Witness Name: Dr Neil McDougall
Statement No.: WITN3322002
Exhibits: WITN3322003 - WITN3322006
Dated: 18 December 2019

INFECTED BLOOD INQUIRY

WRITTEN STATEMENT OF DR NEIL MCDOUGALL

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 20th May 2019.

I, Dr Neil McDougall, will say as follows: -

Section 1: Introduction

1. My name is Dr Neil Ian McDougall. Date of Birth GRO-C 1965. My professional address is The Liver Unit, 1st Floor East Wing, Royal Victoria Hospital, Grosvenor Road, Belfast. My professional qualifications include Bachelor of Medicine and Surgery (MB, BCh, BAO) awarded by Queen's University Belfast in 1989, Membership of the Royal College of Physicians (MRCP) obtained 1992 and Doctorate of Medicine (MD) awarded by Queen's University of Belfast in 1996. I was elected to Fellowship of the Royal College of Physicians (FRCP) in 2002.

2. I took up my current post as Consultant Gastroenterologist and Hepatologist in the Royal Victoria Hospital, Belfast in January 2004. My first consultant post was as Consultant Gastroenterologist in Antrim and Whiteabbey Hospitals from July 1999 until December 2003. Prior to my appointment as a consultant in 1999, I was a registrar and senior registrar in the Northern Ireland Medical and Dental Training Agency gastroenterology training program, obtaining my Certificate of Completion of Specialist Training (CCST) in August 1998. I then completed two consecutive specialty training fellowships in Royal Perth Hospital, Australia (July 1998-Jan 1999)

and in The Liver Transplant Unit, Kings College Hospital, London (Feb 1999 – July 1999).

3. My role as a hepatologist in the Royal Victoria Hospital has included taking a lead in the field of viral hepatitis (B and C). I have been the clinical lead for viral hepatitis in the Regional Liver Unit, RVH since 2004. Since 2007 I have been the Clinical Lead for the Northern Ireland Hepatitis C Managed Clinical Network that coordinates initiatives by public health, addictions services, prison service, laboratories services, maternity services and other patient support groups to improve strategies for the management of hepatitis C (and in more recent years hepatitis B). This has included participating in numerous educational events and several annual network events to engage with the public and patient interest groups.

4. I have been responsible for working with the Public Health Agency and Department of Health to try and expedite the approval and introduction of every new therapeutic advance in the field of treatment of hepatitis C since 2004. In recent years since the advent of Direct Acting Antivirals (DAAs) this has resulted in the latest NICE (National Institute of Clinical Excellence) approved hepatitis C treatments being made available to patients in Northern Ireland within a few months.

5. I was the Clinical Lead for the Regional Liver Unit from 2009 until 2018 when I moved to a more senior medical management role in Belfast Health and Social Care Trust (Chair of Division for Medicine and Cardiology). During this time, I have worked tirelessly to expand the service in an effort to meet the growing burden of liver disease on our society. This has included obtaining two hepatitis nurse specialists to augment the hepatitis C treatment program and improve the patient experience.

6. In my work as a hepatologist I have been a strong advocate for two disadvantaged patient groups with stigmatised liver diseases – alcoholic liver disease and chronic viral hepatitis (B and C). I have worked against the well documented discrimination (by the public and the medical profession) against those with alcoholic liver disease, through educating medical students, GPs and hospital colleagues. I have also done media work with the public and work on alcohol minimum pricing with DoH. Similarly, with chronic hepatitis C I have developed initiatives with the prison service (personally providing clinics within the prison) and the homeless (working with community services to improve access for patients) in an effort to provide treatment for difficult to reach patients.

7. In addition to my work as an advocate for disadvantaged patients with liver diseases, I have been an advocate for patients through working with various patient charities. In particular, I have supported the RVH Liver Support Group (a Northern Ireland wide charity) since 2004 and recently I helped the British Liver Trust to set up a Love your Liver campaign station in Northern Ireland for a few days.

8. I have not been a member of any committees or groups relevant to the Inquiry's terms of reference.

Section 2(a): Response to criticism in respect of Seamus Conway

9. I met Mr Seamus Conway on just one occasion, at my clinic on 6th October 2017 (Exhibit WITN3322003). He had been referred to the clinic by Dr Gary Benson and therefore my letter was addressed to Dr Benson and copied to the patients GP.

