydrocodeine is a bit unorthodox but I have seen it used many times in the prison population by prison doctors in the acute setting because of its sedative effects and to combine it with diazepam is not unusual with regards producing sedation.

(d) The records are unfortunately too scant for me to comment on the appropriateness of the assessment regarding fitness to travel or attend Court. Many chronic Schizophrenic patients hear voices habitually yet they are considered stable and are considered competent and to have capacity to understand the consequence of their actions and therefore attend Court. Therefore this assessment may well have been entirely correct. On the other hand if this was an acute deterioration in an otherwise normally stable patient then the assessment may have been incorrect. In this particular case I think more notes need to be sought with regards what the outcome was at Court and with any subsequent Psychiatric evaluation.

5.06 Case of the PHV medical examination dated 15/11/2010. There is no patient ID relating to this event not any original examination papers, only the clinical audit form.

(a) The criticism here related to vision testing during a medical examination for fitness to drive. It is alleged that Dr XXXX scored the patient 6/9 and 6/12 and advised the patient that he be deferred pending an optician assessment. When the auditing doctor performed the test the results were 6/6 in binocular vision and the auditing doctor advised the patient that this satisfied the criteria for a group 2 driving license.

(b) The auditing doctor is wrong here. If you refer to Chapter 6, Visual Disorders of the DVLA current medical standards of fitness to drive under group 2 entitlement (extract copy below), it very clearly states that visual acuity is assessed relating to each eye and must be no worse than 6/9 in the better eye or 6/12 in the other eye. This is an assessment of vision in each eye and not binocular vision. On this basis the above patient did not need deferral to an optician because he actually satisfied the criteria however for Dr XXXX to recommend an Optician review in order to be certain was in my view good and safe practice. If there is doubt in the visual ability of a candidate for a group 2 licence then deferring to an optician is good practice. The advice by the auditing doctor that all he needed to do was achieve 6/6 in binocular vision and to therefore pass the patient was incorrect and could have led to this patient being incorrectly considered fit for the licence. This casts some doubt on the abilities of the doctor that was performing the audit on Dr XXXX.



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CHAPTER 6

VISUAL DISORDERS

The law requires that a licence holder or applicant is considered as suffering a **prescribed disability** if unable to meet the eyesight requirements, i.e. to read in good daylight (with the aid of glasses or contact lenses if worn) a registration mark fixed to a motor vehicle and containing letters and figures 79 millimetres high and 50 millimetres wide (i.e. post 1.9.2001 font) at a distance of 20 metres, or at a distance of 20.5 metres where the characters are 79 millimetres high and 57 millimetres wide (i.e. pre 1.9.2001 font). If unable to meet this standard, the driver must not drive and the licence must be refused or revoked.

Registration for sight impairment or severe sight impairment will normally be regarded as incompatible with holding a driving licence and should be notified. However, attention will be given to the standards indicated below in deciding on fitness to drive.

VISUAL DISORDERS	GROUP 1 ENTITLEMENT ODL - CAR, M/CYCLE	GROUP 2 ENTITLEMENT VOC – LGV/PCV
ACUITY	Must be able to meet the above prescribed eyesight requirement.	New applicants are barred in law if the visual acuity, using corrective lenses if necessary, is worse than 6/9 in the better eye or 6/12 in the other eye. Also, the uncorrected acuity in each eye MUST be at least 3/60. * / *** Grandfather Rights below.
CATARACT	Must be able to meet the above	Must be able to meet the above

