General
Medical
Council

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Fitness to Practise Panel
Session beginning 8 June 2009
Euston Road, London
Dr Jane Ann BARTON

Determination on findings of fact and as to insuffiency supporting a finding of serious professional misconduct.

20 August 2009

Dr Barton

This case centres on 12 patients, all of whom died between 1996 and 1999 on wards where you were employed as a Clinical Assistant. In order to reach conclusions on the facts alleged it has been necessary for the Panel to build up a clear picture of the practices, procedures, pressures and personalities that characterised the situation on those wards at the time. It has done this through the reception of a great deal of evidence adduced by both parties, and through its own searching, and sometimes challenging questions.

The process has been hampered by the very considerable passage of time since the events in question, the inevitable dimming of memories over that period, the equally inevitable unavailability of some witnesses, and the admitted deficiencies in your own notes, and to some extent those of the nursing staff.

Counsel have reflected on a number of general points which, though they might not form a part of specific allegations, nonetheless require the Panel to have evaluated them before they rule on the facts.

This determination falls into three parts and one annexe. The Panel will deal, firstly, with those general issues which have required consideration during the course of the case. The Panel will, secondly, set out its formal findings as to fact. Thirdly, the Panel will set out its determination as to whether the proved or admitted facts would be insufficient to support a finding of serious professional misconduct. Attached to this determination will be an annexe detailing the final and definitive heads of charge which take account of each and every amendment made since this session commenced on 8 June of this year.

PART ONE

1. Inappropriate transfers onto Dryad and Daedalus wards

i. The Panel heard and accepted evidence from many witnesses that at the time in question there was a sense among the nursing and medical staff at Gosport War Memorial Hospital (GWMH) that, due to pressure on bed space in the acute wards of Queen Alexandra and Royal Haslar Hospitals, some patients were being transferred to Dryad and Daedalus wards when their medical condition was insufficiently stable to warrant such a move. Further, that such patients were often transferred in circumstances where their medical and nursing needs were beyond the staffing and equipment capabilities of the receiving wards.

ii. The Panel received and accepted evidence that in a number of the cases before it there was an apparent incongruity between patients' discharge notes and the assessments of nursing and medical staff when the patients arrived at Dryad or Daedalus wards.

iii. The Panel also heard and accepted evidence that some patients and their families were given the impression by some staff at the transferring hospitals that the purpose of the transfer and the role of the receiving wards were more optimistic than patients' true prognoses allowed.

2. Propensity to sudden deterioration, the effects of transfer and the appropriateness of investigation

i. The Panel heard and accepted evidence from many sources, including the General Medical Council's (GMC) medical expert, Professor Gary Ford, that elderly patients with a range of co-morbidities, such as those routinely found in Dryad and Daedalus wards at the time in question, had a natural propensity toward sudden deterioration and even death, no matter how well cared for.

ii. Further, the Panel heard and accepted evidence from those sources that the physical and mental stress to such patients when subjected to inter-hospital or even inter-ward transfer, was frequently followed by deterioration in the patient. The Panel heard and accepted evidence that such deterioration occurred no matter how short and comfortable the transfer, and that the deterioration might turn out to be temporary or permanent.

iii. Whilst the Panel is of the view that early assessment of a patient is always necessary, the above made it clear that there may well be need for further re-assessments and/or investigations after an initial period of observation.

iv. The Panel noted that there appeared to be agreement among the experts that when a patient was on the terminal pathway, it would be inappropriate to subject the patient to unnecessary investigation.

3. Your dealings with patients' relatives

i. The Panel heard a large amount of evidence from health professionals who witnessed your interactions with patients' relatives, and also from patients' relatives and even patients themselves. Most characterised your approach to relatives as caring and compassionate, and the Panel heard that you would frequently come into the hospital in your own time to meet with relatives.

ii. Some relatives did not have such a positive recollection of their meetings with you, describing you as 'brusque', unfriendly and indifferent. The Panel heard evidence from some nurses who, while generally supportive of you, indicated that you had a tendency toward plain speaking. One said that you 'did not suffer fools gladly', and another that you 'called a spade a spade'.

iii. The Panel also heard evidence from you and other health professionals that your meetings with relatives were sometimes made more difficult by the fact that the relatives had been given unrealistic expectations of the progress that the patient might be expected to make at GWMH, and were often shocked by sudden deterioration in the patient, particularly when this was manifested on or shortly after transfer.

iv. The Panel concluded that your straightforward approach was not appreciated by all relatives, and that to some you might at times appear distant or even unfeeling, albeit that this was far from your intention. The Panel further concluded that the stress experienced by relatives meeting with the doctors of a loved one who was fast approaching death frequently prevented them from taking in all that they were told. It was inevitable in such circumstances that some relatives would leave a meeting with an incomplete or inaccurate view of what had taken place.

4. 'Happy for nurses to confirm death.'

i. The Panel heard considerable discussion about the significance to be attached to the use of this phrase in your notes on individual patient records. It has accepted the view of Professor Ford and numerous other witnesses that the vast majority of patients being admitted onto Dryad and Daedalus wards at the time in question would have had a natural potential to deteriorate rapidly and without warning.

ii. The Panel further accepted Professor Ford's view that it was appropriate for medical staff in these circumstances to delegate the task of confirmation of death to nurses, and that this delegation might usefully have been noted at the time of a patient's admission onto the ward. The Panel also noted his observation that "one would prefer to have a policy for a unit rather than it being done on individual patients."

5. The role of note-taking in clinical care

i. You made a number of admissions in respect to the inadequacy of your note-taking. However, Mr Kark observed "it has been suggested on numerous occasions to witnesses that Dr Barton simply did not have the time. It was a case of either looking after the patient and not making a note about it, or making copious notes but not actually looking after the patient."

ii. Professor Ford told the Panel: "with any important clinical contact where there is a major change of patient status or a major change in treatment I think it is difficult to say one is too busy to write a three, four, five line summary of what has happened. It only takes a short time to write a brief summary."

iii. The Panel notes paragraph 3 of 'Good Medical Practice' 1995 edition which states under the heading *Good Clinical Care*: "In providing care you must....keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed..."

iv. The Panel further notes the acceptance by Professor Karol Sikora, your own medical expert, that note-taking is an integral part of clinical care, and that "any suggestion that on the one hand you will take care of the patient, and then you will do the notes, is by definition inappropriate."

6. The absence of notes of specific events

i. The Panel has heard that medical students are frequently taught that 'if it isn't recorded it didn't happen.' However, as Mr Langdale pointed out in his closing remarks, you are of undisputed good character, and that adage cannot be applied to the Panel's consideration of the facts.

ii. The Panel recognises that the admitted inadequacies in your note-taking mean that while you may on certain occasions lack the corroboration that an appropriate note might have afforded you, the lack of such a note gives the Panel no assistance one way or another in deciding whether or not a claimed event took place. Accordingly, where you have said that you failed to record it but it did happen, the Panel has afforded your evidence the same weight as any other statement as to fact by a person of good character.

