This case was considered by a Fitness to Practise Panel which applied the General Medical Council's Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988

Date of Fitness to Practise Panel Hearing:	3 – 16 November 2005
Name of respondent doctor:	DAVID, Ann Clair
Registered qualifications:	MB ChB 1982 Dund SR
Registration number:	2597306
Panel:	Professor Whitehouse (Chairman) Mr Bergmann Dr Gunasekera Dr Howard Miss Killick Mr Yates
Legal Assessor:	Mr Nigel Parry
Secretary to the Panel:	Nilla Varsani
Type of Case:	New case of Fitness to Practise

Representation:

Ms Sally Smith QC and Mr Christopher Mellor, Counsel, instructed by Mr Andrew Baum of Field Fisher Waterhouse, represented the complainant.

Dr David was present and was represented by Mr John Hendy QC and Ms Louise Chudleigh, Counsel, instructed by Mr Ian Sadler of RadcliffesLeBrasseur.
(Dr David and her legal representatives withdrew from the hearing after admissions were made)

Charge:

"That, being registered under the Medical Act,

'1. a. On 22 January 1999 Patient S was transferred from a medical ward at Basildon Hospital to Intensive Treatment Unit (ITU) in a hypotensive dehydrated hypoxic condition and a plan was made to correct his dehydration with intravenous fluids, insert a naso-gastric tube for feeding, continue him on antibiotics and to ventilate artificially if necessary,
Admitted and Found Proved

b. i. from on or about 25 January 1999 until his death you were involved in the clinical intensive care of Patient S in ITU,
Admitted and Found Proved

ii. from on or about 6 February 1999 until his death you were the Consultant responsible for Patient S's clinical intensive care,
Admitted and Found Proved

c. On 26 January 1999 Patient S's condition was such that he was intubated and mechanically ventilated on your instructions,
Admitted and Found Proved

d. On 10 February 1999 you performed a tracheostomy on Patient S,
Admitted and Found Proved

e. On 16 February 1999,

i. you formed the view that it was appropriate to withdraw treatment from Patient S on the grounds that he had an overwhelming infection that was not responding to treatment with strong antibiotics, his ventilatory requirements were increasing and there was no possibility of survival off the ventilator,
Admitted and Found Proved

ii. you ~~informed~~ discussed with Patient S's family ~~of~~ the view you had formed and ~~of~~ your intention to withdraw treatment from Patient S,
Admitted and Found Proved

iii. Patient S's wife and family told you they did not want you to withdraw treatment and were strongly opposed to you taking that course,
Found Proved

iv. at or about 14:50 hours you took or caused to be taken the following steps: withdrawal of ventilation, 20mg intravenous diazemuls administered, patient extubated,
Found Proved

v. Patient S died at or about 15:10 hours,
Admitted and Found Proved

vi. the cause of death was given as staphylococcal pneumonia;
Admitted and Found Proved

'2. a. Between 12 and 16 February 1999,

i. you failed to provide Patient S with adequate ventilatory support,

Found Proved

ii. you wrongly interpreted Patient S's rising CO_2 as being attributable to worsening lung function rather than to inadequate ventilatory support,
Found Proved

b. You failed, prior to making the decision to withdraw treatment, to explore further reasonable treatment options, namely,

i. adjustments to ventilation,
Found Proved

ii. administration of diuretics,
Found Proved

iii. the tapping of pleural fluid,
Found Proved

iv. investigation for unusual infections and treatment if appropriate with antibiotics and anti-fungal agents,
Found Proved

c. Your decision to withdraw treatment given Patient S's condition at that time was,

i. clinically unjustified,
Found Proved

ii. inappropriate,
Found Proved

iii. premature,
Found Proved

iv. not in the patient's best interests,
Found Proved

d. You made the decision to withdraw treatment in the absence of adequate and appropriate consultation with,

i. your professional colleagues,
Found Proved

ii. Patient S's relatives,
Found Proved

e. The manner of treatment withdrawal you adopted,

i. entailed active measures to bring about Patient S's death,
Found Proved

ii. brought Patient S's life to an end earlier than would have occurred naturally,
Found Proved

iii. was inappropriate,
Found Proved

iv. was not in Patient S's best interests,
Found Proved

v. failed to take into account the sensitivities of Patient S's wife and family,
Found Proved

f. Your treatment as set out in charges 2.a. – e. was,

i. irresponsible,
Found Proved

ii. unprofessional,
Found Proved

iii. overall, not in Patient S's best interests;
Found Proved

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."
Guilty of serious professional misconduct

Determination:

"Miss Smith:

The Panel has considered this case in accordance with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988.