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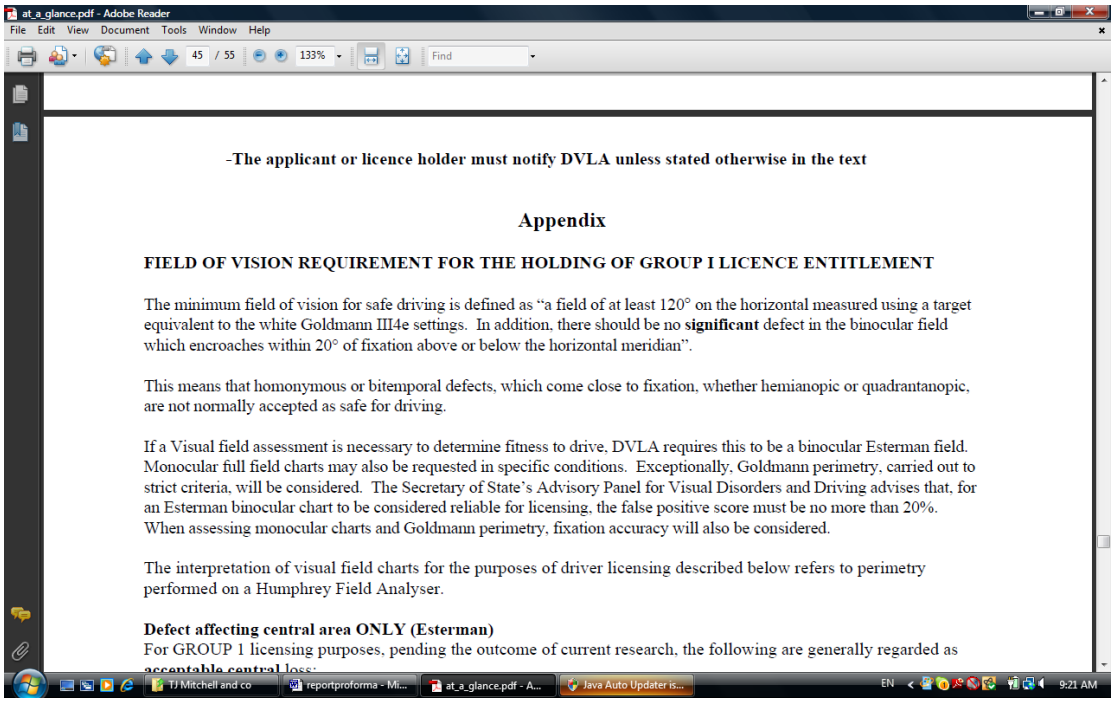
(c) Another criticism mentioned in the audit notes was that the Snellen chart was not turned to the wall at the beginning of the consultation. This is a minor mistake and can happen very easily in a busy clinic.

(d) A third criticism was raised by the auditing doctor that Dr XXXX, when assessing visual fields, started from 120 degrees rather than the usual 180 degrees. Certainly at medical school you are taught to assess from 180 degrees however it is important to note that on page 43 of the DVLA fitness to drive guide relating to visual fields (extract copy below), a field of vision of at least 120 degrees is required this would therefore support Dr XXXX ensuring that the patient had at least this degree of visual field.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Appendix

FIELD OF VISION REQUIREMENT FOR THE HOLDING OF GROUP I LICENCE ENTITLEMENT

The minimum field of vision for safe driving is defined as "a field of at least 120° on the horizontal measured using a target equivalent to the white Goldmann III4e settings. In addition, there should be no **significant** defect in the binocular field which encroaches within 20° of fixation above or below the horizontal meridian".

This means that homonymous or bitemporal defects, which come close to fixation, whether hemianopic or quadrantanopic, are not normally accepted as safe for driving.

If a Visual field assessment is necessary to determine fitness to drive, DVLA requires this to be a binocular Esterman field. Monocular full field charts may also be requested in specific conditions. Exceptionally, Goldmann perimetry, carried out to strict criteria, will be considered. The Secretary of State's Advisory Panel for Visual Disorders and Driving advises that, for an Esterman binocular chart to be considered reliable for licensing, the false positive score must be no more than 20%. When assessing monocular charts and Goldmann perimetry, fixation accuracy will also be considered.

The interpretation of visual field charts for the purposes of driver licensing described below refers to perimetry performed on a Humphrey Field Analyser.