10. My letter contains a factual account of Mr S Conway's description of his estimated alcohol intake along with a factual statement that his intake was above the recommended limit (14 units per week). Mr S Conway also told me that his alcohol intake had been heavier in the past due to a few very significant social problems. I think it is important that I mentioned that there had been a provoking factor for his heavier alcohol intake.

11. I did not make any judgement of Mr Conway's behaviour in my letter and I definitely did not label him as 'an alcoholic'. I did not suggest that Mr S Conway's liver disease was caused by alcohol rather than hepatitis C. In fact, at the time of the consultation we were unaware that Mr S Conway had liver cirrhosis.

12. I check the alcohol history for every patient who is being considered for treatment of chronic hepatitis C. This is because alcohol can be a co-factor with hepatitis C in causing damage to the liver. If I identify an alcohol intake that is above the recommended limit, I ask patients to modify their alcohol intake for the duration of hepatitis C treatment to minimise the risk of it interfering with the treatment.

13. I concluded my letter by agreeing with Mr S Conway that he should be added to the waiting list for hepatitis C treatment. I also requested both an ultrasound scan and a

Fibroscan to help clarify if there was any evidence of cirrhosis as this would have had an impact on the treatment plan and Mr S Conway's follow up requirements.

14. Ms McLaughlin did not name me in paragraph 23 of her statement. My clinic letter from my only interaction with Mr S Conway shows that I did not infer that alcohol was the cause of his liver problems and I did not call him an alcoholic. I simply documented Mr S Conways own statements on his alcohol consumption and I have outlined above why this was an essential part of his assessment

Section 2(b): Response to criticism in respect of Edward Conway

15. My clinical meeting with Mr Edward Conway on 28/11/18 was not planned. He attended my colleague Dr Cash at liver outpatient clinic on 28/11/18. Dr Cash had arranged for Mr Conway to go to the Ambulatory Care Centre (ACC) for a Fibroscan after his outpatient consultation was completed. I was speaking to Dr Cash about a separate matter by phone (I was not at the clinic) and he mentioned that he had seen Mr Conway and sent him for a Fibroscan. I know that occasionally Fibroscans can be technically challenging and can require consultant input. Therefore, as lead for the hepatitis treatment program I decided to go to ACC and ensure all was well.

16. When I arrived in ACC, Karen Patterson who is one of our two hepatitis nurse specialists told me that she had been unable to get a successful set of readings from Mr Conway's Fibroscan. I offered to help by attempting a Fibroscan.

17. After completing the Fibroscan I sent K Patterson to get Ms McLaughlin from the waiting area so that I could explain the result to both of them. Mr Conway appeared to be fully engaged with me, but I was aware that he had some memory issues and I wanted to make sure a close family member was present. Karen Patterson was also present for the entire discussion with Ms McLaughlin and Mr Conway.

18. I explained the following about the Fibroscan
    a. It showed a high reading suggestive of cirrhosis. We can grade the level of scarring in a liver as none (normal), mild fibrosis, moderate fibrosis, advanced fibrosis and cirrhosis. It is generally accepted in hepatology that fibrosis is potentially reversible, but cirrhosis implies that there is permanent damage. I did not use the term advanced cirrhosis but I probably used the term

advanced fibrosis. I am sure this is where the confusion arose causing Ms McLaughlin to use the term 'advanced cirrhosis'.

b. I explained that the ultrasound scan did not show evidence of cirrhosis but that the Fibroscan is a much more accurate device for measuring this. For this reason, we use a Fibroscan to assess all patients before they commence hepatitis C treatment.

c. I explained that despite the diagnosis of cirrhosis, he could still receive treatment for his hepatitis C and that the treatment would still have a very high chance (over 95%) of successfully clearing the hepatitis C infection.

d. I said that when patients are diagnosed with cirrhosis and are otherwise fairly well, we offer them screening with ultrasound liver and a blood test (alpha fetoprotein) every 6 months. This screening is used to detect small cancerous tumors (hepatocellular cancer or HCC) within the liver. If we detect HCCs when they are small then we have more treatment options.