The Panel has heard that on 22 January 1999 Patient S was transferred from a medical ward at Basildon Hospital to the Intensive Treatment Unit (ITU) in a hypotensive dehydrated hypoxic condition and a plan was made to correct his dehydration with intravenous fluids, insert a naso-gastric tube for feeding, continue him on antibiotics and to ventilate artificially if necessary. From on or about 25 January 1999 until his death Dr David was involved in the clinical intensive care of Patient S in ITU and from on or about 6 February 1999 until his

death she was the Consultant responsible for Patient S's clinical intensive care.

On 26 January 1999 Patient S's condition was such that he was intubated and mechanically ventilated on Dr David's instructions and on 10 February 1999 she performed a tracheostomy on Patient S. On 16 February 1999 Dr David formed the view that it was appropriate to withdraw treatment from Patient S on the grounds that he had an overwhelming infection that was not responding to treatment with strong antibiotics, his ventilatory requirements were increasing and there was no possibility of survival off the ventilator.
Dr David discussed with Patient S's family the view that she had formed and her intention to withdraw treatment from Patient S. The Panel has heard evidence from Patient S's wife and family, and has found proved that they told Dr David that they did not want her to withdraw treatment and were strongly opposed to her taking that course. Nevertheless at or about 14:50 hours
Dr David took or caused to be taken the following steps: withdrawal of ventilation, 20mg intravenous diazemuls administered and patient extubated. As a result Patient S died at or about 15:10 hours. The cause of death was given as staphylococcal pneumonia.

The Panel has found proved that between 12 and 16 February 1999, Dr David failed to provide Patient S with adequate ventilatory support and she wrongly interpreted Patient S's rising CO_2 as being attributable to worsening lung function rather than to inadequate ventilatory support. The Panel has found proved that Dr David failed, prior to making the decision to withdraw treatment, to explore further reasonable treatment options, namely, adjustments to ventilation, administration of diuretics, the tapping of pleural fluid, investigation for unusual infections and treatment if appropriate with antibiotics and anti-fungal agents. The Panel has found that Dr David's decision to withdraw treatment given Patient S's condition at that time was, clinically unjustified, inappropriate, premature and not in the patient's best interests.

The Panel has also found proved that Dr David made the decision to withdraw treatment in the absence of adequate and appropriate consultation with her professional colleagues and Patient S's relatives.

The Panel has further found proved that the manner of treatment withdrawal Dr David adopted, entailed active measures to bring about Patient S's death, brought Patient S's life to an end earlier than would have occurred naturally, was inappropriate, was not in Patient S's best interests and failed to take into account the sensitivities of Patient S's wife and family.

This treatment as set out above was, irresponsible, unprofessional and not in Patient S's best interests.

The Panel is concerned by the findings that it has found proved against
Dr David and in particular,

1. her decision to withdraw treatment at that time which was clinically unjustified, inappropriate, premature and not in the patients best interests.

2. her lack of consultation with professional colleagues and the family of patient S.

3. the manner of withdrawal of treatment. Dr David had prior knowledge of the amount of diazemuls required for sedation in this patient. Her subsequent use of a far higher dose given more rapidly is clear evidence of substantial incompetence which directly caused the death of Patient S. The Panel bore in mind the legal doctrine of double effect but felt that this unequivocal evidence led to the clear conclusion that Mr S's death occurred sooner that it might otherwise have done.

In coming to these findings the Panel was assisted by the expert evidence of Dr A, Dr L and Professor H.

The Panel considers that when a doctor is contemplating the withdrawal or withholding of treatment he/she has a responsibility not only to recognise the law but to deal sensitively with the patient and their family. In circumstances such as this, this places an increased burden on the doctor to ensure that all processes are given the fullest attention.

Withdrawal of treatment can be justified on clinical grounds where the patient's physical condition has become hopeless and it is clear that treatment of any sort, including life-sustaining treatment, is producing no useful benefit. It is imperative that a doctor differentiates between actively ending the patient's life - an unlawful act, and letting a patient die without distress.