7. Allegations that you did not sufficiently record the drug regime in respect of specific patients

i. Mr Kark advanced the view that any failure to reduce into writing instructions governing the circumstances and required procedures in relation to the administration of anticipatory prescriptions was serious. He argued that such failure in respect of a prescription which gave nurses the authority to initiate syringe drivers at an unspecified date, and loaded with a variable dose of Diamorphine / Midazolam mix was especially serious as it reduced the ability of the prescriber to safeguard patients' interests against inappropriate action by nursing staff.

ii. The Panel observed that in managing risk it is necessary to consider not only what might happen when the best, most highly trained and experienced nurses were on duty, but also to consider what might happen when the least trained and experienced nurses were on duty. In the absence of a clear written protocol governing the administration of anticipatory prescriptions – especially those for opiates delivered by syringe driver – patients were entitled to expect that clear written instructions would be available to all those who might be expected to administer the prescription. The Panel noted with concern that nurses had used their own discretion to start a higher dose than the

minimum prescribed dose, and that a nurse had doubled the existing dose of Midazolam at a time when the corresponding dose of Diamorphine had been halved on the instruction of a consultant because of over-sedation.

iii. The Panel noted the evidence that nurses would have been aware of your wishes in this respect because they would have attended verbal handover sessions on each occasion before they started on the ward. While recognising the value and importance of handover sessions, the Panel did not accept that this was a safe or prudent way of ensuring that prescriptions were administered appropriately.

8. Euphemisms relating to end of life status

i. The Panel has heard that throughout the health service at the time in question, health professionals routinely shied away from the use of direct and plain language when recording judgments relating to the palliative care of patients close to death. The Panel noted that even today phrases such as 'on the terminal pathway' are used to indicate that a patient is expected to die within a matter of days. At the time in question:

a. 'For TLC', an acronym for 'tender loving care' was widely used as a euphemism to note that the patient was now to be treated palliatively, and frequently carried the additional connotation that the patient was close to death.

b. 'Make comfortable' meant the same as TLC.

c. The Panel also heard from numerous sources that an entry on the notes indicating that a patient had been started on a syringe driver with a combination of at least Diamorphine and Midazolam was a clear indication that the patient had entered the terminal pathway and was expected to die within a matter of days.

9. Guidelines and the Analgesic Ladder

The Panel heard that the British National Formulary (BNF) is the definitive evidence-based guide for doctors on the prescribing of drugs. It gives clear advice on prescribing in specific situations such as *Prescribing in Palliative Care* and in *Prescribing for the Elderly* where extra care needs to be exercised.

The Panel also heard evidence about the Palliative Care Handbook (The Wessex Protocol) which was in local use at the time of the allegations, and which you told the Panel you kept in your pocket when you were on the wards.

These documents contain Conversion Charts which show, for example, the equivalency of dose between oral morphine and subcutaneous Diamorphine.

Both expert witnesses gave evidence about the World Health Organisation's *Analgesic Ladder* which emphasises the importance of using analgesics appropriate to the severity of pain, and of moving from weaker to stronger analgesics in a step-wise fashion. Professor Ford encapsulated this principle as "start low, go slow".

10. Opiates in the treatment of distress, restlessness, agitation and pain

i. The Panel heard a range of opinion as to the appropriate use of opiates in patients of advanced age with a range of co-morbidities. While there was no dispute that opiates provided effective analgesia for high levels of pain, there was a divergence of view as to the appropriateness of its use in the control of distress, restlessness, and/or agitation in the presence or absence of pain.

ii. Your experience, supported by Dr Logan, other consultants with whom you worked and Professor Sikora was that the euphoric and other properties of opiates rendered them helpful in dealing with terminal distress, restlessness and agitation, whether or not pain was also present.

iii. Professor Ford did not share this view. He conceded that there might be geriatricians who would give Diamorphine to patients who were not in pain, but he noted that such a course is neither promoted nor recommended in the palliative care literature and guidelines.

11. Side effects / adverse consequences of opiates

i. The Panel heard considerable evidence on this subject. In particular, it heard that opiates are extremely powerful drugs, especially in the treatment of the elderly who tend to be particularly sensitive to their effects.

ii. The Panel heard that common side-effects or adverse consequences of opiate use include, but are not limited to:

- Drowsiness, potentially leading to unconsciousness
- Respiratory depression, potentially leading to unconsciousness and ultimately death
- Confusion
- Agitation
- Restlessness
- Hallucination
- Nausea

iii. Professor Ford told the Panel that, when dealing with elderly patients, it was incumbent on prescribers to exercise extreme caution in determining dosage to protect the patient from over-sedation. He cited the Analgesic Ladder, the BNF and the Wessex Protocol as sources of guidance on appropriate usage and dosage of opiates.

iv. You told the Panel that you were well aware of each of these sources and of the side effects and potential adverse consequences of opiate use.

v. The Panel heard a range of evidence on the difficulty of distinguishing agitation and restlessness from pain, especially in cases of dementia and unrousable or unconscious patients. The Panel concluded that in such cases the distinction was a difficult one, and that even medical and nursing staff with considerable experience of opiates in palliative care would not always be able to make that distinction.

vi. The Panel heard that it would be extremely hard to tell whether such symptoms were

occurring as a natural part of the dying process or whether they were occurring as a side effect of the opiates themselves. The Panel noted your view that when a patient was on a syringe driver drug their unconsciousness would be constant if it was induced by the medication, whereas it would fluctuate if it was natural.

12. The Diamorphine / Midazolam mix

i. You told the Panel that in your experience a combination of Diamorphine and Midazolam was an effective means of controlling pain, agitation and restlessness in patients who were on a terminal pathway. You and Professor Sikora both accepted that Midazolam has a powerful sedating effect, and that one has to be doubly cautious using Midazolam in combination with Diamorphine.

ii. Professor Sikora accepted that if a patient is on a terminal pathway that does not avoid the necessity of using the Analgesic Ladder or guidelines so as to ensure that one is not over-sedating, because the danger otherwise is that one can end up with a patient who is unnecessarily unconscious or dead.

