Verbal statement given by Dr , (GMC:)

Friday 21/01/22 – Office, Jersey General Hospital

Present: , , and .

I was asked to provide this verbal statement by Mr Patrick Armstrong, , and , having given notice to resign from my recently commenced post of in Medicine at Jersey General Hospital.

This statement is following my concerns regarding the Consultant ward round with , in particular the ward on 17/01/22. I found the ward round to be poor, and I was frustrated by the ward round style. infrequently reviewed patient clinical notes, blood test results, or imaging himself. rarely clinically examined patients. The ward round was generally rushed, and therefore not thorough. would generally enter the room to look at a patient, and may say a few words, such as "how you are feeling", and then leave. Observation charts were reviewed for some but not all of the patients.

A specific incident relates to a prescription for a chemotherapy medication, regarding which I have provided a separate written statement on the next page. This written statement was sent to via email on the morning of Friday 21/01/2022, shortly before this meeting. was rude and negative toward me in this incident. ( ) prescribed the chemotherapy medication in the end. would have witnessed these events, and there were also nursing and other staff present, but I cannot recall who they were.

A patient admitted via the medical-take on 20/01/22 with did not have a consultant-led management plan because the post-take ward round did not take place. The patient in question did not receive a specialist review, and a comprehensive management plan was not in place before the night medical handover.

During post-take ward rounds, it is generally good practice for the Consultant to review a patient's medical history, blood test results, and imaging him/herself. This provides a safety net to ensure that nothing has been missed during the patient clerking, and that an appropriate management plan is in place. In my experience, these things do not always happen. A standardised proforma for clerking and the post-take ward round would support this process. The EPR used here at Jersey General Hospital does not facilitate this because all electronic medical notes are entered via a free text box that provides no formatting; therefore, the quality of clerking and post-take ward round documentation is variable. In my opinion, the current model of having a mixture of electronic and paper notes, which are used variably across different departments and wards, could be a potential risk.

I have been working with today in , and has been thorough in assessments of the patients, and has shown good judgement in my opinion. did not introduce to me at first. When working in during my first week, I felt well supported by ; is generally approachable and helpful.

general attitude, and approach toward myself was extremely negative. If I had met during my job interview panel , I believe it is likely that I would have re-considered coming to work at Jersey General Hospital.

I have never raised an issue like this in the past while working in the NHS because I have never felt compelled to do so. However, is a , and I would not consider to be a good role model.

01/02/22

Appendix: written statement given by Dr , (GMC:)

Friday 21/01/22 – sent via email to

During my first ward round with on 17/01/22, which was shortly after meeting for the first time, attempted to pressure me into prescribing systemic chemotherapy for a patient , which I politely refused to do. was taken aback by my stance, and the explanation that I gave. stated to the effect, "where is it written that you can't do this"..."show me where"..."it's your job"..."we do things differently here"..."this is going to be a problem". tone and the quality of this discussion shortly after meeting for the first time was generally unprofessional, and inconsistent with a Consultant Physician in a . The prescription concerned was for cyclophosphamide, as part of the chemotherapy regimen bortezomib (Velcade), cyclophosphamide, and dexamethasone (VCD) for a patient .

The prescription, preparation, and administration of cytotoxic medications is a high-risk activity, which should be restricted to appropriately trained individuals. There have been many serious untoward incidents and avoidable deaths relating to the erroneous prescription, preparation, and administration of systemic anti-cancer therapies (SACTs), some of which have led to national patient safety inquiries, civil court cases, and even criminal prosecution of individual clinicians for statutory gross negligence manslaughter in England and Wales.

In England, the National Chemotherapy Advisory Group of the Department of Health, in alignment with international, regional, and local bodies, issues clear guidance. "Chemotherapy services in England: ensuring safety and quality" states that:

"2.22 Prescribing of chemotherapy for cancer patients should only be undertaken by appropriately trained staff (Clinical Oncologists, Medical Oncologists, Haematological Oncologists, and non-medical independent and supplementary Oncology Nurse and Oncology Pharmacist prescribers)."

The NHS National Cancer Programme "Manual for Cancer Services: Chemotherapy Measures" states that:

"11-1E-105s From the time of publication of these measures, the following may be considered initially capable and authorised to assess staff competency and, therefore, automatically competent, themselves:

- Consultant Oncologists, in the protocols relating to the tumour types they subspecialise in - for prescribing chemotherapy;

- Chemotherapy Nurses at band 7 or above, or lead Chemotherapy Nurses - for administering chemotherapy;

- Designated Oncology Pharmacists - for prescription checking and dispensing chemotherapy."

The Joint Royal Colleges of Physicians Training Board (JRCPTB) states that:

"Several levels of competency in prescribing SACTs are described, and trainees will only be permitted to prescribe under appropriate supervision within their competency level. Progress to the next level of competency requires that trainees are assessed as competent by an appropriate supervisor having demonstrated the required knowledge, skills and behaviours required."

More specifically, in the Medical Oncology Specialty Training Curriculum (JRCPTB), the entry level competency (level 2) descriptor is, "can undertake a review of a patient receiving systemic anticancer therapy, and can authorise the next cycle of treatment to proceed. All prescriptions require countersignature." The next level competency (level 3) descriptor is, "can continue a

prescription for systemic anticancer therapy without countersignature, but cannot prescribe the first cycle of systemic chemotherapy", and so on to level 5, which is the competence level expected of a Consultant Oncologist at completion of Specialty Training (CCT). Level 0 and 1 competency relates to Foundation and Internal Medicine Training (IMT) doctors, and the descriptor states, "can recognise that a patient is receiving systemic cytotoxic or immunosuppressive therapy, and alerts senior team members appropriately. No prescription can be undertaken."

With reference to all of the above, and in general, SACTs should only be prescribed by clinicians with appropriate training, and who are assessed to be competent to prescribe by a competent clinician, and who are maintained on a local or regional register of competence. This in practice means a Consultant Oncologists or Haematologist, or a senior Specialty Trainees in Oncology or Haematology who has achieved the required competencies. In this case, I believe that [redacted] was asked to make the prescription after my refusal to do so.

Furthermore, the GMC's "Good Medical Practice" states that, "14 You must recognise and work within the limits of your competence."

I have not had sufficient time to research, but I am unsure whether the Government of Jersey Health and Community Services (HCS) Department has a policy relating to the prescription, preparation, and administration of systemic anticancer therapies (SACTs) and other cytotoxic medications that is in line with national and international policies, standard operating procedures, and accepted safe practices. This is a high-risk area of medical practice with regards to patient safety, and also medicolegally. In my opinion, it is essential that all medical and nursing staff, especially those in senior positions, are aware of the issues around SACT in-order to practice safely. Had I naively followed the direction of [redacted], and had a harmful or fatal error have been made subsequently, it would be indefensible for myself, [redacted], and the HCS Department in court (both civil and criminal), before the GMC, and to the patient's family and the general public.

[redacted] 01/02/22