The Panel recognises that even if all possible steps had been taken this patient may still have died. However, Mr S had an undeniable right to all reasonable treatments before the decision to withdraw treatment was made. No decision should have been taken until all attempts at diagnosis and treatment had been made.

The Panel is concerned by the earlier failure of those involved to explore adequately the underlying causes of Mr S's condition. It is also concerned by the failure of the hospital and its ITU department to have a clear policy on withholding and withdrawing treatment. The Panel noted that at the time in question a draft policy had been in existence since 3 December 1997.

The General Medical Council's guidance Good Medical Practice (July 1998) makes clear that patients must be able to trust doctors with their lives and well-being. To justify that trust, doctors as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. Essential elements of this are professional competence; good relationships with patients and colleagues and observation of professional ethical obligations.

The Panel has been mindful of the additional responsibility placed upon it by the absence of Dr David and her legal team, albeit their decision to withdraw was voluntary.

The Panel has concluded that Dr David did not adequately investigate Mr S, did not recognise the developing fluid overload, did not make the adjustments to his assisted

respiration necessary to diminish his arterial CO_2 and proceeded to advise the family of her decision to withdraw treatment without any consultation with colleagues. There was no proper clinical justification for that decision, at that time. Dr David's consultation with the family was inadequate so that they were not able to understand nor support the decision. The patient was not in imminent danger of dying and was recorded as being conscious and orientated. Before proceeding to extubate Mr S, Dr David administered a very large dose of diazemuls thereby causing his death. Her fault in ending his life, whatever her motives, is very serious. The Panel therefore finds her guilty of serious professional misconduct.

The Panel then considered what action, if any, to take in relation to Dr David's registration. In doing so the Panel has carefully considered the Indicative Sanctions Guidance published by the GMC, and has taken account of the advice given by the Legal Assessor. It has borne in mind that sanctions must be proportionate and that their purpose is not to be punitive, but to protect members of the public and the public interest. The public interest includes not only the protection of patients, but also the maintenance of public confidence by upholding proper standards of conduct and thereby the reputation of the profession.

The Panel, having balanced the interests of patients and the public against Dr David's interests, is in no doubt that it is necessary to take action against her registration. In this context the panel is mindful of the observation in the case of Bolton v The Law Society and adopted in the case of Dr Gupta, as noted in the Indicative Sanctions Guidance:-

> *"The reputation of the profession is more important than the fortunes of an individual member. Membership of a profession brings many benefits, but that is part of the price."*

The sanction imposed must mark strong disapproval of Dr David's behaviour. The Panel is in no doubt therefore that having regard to the serious nature of her conduct reprimand or conditions would not be appropriate.

The Panel has given consideration as to whether it would be sufficient to suspend Dr David's registration but has decided that no period of suspension could adequately reflect its very serious concerns.

Dr David's behaviour in causing the death of a patient is fundamentally incompatible with continuing to be a registered medical practitioner. The Panel has balanced the need to uphold proper standards and maintain confidence in the medical profession against Dr David's interests and is in no doubt that its decision is wholly proportionate to the gravity of the offences.

Accordingly, the Panel has determined that Dr David's name should be erased from the Medical Register.

The effect of the foregoing direction is that, unless Dr David exercises her right of appeal, her name will be erased from the register 28 days from the date on which notice of this direction is deemed to have been served upon her.

Having concluded that Dr David's name be erased from the Register, the Panel will now go on to determine whether it considers it necessary for the protection of members of the public, or in her own best interests, to order that Dr David's registration shall be suspended forthwith. Before deciding whether it is necessary to do so, the Panel will now hear any submissions on this matter from Miss Smith."

Further determination on suspension forthwith:

"Miss Smith: The Panel has considered the submissions made by you on behalf of the complainant.

The Panel has balanced Dr David's interests against the wider public interest which includes not only the protection of patients but also the maintenance of public confidence in the profession and upholding proper standards of conduct.

Given the gravity of the misconduct the Panel has concluded that it is in the public interest to suspend Dr David's registration forthwith.

The effect of the foregoing order and the direction for erasure previously announced is that Dr David's medical registration will be suspended from today and, unless she exercises her right of appeal, her name will be erased from the Register 28 days from the date on which notice is deemed to have been served upon her.

That concludes this case."

Confirmed

16 November 2005 Chairman