13. Prescribing opiates outside the guidelines

i. The Panel heard evidence from both medical experts and from a number of consultants and other medical staff that in order to relieve pain they had had occasion to prescribe opiates at levels which exceeded the guidelines contained in publications such as the BNF and the Wessex Protocol, sometimes at very high doses.

ii. It was generally accepted that such a course may be justified, and that, within reasonable limits and in the absence of other evidence, it is a matter for the judgment of the clinician on the ground who is frequently best able to assess whether the analgesic needs of the patient in question require it.

iii. The general view appeared to be that departures from the guidelines were exceptional rather than routine. However it appeared to the Panel that when placing patients on syringe driver you routinely prescribed outside those guidelines in order to ensure that the patient would not experience pain.

iv. You told the Panel that you were familiar with the guidelines in both the BNF and the Wessex Protocol. However, when asked about judging accurately a patient's needs for analgesics Professor Sikora told the Panel that "the only way is to be with the patient and see what happens after a given dose of an analgesic ... is given." In your experience, you told the Panel, the doses you prescribed were necessary if the anticipated analgesic needs of the patient were to be met.

v. The Panel also heard and accepted evidence from Professor Sikora that the response to opiates varied widely from patient to patient and that "that is why the teaching is '*Look at the patient and see what happens*', rather than use any pre-conceived dosage or formula."

vi. The Panel noted that the evidence indicated that it was also accepted that when clinicians deliberately depart from the guidelines it is important that they record in the medical notes precisely what they have done and their reasons for doing so.

vii. Mr Langdale advanced the view that in the absence of such a note, no Panel could properly form the view that you had acted inappropriately. The Panel concluded that in deciding specific allegations that you had prescribed inappropriately they were required to review all the evidence and then ask themselves whether they could be sure on the basis of that evidence that you had prescribed inappropriately.

14. Anticipatory prescribing and the delegation of powers

i. The Panel heard a great deal of evidence about anticipatory prescribing and the delegation of powers. It heard that the practice of prescribing a drug in anticipation that it might be required, but before it is actually required is not uncommon, especially in the management of pain. The justification for such a practice is said to be that, if and when the immediate administration of the prescription becomes necessary, nursing staff have the discretion to administer it without having to wait for a doctor to respond to a call to come to prescribe it. If it is never required it is never administered.

ii. The value of such a practice in the swift treatment of pain is obvious. The Panel heard evidence from both Professors Ford and Sikora, as well as from the consultants who gave evidence, that they had all engaged in anticipatory prescribing.

iii. It was acknowledged that one risk attendant on anticipatory prescribing is that nursing staff might decide to administer the prescription at a time when it was not clinically justified.

iv. It was further acknowledged that this risk became of particular significance on Dryad and Daedalus wards when the prescription included variable doses of a mix of Diamorphine and Midazolam to be delivered by syringe driver. As previously noted, it was generally accepted that the starting of a syringe driver loaded with such a mix was a clear indication that the patient was now on the terminal pathway and expected to die in a matter of days. Further, and also as previously noted, Mr Kark advanced the view that one means of providing patients with some safeguard against the inappropriate administration of such a prescription would have been the provision of clear written instructions.

v. There was some inconsistency in the evidence as to the extent to which nursing staff on Dryad and Daedalus would seek approval from medical staff before starting a patient on syringe driver, and the Panel received evidence of occasions when syringe drivers had been started at the sole discretion of nursing staff. In any event, you gave clear evidence that you trusted your nursing staff to exercise their discretion appropriately, and that while you would expect them to seek approval, in the event that they were unable to reach a doctor to obtain that approval it was "their prerogative" to proceed without it.

vi. The Panel heard that the risk of inappropriate exercise of discretion to administer a prescription generally was adequately safeguarded by the fact that drugs could only be administered by two fully qualified nurses working together; and that the nurses on Dryad and Daedalus were of a calibre that rendered the risk acceptable.

vii. The Panel also heard that it was not unusual for anticipatory prescribing to allow for a range of doses. The reason for this was to enable the trained nurses administering the drug(s) to exercise their discretion as to the dose currently required by the patient

before them. The Panel heard that it was usual for nurses to begin administration of a prescription by starting at the lowest dose prescribed, though it was accepted that they were able to administer at a higher rate if they determined that it was appropriate to do so; and the Panel received evidence of occasions when they did so.

viii. The Panel noted with concern your apparent assumption when prescribing on an anticipatory basis that the required dose would increase. As a consequence the lowest dose prescribed by you in an anticipatory range would be set at a higher level than whatever was the current dose at the time of prescription, despite the fact that when you wrote the prescription you had no way of knowing when it would be administered. The Panel has seen from the specific cases with which it is concerned that the delay between prescription and administration could be anything from a matter of hours to a matter of days.

ix. *It follows that the danger was if at the time of administration the prescribed minimum* dose was too high that excessive dose was likely to be administered anyway. Indeed, if the nurses were to form the view that the lowest dose in the variable range was too high, in the anticipated event that they were unable to obtain assistance from a doctor, their choice of action was limited to not administering the medication at all or administering it at what they judged to be too high a dose. In the Panel's view, the appropriate safeguard would have been for you, whenever you were anticipatorily prescribing a variable range of diamorphine, to match the lowest dose in the range to the equivalent of the dose the patient was on at the time of prescription. In the case of an opiate naïve patient, the Panel accepted Professor Ford's view that a prescription in line with the Analgesic Ladder referred to at paragraph 9 above would be appropriate.

x. So far as the prescription of Midazolam in combination with Diamorphine is concerned, the Panel noted that both drugs have a sedative effect and that particular care should be exercised to take account of this when prescribing them in combination.

xi. The Panel accepted Professor Ford's view that in anticipatory prescribing a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide.

xii. You told the Panel that, where a dose of subcutaneous analgesia was not controlling the pain or other symptoms, you would in general terms follow the practice of "doubling up". The Panel noted that this would be almost certain to prevent the manifestation of breakthrough pain. However, it also greatly increased the risk of over-sedation and adverse side-effects.

xiii. In the Panel's view, this practice demonstrated your approach to protecting patients from pain even at the cost of protecting them from over-sedation and adverse side-effects.

xiv. Mr Langdale advanced the argument that although you admitted that there were occasions when the range of doses you had prescribed was too wide, the doses actually administered never reached the highest dose that the prescriptions allowed for, and were frequently a good deal lower. The Panel takes the view that while this was fortunate, the fact remains that this method of prescribing gave rise to the risk that the highest doses could be administered. This is a matter which the Panel is obliged to take into account when considering the appropriateness of the prescribing and whether or not it was in the best interests of the patient.

