20 July 2009

Misconduct GP to stay on register : A doctor who prescribed "potentially hazardous" levels of drugs to elderly patients who later died has escaped being struck off.

Dr Jane Barton will be allowed to continue working under certain conditions despite being found guilty of serious professional misconduct.

She was accused of a series of failings in her care of 12 patients at Gosport War Memorial Hospital in the 1990s.

Relatives and the General Medical Council criticised the panel's ruling.

Family members of those who had died shouted at the fitness to practise panel when the decision was delivered in central London.

Iain Wilson, the son of Robert Wilson, one of the patients who died, shouted: "You should hang your head in shame."

The panel had previously heard that elderly patients were left in "drug-induced comas" after being over-prescribed painkillers and sedatives.

" Throughout my career I have tried to do my very best for all my patients and have had only their interests and wellbeing at heart "

Dr Jane Barton

Dr Barton was found guilty of putting her patients at risk of premature death.

But the panel said it had taken into account her 10 years of safe practice as a GP in Gosport and 200 letters of support.

Dr Barton said she had to work under "unreasonable pressure" with an "excessive and increasing burden" in caring for patients.

But in a statement after the hearing the GMC criticised the independent panel.

Niall Dickson, GMC chief executive, said: "We are surprised by the decision to apply conditions in this case.

"Our view was the doctor's name should have been erased from the medical register following the panel's finding of serious professional misconduct.

"We will be carefully reviewing the decision before deciding what further action, if any, may be necessary."

Eleven conditions have been placed upon Dr Barton, including a ban on injecting opiates for three years.

In a statement after the panel's ruling, Dr Barton said: "I am disappointed by the decision of the GMC panel.

"Anyone following this case carefully will know that I was faced with an excessive and increasing burden in trying to care for patients at the Gosport War Memorial Hospital.

"None of the nurses who gave evidence were critical of my care of the patients in this inquiry.

"The consultants who had overall responsibility for the patients never expressed concern about my treatment and working practices.

"Throughout my career I have tried to do my very best for all my patients and have had only their interests and wellbeing at heart."

The hearing follows an inquest into 10 patients' deaths which found drugs to be a factor in five cases.

In April last year, a jury inquest at Portsmouth Coroner's Court decided that in the cases of patients Robert Wilson, 74, Geoffrey Packman, 66, and Elsie Devine, 88, the use of painkillers had been inappropriate for their conditions.

Arthur Cunningham, 79, and Elsie Lavender, 83, were prescribed medication appropriate for their condition, but in doses which contributed to their deaths, jurors found.

Dr Barton left the Hampshire hospital in 2000 but still practises as a GP in Gosport.

But she has been under certain conditions since July 2008.

Fears of 'culture of euthanasia'
By Michael Stoddard and David Fenton
BBC News

The jury at the inquests into 10 deaths at a hospital in Hampshire heard from many medical experts during four weeks in court, but there was one they were not allowed to hear from.

Professor Gary Ford, a professor of pharmacology at Newcastle University, prepared a report for Hampshire Constabulary on a total of five deaths - two of which were the subject of the inquests - which occurred at the Gosport War Memorial Hospital more than 10 years ago.

He was one of many experts consulted when detectives opened an investigation into families' claims that patients had died after sedatives such as diamorphine were over-prescribed by staff.

Families of 92 patients came forward with concerns which led to police handing 10 files to the Crown Prosecution Service (CPS), but in October 2007, the CPS said there was not enough evidence to charge anyone.

" **There was certainly no sign of him coming to the end of his life when I last saw him** "
Charles Farthing

Following a long campaign and calls for a public inquiry, the inquests into 10 of the 92 deaths were opened last month with the jury returning a narrative verdict.

The jury found the administration of medication "contributed more than minimally" to five of the deaths, with three of those not receiving "appropriate" medication for their symptoms.

In the other five cases it was found the medication did not contribute to their deaths.

But the panel of five women and three men was not shown Professor Ford's report.

In legal arguments, the families' lawyers called for the report to be included in evidence but the coroner refused and instead relied on two other medical experts who had also prepared reports - of Professor David Black and Professor Andrew Wilcock.