e. I made it very clear on several occasions that his latest ultrasound did not show any evidence of liver cancer. The reason I laboured this point is that I knew they were both anxious because their brother (Mr Seamus Conway) had died from liver cancer in 2018

f. I offered the option of having the follow-up scans and blood tests in Altnagelvin every 6 months for convenience and both Mr E Conway and his sister indicated that they were content with this. Therefore, I sent my letter describing the consultation to Dr C Ferguson, Consultant Gastroenterologist in Altnagelvin and asked him to arrange the follow-up scans (Exhibit WITN3322004). Subsequently, Ms McLaughlin advised us that she wanted her brother to have his follow-up scans in Belfast so I made the necessary arrangements for a follow-up scan in May 2019.

g. We agreed that he would start on treatment for hepatitis C and I offered to ensure that his case was discussed quickly at our Hepatitis C Multidisciplinary Team Meeting so that he could be started on treatment within a few weeks. Mr Conway was discussed at the meeting on 6 Dec 2018.

19. I have no doubt that both Mr E Conway and his sister found their discussion with me upsetting. I was informing them that he had a diagnosis of cirrhosis and needed to have screening because of the RISK of developing an HCC. This immediately revived memories of the loss of their brother to the same disease. For this reason, I went over what I was saying several times to reinforce it and ensured that the

hepatitis nurse was in the room to hear the discussion (as she would be following up Mr E Conway during the treatment).

20. I discovered the following week that Mr Conway had misinterpreted what I had told him. As soon as I discovered this, I phoned his GP and asked the GP to speak with Mr Conway personally to provide him with reassurances that his ultrasound did not show cancer. I summarised my discussion with the GP in a letter (Exhibit WITN3322005). I followed this up with a further letter on 20th Dec 2018 to try and help clarify Mr Conway's follow-up arrangements (Exhibit WITN3322006).

21. Mr Conway was started on a 12-week course of treatment for hepatitis C in December 2018, finishing on 7th March 2019. Follow-up blood tests (HCV PCR) at the end of May 2019 confirmed that the treatment had successfully cleared his hepatitis C infection.

22. Mr Conway had a follow-up ultrasound on 31 May 2019 as part of his HCC surveillance and I reviewed him at my clinic the same day to give him the scan result. This scan showed a small focal lesion in the liver that was not present on his scan on 28th Nov 2018. A follow-up MRI scan was carried out on 7th June 2019 to obtain more detail. This liver lesion did not have the characteristics of a hepatocellular cancer but it requires close radiological follow-up every 3 months at present. At the request of Mr Conway, I am currently arranging his follow-up scans through a colleague in Altnagelvin Hospital and updating Mr Conway on the results by letter. Mr Conway has indicated that he does not wish to return to my clinic in Belfast if it can be avoided (due to the impact that travelling to Belfast has on him). My most recent letter to Mr Conway was on 26th Sept 2019 to update him on the result of his MRI scan of liver carried out in Altnagelvin on 13th Sept 2019.

23. To summarise, Ms McLaughlin is correct in stating that I told her and Mr E Conway that his Fibroscan showed cirrhosis even though the ultrasound scan did not show evidence of cirrhosis. I have no doubt that it is extremely distressing to discover that you have cirrhosis as a result of an infection acquired many years ago through no fault of your own. Thankfully, the treatment has successfully cleared the hepatitis C infection. However, Mr Conway requires close radiological follow-up of his liver to look for any evidence of him developing a liver tumour. I have definitely not left Mr Conway in limbo (as suggested in para 39 of the statement). As demonstrated above, I arranged for him to commence hepatitis C treatment, I reviewed him to

inform him of the outcome of his treatment and I continue to facilitate the radiological follow-up of his cirrhosis.

Section 3: Other Issues

24. There are no other issues that I wish to bring to the inquiry's attention.

Statement of Truth

I believe that the facts stated in this witness statement are true

Signed GRO-C

Dated 18-12-19

Table of exhibits:

Date	Notes/ Description	Exhibit number
06/10/2017	Clinic Letter	WITN3322003
29/11/2018	Letter to Dr C Ferguson, Consultant Gastroenterologist	WITN3322004
07/12/2018	Letter to Dr L W McNeill, GP	WITN3322005
17/01/2019	Letter to Dr L W McNeill, GP	WITN3322006