15. Syringe Drivers

i. The Panel received a great deal of evidence on this subject. The Panel heard that syringe drivers are used to deliver a wide variety of medications, both in the community and in hospitals. It concluded that their principal value lies in the fact that they are capable of delivering medication at a continuous and even rate over periods of up to 24 hours per load. This is particularly important in cases where, for whatever reason, oral medication is not appropriate. This is because the use of a syringe driver:

a) spares patients the discomfort and inconvenience of four hourly injections and
b) in the relief of pain, avoids the 'peaks and troughs' associated with a regular but discontinuous course of injections.

ii. The Panel found that the use of syringe drivers on Dryad and Daedalus wards at the time in question had particular significance because of two factors:

a) They tended to be loaded with combinations of drugs which included Diamorphine and Midazolam, frequently at starting doses of 20 mg of each, (with doses routinely doubling every 24 hours.)
b) There were no facilities on either ward for intra-venous hydration, and the reality was that patients who were unable to swallow, whether because they were unconscious or otherwise, did not receive hydration. Continued lack of hydration would ultimately lead to death.

iii. It was in this context that medical and nursing staff on these wards recognised that starting a patient on a syringe driver was an acknowledgment of the fact that the patient was now on a terminal pathway and not expected to live beyond a matter of days.

16. Syringe drivers and the immediate relief of pain

i. The Panel heard that such use of syringe drivers was not an effective means of providing immediate analgesia because the continuous rate of infusion meant that it would take some hours before the amount of analgesia in the patient's blood stream would reach the optimum level at which it would then be maintained. Professor Ford told the Panel *`if a patient is not already stable on a previous dose of oral morphine or injected subcutaneous morphine or diamorphine you will not see the full effect of that infusion until quite some time later, twenty hours or more.'*

ii. You expressed surprise that there should be such a delay. You told the Panel that your experience was that on your usual dosing Diamorphine / Midazolam mixes took effect a lot quicker than that.

iii. When asked about the potential for dealing with immediate pain by single injection rather than by placing the patient directly onto a syringe driver you told Mr Kark: "I was not in the habit of using intramuscular or subcutaneous Diamorphine in that way."

Mr Kark replied: "Instead of which what you effectively did was you handed the nurses the power to start the path for this lady's death."

Your response: 'I did.'

17. Titration and the use of syringe drivers

i. Professor Ford told the Panel that to ensure a patient did not suffer during the syringe driver's build-up period it was necessary to provide additional alternative analgesia first.

ii. The Panel heard that, depending on the circumstances, opiates could be delivered by a variety of routes:

- Orally (eg liquid Oramorph which will reach peak effect between 30 to 60 minutes, or sustained release tablets which will reach peak effect in a matter of hours)
- Trans-dermally (eg Fentanyl patch which will reach peak effect after about 24 hours)
- Intra-venously (eg morphine injection which will reach peak instantly)
- Intra muscularly or subcutaneously (eg Diamorphine injections which will reach peak between about 15 and 30 minutes, or syringe driver which will peak after 20 hours or more)

iii. In Professor Ford's view:

- When treating an opiate naïve patient, the first issue would be establishing the level of analgesia required to render the patient pain free whilst remaining alert and free of adverse side effects. This could most effectively be achieved by means of titration i.e. treating the patient with a series of escalating doses and observing the effect until a daily dose which completely controlled the pain was found. Ideally this might be through the use of Oramorph, but where oral opiates were not an option individual injections could be used. Once the correct level of analgesia is established a starting dose or bolus could then be administered to cover the delay in the syringe driver taking full effect.

- When treating a patient already receiving opiates, the first issue would be to determine the equivalent dose for delivery by syringe driver. This would be done by reference to the conversion charts in the BNF or Wessex Protocol. The second issue would be how to achieve the transition from the existing delivery method to the syringe driver without either increasing or decreasing the level of analgesic cover during the period of transition. This would require calculations to be made based on a comparison between the start up times of the driver and the end of efficacy times of the previous analgesia. The Panel heard evidence that nursing staff were equipped with the appropriate conversion charts and so would have been capable of calculating and delivering the appropriate dose.

iv. When asked by Mr Kark about the need for titration prior to commencing a syringe driver, Professor Sikora said "That would be the ideal situation to go for; to have either oral morphine or long-acting morphine, or in four-hour injections, work out over a two or three day period what the dose is, set that and then give the subcutaneous morphine." He stated that, unless you did that, there was a serious danger that you are either going to start too low or too high.

v. By contrast, you evinced a marked reluctance to titrate doses before commencing patients on syringe drivers. You told the Panel, "we simply did not have the level of staffing to do that on a ward of 24 people."

When pressed by Mr Kark you said that your patients did not suffer from a lack of

nurses but that "they would have if two trained staff had been tied up titrating and drawing up and giving injections of Diamorphine, even every four hours, let alone every hour."

You also accepted that titrating doses is a basic standard medical principle.

Mr Kark asked you: "And you are saying that under your watch that simply was not being done throughout these three years?"

You replied: "I am saying that. I was not taught it. I was not familiar with using it....it was not practical....it just was not feasible."

18. The effect of staffing pressures on your prescribing practice.

i. The Panel received evidence from a wide range of witnesses that the impression given to the visitor to Dryad and Daedalus wards was that the wards were well run and that patients were taken good care of. You were full of praise for your nursing staff and the job they did. You were clear that the quality of nursing care that your patients received was not compromised by staffing pressures: you stated that opiates were never started earlier, or at a higher rate, because of inadequate staffing; you told the Panel that that would have been quite inappropriate. Your view on the effect of staffing pressures was borne out by Sister Joines and a large number of other witnesses.

ii. In terms of your own prescribing practices however, you told the Panel that staffing pressures did have some effect. You told the Panel that, in addition to reducing the time you had available to make notes in patient records, your system of anticipatorily prescribing wide ranges of opiates for delivery by syringe driver with what some might view as a high starting dose, and in the absence of titration, was a direct and necessary result of staffing pressures.

iii. Mr Langdale asked Professor Sikora: "What effect does ... reduction of staff levels in terms of the availability of numbers and time have on the choices available to a doctor in Dr Barton's position with regard to the pharmacological route?"

He replied: "It means there is not going to be the level of observation that would, perhaps, be optimal on an individual patient in distress and pain. Therefore using the pharmacological route at a higher dose, starting dose and a higher upper limit, would seem a reasonable proposition under those circumstances." The Panel noted that such a strategy might conversely create the need for a higher level of observation if patients are to be adequately protected in the event that adverse consequences manifest themselves.

19. The role of consultants

The Panel heard that, at the time in question, the presence of consultants on Dryad and Daedalus wards was extremely limited. Although the consultants who gave evidence before the Panel were supportive of you, their evidence tended to suggest that they had not critically examined your prescribing practice, and in many instances had not appreciated your admitted prescribing failures. Had they done so, this should have resulted in appropriate changes being made to your prescribing practice.