In his findings, Professor Ford raised concerns there may have been a "culture of involuntary euthanasia on the wards" and claimed the levels of diamorphine administered through syringe drivers were "reckless" and "poor practice".

One of the deaths he looked into was that of former World War II pilot Brian Cunningham.

The jury found the administered medication did contribute to his death but the drugs he was given were appropriate for his condition.

Prof Ford's report states the 79-year-old was suffering from Parkinson's disease, dementia, depression and had difficulty walking, and was admitted to the hospital on 21 September 1998 with a serious bed sore.

His stepson, Charles Farthing, said he was ill but not dying.

"He was weak and frail I would say, yes, but he was 100% there mentally. He was still very lucid and a reasonable sort of chap.

"There was certainly no sign of him coming to the end of his life when I last saw him."

On the first day of his admission, Mr Cunningham was put on a syringe driver and given 20mg of diamorphine - a drug two to three times stronger than morphine.

Four days later the diamorphine was increased from 20mg to 60mg a day.

'Rapid deterioration'

Professor Ford said in his report: "The subsequent threefold increase in diamorphine dose later that day to 60mg [over] 24 hours is in my view very poor practice.

"Such an increase was highly likely to result in respiratory depression and marked depression of conscious level, both of which could lead to premature death."

He said although Mr Cuningham was admitted for treatment to his bed sores "ward staff appear to have considered he was dying and admitted for terminal care".

The diamorphine dose was later increased to 80mg before Mr Cunningham died on 26 September.

His death certificate recorded the cause as bronchopneumonia.

His stepson said: "I didn't believe what was on the certificate, I was certain it was due to the drugs he had been given in hospital and I wanted that shown."

Professor Ford also looked into the death of Robert Wilson, jurors found the medication he received was not appropriate.

The 74-year-old was admitted in 1998 after suffering from a broken arm.

Mr Wilson, who also had liver problems due to a long-standing drink problem, had made an "immense recovery" but died four days later after being given diamorphine through a syringe driver, the inquest heard.

Prof Ford noted: "Mr Wilson was admitted for rehabilitation not terminal care.

"Following treatment Mr Wilson was noted to have had a rapid deterioration.

'Hospital pressures'

"The medical and nursing teams appear to have failed to consider that Mr Wilson's deterioration may have been due to the diamorphine infusion.

"In my opinion when Mr Wilson was unconscious the diamorphine infusion should have been reduced or discontinued."

The report also states the increase in diamorphine was "not appropriate when the nursing and medical notes record no evidence that Mr Wilson was in pain or distressed at this time."

During the inquest, the claims diamorphine caused the premature deaths of patients were rebuffed by other medical experts and staff at the hospital, including Dr Jane Barton.

She was responsible for the care of the 10 patients and the prescribing of their pain medication.

She told jurors of the pressures at the hospital with managers sending more and more seriously ill patients because of a bed blocking crisis at the local general hospital.

"I could have said I couldn't do the job any more and walked away, but if I did, I felt I'd be letting down the staff and, more importantly, my patients," Dr Barton told the inquest.

She said that as a result of the pressures, her medical notes were sometimes "sparse" and that she started a system of "pro-active prescribing" - where prescriptions could be written in advance.

In a statement after the inquest Dr Barton said: "I can say though that I have always acted with care, concern and compassion towards my patients.

"I very much appreciated the kind and supportive comments of the nursing staff who gave evidence at the inquest.

"I am pleased the jury recognised that in all of these cases, drugs were only given for therapeutic purposes."

The inquest also heard families had "unrealistic expectations" about their relatives' chances of survival.

Professor Ford said the skills of nursing and non-consultant medical staff, "particularly Dr Barton, were not adequate".

In his conclusion he said: "Routine use of opiate and sedative drug infusions without clear indications for their use would raise concerns that a culture of involuntary euthanasia existed on the ward."

He added closer scrutiny into the ward practice would be necessary to "establish if this was the case".

His findings were passed to Hampshire Constabulary in 2001, but no criminal prosecutions have ever been brought despite three police investigations.

Some families have vowed to fight for a full public inquiry.

Story from BBC NEWS:
http://news.bbc.co.uk/go/pr/fr/-/1/hi/england/hampshire/8000568.stm

Published: 2009/04/20 15:31:32 GMT