Defect affecting central area ONLY (Esterman)
For GROUP 1 licensing purposes, pending the outcome of current research, the following are generally regarded as **acceptable central** loss:

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5.07 Case 7 relates to a patient with breast cancer. The consultation was on the 26th May 2009 however no details are available to me only the clinical audit report. The report is critical that a patient with known metastatic breast cancer on arimidex medication was prescribed two forms of opiate medications for a fever and chest infection. There is very scant information for me to go on here however all I can say is that opiate medication (codeine) is very effective in suppressing cough and is also a very well considered analgesia in patients with bony pain from metastatic breast cancer.

5.08 Case 8 is referred to in the 'interview with Dr XXXX 21/01/10' but there are no clinical notes available for me to comment on.

(a) The issue relates to a patient who was very obese and had just started the medication Amlodipine for high blood pressure and had developed very swollen feet and legs and epigastric pain. Dr XXXX had considered heart failure as a cause for the swelling and gastritis as a cause for the epigastric pain.

(b) The auditing doctor has suggested that in a case such as this one must consider an acute cardiac cause and without access to an ECG it would be appropriate to refer the patient to hospital and indeed to call an ambulance. This is a reasonable point, however equally there may have been relatively benign causes for this patient's symptoms. There is very little information for me to give an opinion on here other than to make the following comments;

(c) Amlodipine medication is very commonly a cause of ankle swelling, it is a well recognised side effect and therefore this case may have been nothing more than that. The epigastric pain could well have been gastritis.

(d) Dr XXXX holds a postgraduate diploma in cardiology and therefore I expect that he would have a high standard of cardiological awareness

(e) I recommend that further medical records be obtained relating to this patient for an expert to offer an opinion on.

5.09 Case 9 is referred to in the 'interview with Dr XXXX 21/01/10' but there are no clinical notes available for me to comment on.

(a) This case relates to the management of gastro-enteritis presenting with diarrhoea and vomiting. Dr XXXX dispensed stemetil anti-emetic, codeine, ciprofloxacin antibiotic and administered an injection of metoclopramide.

(b) The auditing doctor is critical saying this was an inappropriate antibiotic choice and an unnecessary injection. If this were a self-limiting viral gastro-enteritis then I would agree that an antibiotic is unnecessary and that fluid management is all that is generally required. However if a clinician makes a decision that this was potentially a bacterial infection and there was no time to wait for a stool culture result because the patient was travelling, then the choice of ciprofloxacin is very reasonable, it is a common treatment for traveller's diarrhoea. Also for someone who is vomiting, an injection with metoclopramide is very reasonable, in fact it is relatively routine and standard medical practice.

(c) The criticism appears to relate to the possibility that Dr XXXX was dispensing too many medications in order to collect more dispensing fees however in my view these medications were clinically justified.

5.10 Case 10 is referred to in the 'interview with Dr XXXX 21/01/10' but there are no clinical notes available for me to comment on.

(a) This case relates to a patient with earache, fever and cough that was suffering these symptoms during the UK swine flu pandemic. Dr XXXX dispensed cefalexin antibiotics, tamiflu antiviral medications and codeine as a cough suppressant. The criticism appears to be related to whether there was a need to prescribe both antibiotics and tamiflu.

(b) Once again without the clinical details it is very difficult to offer a robust opinion, however as a GP who worked through the swine flu pandemic, all I can say is that it was not unusual to be prescribing antibiotics and antiviral medications to patients at the same time. It can be clinically difficult to differentiate between viral and bacterial illness and most importantly the major concern with swine flu was secondary bacterial infection, which antibiotics would guard against.

5.11 Case number 11

(a) I have been provided with a copy of emails dated 7th May 2010 from an auditing doctor from Doctors Direct relating to the issue of Dr XXXX prescribing diazepam as a short term treatment for a patient suffering mild anxiety. The auditing doctor is critical of the use of diazepam in this circumstance.