20. Mr Langdale's argument that the very fact that senior medical staff and the visiting pharmacist did not object indicated that you were doing nothing wrong

i. As stated above, the Panel took the view that the consultants on the ward systematically failed to critically examine your prescribing practice. While the effect of this failure might have been to reinforce your view that you were not acting inappropriately, it in no way rendered your inappropriate conduct appropriate. The Panel noted that as a medical practitioner you retained ultimate responsibility for your own actions.

ii. In respect of the pharmacist, the Panel has not had the advantage of receiving any evidence from her. In the circumstances the Panel is unable to draw any conclusions with respect to your actions or inactions as a consequence of her actions or inactions. However, the Panel noted your admissions with regard to your own prescribing deficiencies, and that it has heard no evidence that these were detected and acted upon by the pharmacist.

21. The principle of double effect

i. The Panel heard from Professor Ford that: "The principle of double effect is that one may need to palliate symptoms, and that the treatment one needs to give to palliate symptoms may lead to a shortening of life through adverse effects. That is well accepted as being a reasonable and appropriate aspect that may happen when one adequately palliates symptoms."

ii. Professor Ford told the Panel: "One has to give drugs and doses that are reasonable and appropriate to palliate symptoms. Then, with certain groups of drugs like sedatives, the issue is giving excessively high doses which have an effect which go beyond what the patient needed to palliate their symptoms."

iii. The Panel has examined, in respect of each patient, the issue of the prescribing of drugs which have or might have an effect which goes beyond what the patient needed to palliate their symptoms. The Panel noted that the importance of this issue is partly explained by Professor Ford's evidence on sedation therapy.

iv. Professor Ford told the Panel that: "Sedation therapy, it has been commented, is open to misuse – I am not saying it was misused, but the problem is, because they are so powerful at producing respiratory depression, one systematic review of sedation in end of life care comments that it can ostensibly be used to relieve distress but with the manifest intent of hastening death. I am not saying that was the intent here, I am saying that is the concern about why one needs to document very carefully the use of sedation in an end of life setting, that it is used appropriately to control patients' symptoms."

v. The Panel considered that the importance of this issue is further explained by the view that in addition to the right to be provided with appropriate analgesia, the patient has a balancing right to be kept as alert and conscious as proper management of their pain allows. On the issue of balancing the need to be pain-free with the ideal of being free from side-effects, Professor Sikora told the Panel: "...usually it is achievable, to get pain-free without troubles from the side effects of the medication - including over-sedation side effects – by judicious use of the drugs..."

vi. You were clearly aware of the principle of double effect. For example:

a. Mr Langdale asked you in relation to your treatment of Patient A: "What about the concern that this (high dose) was going to cause respiratory depression or lowering his conscious level?"

You replied: "I accepted that that was a price that we might have to pay in exchange for giving him adequate pain and symptom relief."

Mr Langdale asked "Why not leave it because of the risk of it having an adverse effect?"

You replied: "At that point I was not concerned about any potential adverse effect. I wanted **Code A** comfortable and free of all these wretched symptoms."

b. With regard to Patient B you told the Panel: "The judgment is that I wanted to give her adequate pain relief and relief of her symptoms, of what were now becoming terminal restlessness, so I was minded to give her adequate analgesia and sedation to control those, and I was accepting that she might well be over-sedated."

c. With regard to Patient C you were asked whether there was any risk of over-sedation or respiratory depression because of the declining effects of Fentanyl.

You replied: "There would always [be] a risk. I was prepared to accept that risk in order to give her adequate analgesia and to add in the Midazolam. I thought that the risk was acceptable in this particular patient."

With respect to Patient B Mr Langdale asked you why you did not reduce the level of medication so that while managing your patient's pain you also kept her alert.

Your response was: "More alert to feel more pain."

vii. The Panel took the view that this final response gave a clear insight into how you viewed the desirability of balancing pain relief with the desirability of keeping the patient as free as practicable from the side effects of opiates.

PART TWO

At the outset of the hearing, Mr Langdale admitted a number of parts of the allegation on your behalf and the Panel found them proved.

In respect of the unadmitted parts of the allegation, the Panel has considered all of the evidence and has taken account of Mr Kark's submissions on behalf of the GMC and those made by Mr Langdale on your behalf.

The Panel has borne in mind that the burden of proof rests on the GMC and that the standard of proof applicable in these proceedings is the criminal standard, namely that the Panel must be sure beyond reasonable doubt.

Having considered each of the remaining allegations separately, the Panel has made the following findings:

Head 1 has been admitted and found proved.

Code A **(Patient A)**

Head 2a in its entirety has been admitted and found proved.

Head 2b i in relation to head 2a ii (in relation to Diamorphine only, as Midazolam was not prescribed) has been found proved.

The Panel has accepted the evidence of Professor Ford that the appropriate lowest dose in the range for this opiate naïve patient would at this stage have been 15 mg of Diamorphine. The lowest dose of Diamorphine that you prescribed was 40 mg.

Head 2b i in relation to head 2a iii in relation to the Diamorphine has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of analgesia provided for in the existing prescription and was therefore too high.

Head 2b i in relation to head 2a iii in relation to the Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Head 2b ii in relation to head 2a ii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 2b ii in relation to head 2a iii has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 2b iii has been admitted and found proved.

Head 2c has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person on both occasions and exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the doses administered were excessive to the patient's needs.

Head 2d has been found proved.

The Panel noted paragraphs 12 i and 14 x above which indicate that great care should be exercised in prescribing Diamorphine and Midazolam in combination, as both have sedative effects. The Panel also notes that this prescription contained a combination of Diamorphine, Midazolam, Haloperidol and Nozinan. The Panel notes your admission that, as Haloperidol and Nozinan both have sedative effects, you should have discontinued the Haloperidol when you introduced the Nozinan.

Heads 2e i – iii in relation to head 2a ii have been found proved.

In the light of the Panel's findings that the lowest prescribed dose of Diamorphine was too high and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that this prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 2e i and iii in relation to head 2a iii have been found proved.
Head 2e ii in relation to head 2a iii has been admitted and found proved.

Having found that the lowest doses prescribed were too high, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and your having admitted and the Panel having found that the prescription was potentially hazardous, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

Heads 2e i and iii in relation to head 2a iv have been found not proved.
Head 2e ii in relation to head 2a iv has been found proved.

Heads 2e i and iii in relation to head 2a v have been found not proved.
Head 2e ii in relation to head 2a v has been found proved.

Given that the charge relating to the doses of Diamorphine administered on both 15 and 17 January 1996 was not found proved the Panel could not be sure that the prescription was either inappropriate or not in the best interests of Patient A although,

by the nature of the prescription, the Panel did conclude that it was potentially hazardous.

Heads 2e i – iii in relation to head 2a vi have been found proved.

Having found that the prescription of 18 January 1996, in combination with other drugs already prescribed, was excessive to the patient's needs and, given the sedative effect of the prescribed drugs in combination, the Panel was satisfied that the prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Elsie Lavender (Patient B)

Heads 3a i – iv in their entirety have been admitted and found proved.

Head 3b i in relation to head 3a iii in relation to the Diamorphine has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the level of analgesia the patient was on at the time of prescription, and was therefore too high.

Head 3b i in relation to head 3a iii in relation to the Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Diamorphine has been found not proved.

The Panel had regard to paragraph 13 above, in respect of prescribing outside the guidelines. The Panel noted that you attended the patient in person prior to issuing this prescription, and that you exercised your own clinical judgment in assessing the appropriate dose. Having reviewed all the evidence, the Panel cannot be sure that the lowest dose prescribed was too high.

Head 3b i in relation to head 3a iv in relation to the Midazolam has been found proved.

In reaching this finding, the Panel has accepted Professor Ford's evidence that Midazolam is not indicated for pain. Further, the Panel reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 x above in relation to the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Heads 3b ii and iii have been admitted and found proved.

Heads 3c i - iii in relation to head 3a ii have been found not proved.

The Panel noted Professor Ford's opinion that the prescription of Morphine Slow Release Tablets (MST) 10 mg twice a day might be acceptable. Accordingly, the Panel could not be sure that this prescription was inappropriate, potentially hazardous and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iii have been found proved.
Head 3c ii in relation to head 3a iii has been admitted and found proved.

On 26 February 1996 you increased the prescription for MST from 10 mg to 20 mg twice a day and prescribed a variable dose combination of Diamorphine and Midazolam on syringe driver. The Panel considers that the increased dose of MST was in itself high. The Panel has noted that at the outset of the hearing you admitted that this

prescription was too wide, potentially hazardous and created a situation whereby drugs could be administered which were excessive to the patient's needs. Further, and having regard to paragraphs 11 – 14 above, in relation to the prescription of opiates, their side-effects and effect in combination with Midazolam, the Panel is satisfied that your actions in issuing this prescription were inappropriate and not in the best interests of Patient B.

Heads 3c i and iii in relation to head 3a iv have been found proved.
Head 3c ii in relation to head 3a iv has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above in relation to prescribing opiates outside the guidelines and the effects of opiates in combination with Midazolam. In addition, you admitted that your prescription for Diamorphine and Midazolam in combination was too wide, was potentially hazardous, and created a situation whereby drugs could be administered which were excessive to the patient's needs. Accordingly the Panel has found that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Head 3d i has been found not proved.

In reaching this finding, the Panel noted Mr Kark's concession in his closing submissions that Professor Ford found no fault with your management of the patient at the time of her admission and that your examination of her was appropriate.

Head 3d ii has been found proved.

The Panel accepted Professor Ford's view that you should have addressed the question of the cause of pain complained of by the patient. Your continuing failure to address the reason why she was experiencing pain rendered your assessment of her, as her condition deteriorated, inadequate.

Head 3d iii has been found not proved.

The Panel has noted that you saw the patient's family on 26 February 1996 and that they were aware of your assessment that she was now on the terminal pathway. Other than this, your clinical notes did not include a treatment plan beyond the need for a Pegasus mattress and analgesia if necessary. Nonetheless, whether adequate or not, there was a treatment plan.

Head 3d iv has been admitted and found proved.

Heads 3e i and ii have been found proved.

In the light of the Panel's multiple findings against you in relation to your management of the patient, the Panel concluded that your actions and omissions were inadequate and not in the patient's best interests.

Heads 14a i - iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Eva Page (Patient C)

Heads 4a and b in their entirety have been admitted and found proved.

Heads 4c i and iii have been found proved.
Head 4c ii has been admitted and found proved.

The Panel has had regard to paragraphs 12, 14 x, 16 and 17 above in relation to the combination of Diamorphine and Midazolam and the use of syringe drivers. In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient. The Panel further noted that at the time you made this prescription you had also prescribed a Fentanyl patch.

Heads 14a i –iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.

Head 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Alice Wilkie (Patient D)

Heads 5a and b in their entirety have been admitted and found proved.

Heads 5c i and iii have been found proved.
Head 5c ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

Further, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads14b i and ii have been admitted and found proved.

Heads 15a and b have been found proved.

The Panel has received no documentary evidence to indicate that you assessed this opiate naïve patient prior to prescribing opiates. You told the Panel that you could not be sure that you had formally assessed the patient as you might have been away around that time. You told the Panel that on your return to the ward on about 17 August

1998 that "we had mayhem occurring", and that though you might have seen the patient, you would have relied on the verbal reporting of assessments made by nursing staff. It follows that this prescription to an opiate naïve patient was not based on an appropriate assessment by you, and that your failure was not in the patient's best interests.

Mrs Gladys Richards (Patient E)

Heads 6a and b in their entirety have been admitted and found proved.

Heads 6c i – iii in relation to head 6a ii have been found proved.

You conceded that although this patient had experienced an earlier adverse reaction to Morphine, she was effectively opiate naïve on admission to Daedalus ward on 11 August 1998. At this time her pain was being managed by Co-codamol. Accordingly the Panel had regard to paragraphs 9 and 14 ix above as to guidelines and the Analgesic Ladder and the equivalence of doses, and accepted the view of Professor Ford that you should have followed the Analgesic Ladder in prescribing for this patient.

Heads 6c i and iii in relation to head 6a iii have been found proved.
Head 6c ii in relation to head 6a iii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing. The Panel accepted Professor Ford's view that you should have followed the Analgesic Ladder in prescribing for this patient.

In addition, the Panel noted that you admitted that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Ruby Lake (Patient F)

Heads 7a and b in their entirety have been admitted and found proved.

Head 7c i in relation to head 7a ii has been found not proved.

The Panel noted that you prescribed Oramorphine in response to complaints of pain by an opiate naïve patient. The Panel further noted that it is your view that this was justified as you considered her to be exhibiting symptoms of congestive cardiac failure. In the circumstances, the Panel could not be satisfied that this prescription was inappropriate.

Head 7c ii in relation to head 7a ii has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing. The Panel noted that by its very nature, any prescription of opiates is potentially hazardous.

Head 7c iii in relation to head 7a ii has been found not proved.

The Panel concluded that the prescription may by its nature be potentially hazardous, but nonetheless in the best interests of the patient, and not inappropriate. That was the case here.

Heads 7c i and iii in relation to head 7a iii have been found proved.
Head 7c ii in relation to head 7a iii has been admitted and found proved.

You admitted that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous. In the circumstances, the Panel concluded that this prescription was inappropriate and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mr Arthur Cunningham (Patient G)

Heads 8a and b have been admitted and found proved.