(b) I am heavily constrained by the lack of records supplied relating to this case but I can advise that diazepam is licensed as a short term treatment for anxiety and indeed it is regularly used in the General Practice setting very reasonably. It should not be prescribed for the long term because it is addictive and on occasion other drugs may be more useful especially to avoid any sedative effects however because I am not aware of the actual circumstances relating to this case I am unable to be more specific than this.

5.12 There is a further issue I picked up in the notes of this interview and this relates to the auditing doctor asking which Dr XXXX he was; was he or was he not on the GP register. I do note that there are two Dr Naresh XXXX's on the GMC register, one is a GP in the midlands and the other is this particular Dr XXXX. It took me all of five minutes to find this out therefore for the auditing doctor to imply that Dr XXXX was in some way concealing who he was seems in my view to be rather unreasonable. It would have been easy to check and I assume that Doctors Direct must have suitable records of who they employ.

5.13 I also note that there has been some criticism levelled at Dr XXXX for the short clinical notes taken. Although it is of course always best practice to make detailed records, the reality of every day practice is that records need to be concise. In several of these cases I have not seen the clinical records and have only had the auditing doctor's remarks. In the first few cases of this report I have seen the original records and Dr XXXX was constrained by the small box of the Doctors Direct proforma sheet but from what I can see he has made appropriate salient notes and ticked the relevant boxes of the proforma. One can argue that if Doctors Direct wanted Dr XXXX to make more notes why did they not provide a proforma sheet with a larger space in order to write them? On the whole the records that I have seen are not untypical of a standard GP's concise record keeping.

5.14 In summary, given the information presented to me and accepting the very limited information I have been provided with relating to several of the cases, in ten out of the eleven cases I consider there to have been very reasonable care provided by Dr XXXX. The case involving the paracetamol overdose could have been dealt with differently depending on what levels of medical care were available in custody however I suspect that given the circumstances, there is a body of responsible General Practitioners that may well have done the same.

6 Statement of compliance

(a) I understand that my overriding duty is to assist the Court in matters within my expertise, and that this duty overrides any obligation to those instructing their Clients or me. I confirm I have complied with that duty and will continue to do so, I am aware of the requirements set out in Part 35 of the Civil Procedure Rules and the accompanying Practice Direction, the Protocol for the Instructions of Experts to give Evidence in Civil Claims, and the Practice Direction for Pre-action conduct. I am also aware of my obligations under part 33 of the Criminal Procedure Rules. I have obtained the Bond Solon Civil Procedure Rules for Expert Witnesses Certificate to evidence my understanding and compliance with the above requirements.

(b) I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

(c) I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters, which I regard as relevant to the opinions I have expressed.

(d) I consider that all the matters on which I have expressed an opinion lie within my field of expertise.

(e) I have drawn to the attention of the court all matters, of which I am aware, which might adversely affect my opinion.

(f) In preparing and presenting this report I am not aware of any conflict of interest actual or potential save as expressly disclosed in this report.

(g) In respect of matters referred to which are not within my personal knowledge, I have indicated the source of such information.

(h) I have not included anything in this report, which has been suggested to me by anyone, including the lawyers instructing me, without forming my own independent view of the matter.

(i) Where, in my view, there is a range of reasonable opinion relevant to the opinions I express, I have indicated the extent of the range in the report.

(j) At the time of signing the report I consider it to be complete and accurate. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any alteration, correction, or qualification.

(k) I understand that this report will be the evidence that I will give, if required, under oath, subject to any correction or qualification I may make before swearing to its veracity.

(l) I have attached to this report a statement setting out the substance of all the facts and instructions given to me, which are material to the opinions expressed in this report or upon which those opinions are based.

7 Statement of truth

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matter to which they refer.

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Date: 30th January 2012
Time: 15.20 hrs
Location: GB Expert General Practitioner offices
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MBChB DGM DFSRH DRCOG FRCGP MEWI PGCert

Dated 30th January 2012

END OF REPORT