Heads 8c i and iii in relation to head 8a ii have been found proved.
Head 8c ii in relation to head 8a ii has been admitted and found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

In addition, the Panel noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription was potentially hazardous.

Heads 8c i and iii in relation to head 8a iii have been found proved.
Head 8c ii in relation to head 8a iii has been admitted and found proved.

The Panel had regard to paragraphs 12 – 14 above as to combining Diamorphine and Midazolam, prescribing opiates outside the guidelines, and anticipatory prescribing, and noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that your actions in prescribing the drugs were potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing these drugs were inappropriate and not in the best interests of the patient.

Head 8d has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mr Robert Wilson (Patient H)

Head 9a in its entirety has been admitted and found proved.

Heads 9b i, ii and iv in relation to head 9a ii have been found proved.
Head 9b iii in relation to head 9a ii has been found not proved.

The Panel noted that this was a prescription for immediate administration, and the Panel had regard to paragraph 13 above with reference to prescribing opiates outside the guidelines. The Panel noted however that the patient's alcohol related liver disease fundamentally altered the prescribing situation. The Panel accepted Professor Ford's view that "best practice would have been to go through the Analgesic Ladder through a moderate opioid to begin with, with paracetamol ..."

The Panel further accepted Professor Ford's view that, if Oramorphine became appropriate, it would have been important to have started with a low dose, bearing in mind the increased risks the prescription of opiates posed to a patient with alcohol related liver disease.

In all the circumstances the Panel concluded that the prescription at this time was:

- inappropriate;
- potentially hazardous in that it had the potential to lead to serious and harmful consequences for the patient. The Panel was unable to be sure however that the prescription was likely to lead to serious and harmful consequences for the patient;
- not in the best interests of the patient.

Head 9c in its entirety has been admitted and found proved.

Heads 9d i – iii in relation to head 9a ii have been found proved.

The Panel relies on its findings above in relation to heads 9b i – iii.

Heads 9d i and iii in relation to head 9a iii have been found proved.
Head 9d ii in relation to head 9 a iii has been admitted and found proved.

At the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. The Panel had regard to paragraph 14 ix above concerning equivalence of doses, and applying the appropriate conversion rate, noted that the anticipatory prescription did provide for an increase in the lowest level of analgesia, and was therefore too high. The Panel further noted your admissions in relation to your prescription that the dose range was too wide, the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drug was potentially hazardous.

Heads 9d i and iii in relation to head 9a iv have been found proved.
Head 9d ii in relation to head 9 a iv has been admitted and found proved.

The Panel concluded that in the light of the patient's alcohol related liver disease the prescription of even a small amount of Midazolam was inappropriate and not in the best interests of the patient, especially given that the patient had already been prescribed a significant dose of Diamorphine. The Panel further noted your admission that your actions in prescribing Midazolam were potentially hazardous.

Head 9e has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Enid Spurgin (Patient I)

Head 10a in its entirety has been admitted and found proved.

Head 10b in its entirety has been found not proved.

The Panel noted that Dr Reid had assessed the patient shortly before her transfer to the ward. The Panel also noted Professor Ford's view that it would not have been necessary for you to investigate the cause of the patient's pain at the time of admission; albeit that he felt such an investigation would have been necessary at a later stage. In the circumstances, the Panel could not be satisfied that your assessment of the patient on admission was either inadequate or not in her best interests.

Head 10c in its entirety has been admitted and found proved.

Heads 10d i and iii in relation to head 10a ii have been found proved.
Head 10d ii in relation to head 10a ii has been admitted and found proved.

In the light of your admission that the dose range of Diamorphine and Midazolam was too wide, that its prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your actions in prescribing them were potentially hazardous, the Panel found that your actions in prescribing them were also inappropriate and not in the best interests of the patient.

Heads 10e i – iii in relation to head 10a iii have been found proved.

The Panel had regard to paragraph 13 above relating to prescribing opiates outside the guidelines. However, it noted that when Dr Reid saw this patient on his ward round, he observed that she was over-sedated and that the width of dosage range was too wide. He ordered the dosage of Diamorphine to be reduced by 50%. In the circumstances the Panel was sure that the dosage authorised/directed by you was excessive to the patient's needs and was inappropriate, potentially hazardous and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mr Geoffrey Packman (Patient J)

Head 11a in its entirety has been admitted and found proved.

Head 11b i in relation to head 11a v in relation to the Diamorphine has been found not proved.

The Panel noted that, at the time of this anticipatory prescription, the patient was already subject to a prescription for analgesia. Having regard to paragraph 14 above concerning equivalence of doses, and applying the appropriate conversion rate, the Panel calculated that the anticipatory prescription did not provide for an increase in the equivalent level of analgesia provided for in the existing prescription, and was not therefore too high.

Head 11b i in relation to head 11a v in relation to Midazolam has been found proved.

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs 12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

Heads 11b ii and iii have been admitted and found proved.

Heads 11c i – iii in relation to head 11a ii have been found not proved.

Professor Ford was not critical of you for giving verbal permission for 10 mg of Diamorphine to be administered to the patient on 26 August 1999. In his closing submissions, Mr Kark conceded that in the light of Professor Ford's concession in respect of this head, the Panel might think it appropriate that it should fall. The Panel accepted that view.

Heads 11c i and iii in relation to head 11a v have been found proved.
Head 11c ii in relation to head 11a v has been admitted and found proved.

The Panel has found that the lowest dose of Midazolam prescribed was too high, and you have admitted that the dose range of Diamorphine and Midazolam was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, and that your action in prescribing the drugs was potentially hazardous. In all the circumstances, the Panel concluded that your actions in prescribing the relevant drugs were inappropriate and not in the best interests of the patient.

Heads 11d i and ii in relation to head 11a iv have been found proved.

The Panel had regard to paragraph 2 iv above in relation to investigating the patient's condition. It noted Professor Ford's view that "...there would have to be a clear senior decision in a man like this ... to make a decision not to undertake active intervention for his problem...".

The Panel noted with concern your assertion that it would have made no difference to this patient's care/condition if you had obtained further medical advice and/or undertaken further investigations. In the Panel's view you should have done both before making the decision to put the patient onto the syringe driver. Accordingly, the Panel has concluded that your failure was inappropriate and not in the patient's best interests.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Elsie Devine (Patient K)

Head 12a in its entirety has been admitted and found proved.

Head 12b has been found proved.

This was an anticipatory prescription for an opiate naïve patient, and the Panel had regard to paragraphs 9 -14 above in relation to guidelines and the Analgesic Ladder, the use of opiates and their side-effects, and anticipatory prescribing.

The Panel noted Professor Ford's view that your prescription was not justified in the light of the patient's presenting symptoms, i.e. confused and agitated but no complaint of pain. The Panel accepted his view that if there were to be an anticipatory prescription for this opiate naïve patient, 2.5 mg would be the appropriate starting dose and 10 mg would be high. In all the circumstances, the Panel concluded that this prescription was not justified.

Head 12c i in relation to head 12a iv has been found proved.

The Panel noted that there had been no attempt at titration, and that even the lowest doses of Diamorphine and Midazolam would have been likely to induce a very powerful sedative effect with a consequent risk of respiratory depression.

The Panel had regard to paragraphs 11, 13 ii, 16 and 17 above in relation to the side-effects / adverse consequences of opiates, prescribing opiates outside the guidelines, and the use of syringe drivers. The Panel accepted Professor Ford's view that the lowest doses of Diamorphine and Midazolam would have had a profoundly sedating effect, especially in combination with the Fentanyl which was already prescribed. Professor Ford told the Panel that when the syringe driver started the level of Fentanyl already in the patient's blood stream would have been at its peak. The Panel took the view that, as a consequence, this prescription put the patient at severe risk of respiratory depression, coma and premature death. The Panel noted that the patient lapsed into unconsciousness shortly after the syringe driver commenced at 09:25 on 19 November and that she remained unconscious until her death at 20:30 on 21 November.

Head 12c ii in relation to head 12a iv in relation to Diamorphine has been found not proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range did not offend against that principle.

Head 12c ii in relation to head 12a iv in relation to Midazolam has been found proved.

The Panel noted its acceptance at paragraph 14 xi above of Professor Ford's view that a dose range which allowed for an increase of more than 100% from the lowest to the highest parameter was too wide. This dose range offended against that principle.

Head 12c iii in relation to head 12a iv has been found proved.

It follows from the Panel's finding that the lowest doses of Diamorphine and Midazolam prescribed were too high that your prescribing created a situation whereby drugs could be administered which were excessive to the patient's needs.

Heads 12d i – iii in relation to head 12a ii have been found proved.

In the light of the Panel's finding that your prescription of Morphine solution was not justified, the Panel concluded that your actions in prescribing it were inappropriate, potentially hazardous (by the very nature of the drug prescribed) and not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iii have been found proved.

The Panel accepted Professor Ford's view that, given the patient's condition, especially her dementia, and the potential side-effects of Fentanyl on such a patient, made it an inappropriate and potentially hazardous prescription which was not in the best interests of the patient.

Heads 12d i – iii in relation to head 12a iv have been found proved.

The Panel having found that the lowest doses of Diamorphine and Midazolam prescribed were too high, that the dose range in respect of the Midazolam was too wide, and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that your actions in prescribing these drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 12e has been admitted and found proved.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

Mrs Jean Stevens (Patient L)

Head 13a has been admitted in its entirety and found proved.

Head 13b i in relation to head 13a ii has been found proved.

The Panel noted that, at the time of this anticipatory prescription, the patient had already been receiving low levels of opiates. The Panel had regard to paragraph 14 ix above in relation to equivalence of doses, and applying the appropriate conversion rate, calculated that the anticipatory prescription provided for an increase in the equivalent level of opiates which the patient had already been receiving. Consequently, there was insufficient clinical justification for this prescription of the opiates.

With regard to the anticipatory prescription for Midazolam, the Panel noted Professor Ford's view that there was no clear evidence that the patient was suffering terminal restlessness. Further, the Panel had regard to paragraphs 12 and 14 x above concerning the caution required before prescribing Midazolam for a patient who was already receiving opiates. The Panel concluded that in light of the inherent dangers in prescribing Midazolam in conjunction with opiates, and its acceptance of the view that there was no clear evidence that the patient was suffering from terminal restlessness, there was insufficient clinical justification for the prescription of Midazolam.

Heads 13b ii and iii in relation to head 13a ii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a ii have all been found proved, save for head 13b iv b which in relation to Diamorphine has been admitted and found proved.

You admitted and the Panel found proved that the dose range of Diamorphine and Midazolam was too wide, that the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs, and that the prescription of the Diamorphine was potentially hazardous. The Panel further found that there was insufficient clinical justification for the prescriptions. In all the circumstances, the Panel concluded that your actions in prescribing the drugs were inappropriate, potentially hazardous and not in the best interests of the patient.

Head 13b i in relation to head 13a iii has been found proved

The Panel having found that there was no clinical justification for the 20 May prescription of Oramorphine, and there being no evidence of relevant change in the patient's condition at the time of this regular prescription for Oramorphine, it follows that there was insufficient clinical justification for this prescription also.

Heads 13b ii and iii in relation to head 13a iii have been admitted and found proved.

Heads 13b iv a – c in relation to head 13a iii have been found proved.

You admitted and the Panel found proved that this prescription created a situation whereby drugs could be administered which were excessive to the patient's needs. The Panel further found that there was insufficient clinical justification for this prescription. In all the circumstances, the Panel concluded that your action in prescribing the Oramorphine was inappropriate, by its nature potentially hazardous, and not in the best interests of the patient.

Heads 14a i – iii have been admitted and found proved.

Head 14a iv has been found proved.

The Panel has had regard to paragraph 7 above as to the desirability of a sufficiently recorded drug regime. You told the Panel that you did not note such details of the drug regime on patient records for the guidance of nursing staff.

Heads 14a v and vi have been admitted and found proved.
Heads 14b i and ii have been admitted and found proved.

Heads 15a and b have been found not proved.

In view of the paucity of evidence in this regard, to which your own poor record keeping contributed, the Panel could not be sure as to the appropriateness or otherwise of any assessment which you may have carried out.

In the light of the Panel's finding on head 15a it follows that head 15b must fall.

PART THREE

The Panel has made multiple findings that your conduct has been inappropriate, potentially hazardous and/or not in the best interests of your patients. It has concluded that the facts found proved (both admitted and otherwise) would not be insufficient to support a finding of serious professional misconduct.

The Panel will invite Mr Kark to adduce evidence, if he wishes to do so, as to the circumstances leading up to the facts which have been found proved, the extent to which those facts indicate serious professional misconduct on your part and as to your character and previous history. The Panel will then invite Mr Langdale to address it on your behalf in relation to those matters and also to adduce evidence in mitigation, if he wishes to do so. Counsel should refer to the GMC's Indicative Sanctions Guidance (April 2009 edition, with 7 August 2009 revisions) when making submissions in relation to sanction.

Thereafter, the Panel will proceed to consider whether you have been guilty of serious professional misconduct in respect of the facts that have been found proved and, if so, they will go on to consider whether or not they should make any direction regarding your registration.