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GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday, 29 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-SEVEN)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.
(Mr Tom Kark was not in attendance for the Determination).

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was not present.
(Mr Timothy Langdale QC was not in attendance for the Determination).

(Transcript of the shorthand notes of T A Reed & Co. Ltd.
Tel No: 01992 465900)

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STRANGERS HAVING BEEN READMITTED

DETERMINATION

THE CHAIRMAN: Good morning everybody.

Mr Jenkins, the Panel has considered Dr Barton's case in accordance with the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988 (Old Rules). As a consequence, when determining whether the facts alleged had been proved, the Panel applied the criminal standard of proof. This means that it had to be satisfied beyond reasonable doubt of the facts alleged before it could find them proved.

The Panel wishes to make clear at this stage that it is not a criminal court and that it is no part of its role to punish anyone in respect of any facts it may find proved.

At the outset of the hearing Mr Langdale QC admitted a number of parts of the allegation on Dr Barton's behalf and the Panel found those facts proved. The Panel made further findings in relation to the un-admitted parts of the allegation and gave detailed reasons for those findings in its earlier determination on the facts.

Serious Professional Misconduct

The task for the Panel at this stage of the hearing is first, to determine whether, on the basis of the facts found proved, Dr Barton has been guilty of Serious Professional Misconduct. If the Panel finds that she has been guilty of Serious Professional Misconduct it is then required to consider what action, if any, to take in respect of that misconduct.

In making this first decision, the Panel has considered whether the actions and omissions found proved in relation to Dr Barton's care of the 12 patients who have featured in this case amounted to misconduct which offends against the professional standards of doctors. If it did, the Panel has then determined whether that misconduct was serious.

The Panel has taken into account all the evidence it has heard and read throughout this hearing. It has referred to its determination on the facts found proved and the reasons for its findings, as well as the GMC's publication *Good Medical Practice* (1995 edition) which was

applicable at the time. Further, the Panel has had regard to the context and circumstances in which Dr Barton was then working.

The Panel considered the submissions made by Mr Kark on behalf the General Medical Council (GMC) and by Mr Langdale and yourself on Dr Barton's behalf, and accepted the advice of the Legal Assessor.

Mr Kark submitted that Serious Professional Misconduct should be viewed historically. He reminded the Panel that while there is no definition of serious professional misconduct the test to apply is whether, when looking at all the facts that have been admitted and found proved, Dr Barton's conduct amounts to a serious falling below the standard which might be expected of a doctor practising in the same field of medicine in similar circumstances.

Mr Langdale concurred.

The Panel took account of the above and exercised its own judgment, having regard to the principle of proportionality and the need to balance the protection of patients, the public interest and Dr Barton's own interests.

The Panel made multiple findings of fact which were critical of Dr Barton's acts and omissions. These included but were not limited to:

- The issuing of prescriptions for drugs at levels which were excessive to patients' needs and which were inappropriate, potentially hazardous and not in the patients' best interests;
- the issuing of prescriptions for drugs with dose ranges that were too wide and created a situation whereby drugs could be administered which were excessive to the patient's needs;
- the issuing of prescriptions for opiates when there was insufficient clinical justification;
- acts and omissions in relation to the management of patients which were inadequate and not in their best interests. These included failure to conduct adequate assessments, examinations and/or investigations and failure to assess appropriately patients' conditions before prescribing opiates;

- failure to consult colleagues when appropriate;
- acts and omissions in relation to keeping notes which were not in the best interests of patients, including failure to keep clear, accurate and contemporaneous notes in relation to patients, and in particular, in relation to examinations, assessments, decisions, and drug regimes.

The Panel has concluded that Dr Barton failed to follow the relevant edition of 'Good Medical Practice' in relation to the following aspects of her practice:

- Undertaking an adequate assessment of the patient's condition based on the history and clinical signs, including where necessary, an appropriate examination;
- providing or arranging investigations or treatment where necessary;
- referring the patient to another practitioner where indicated;
- enabling persons not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor;
- keeping clear accurate and contemporaneous patient records;
- keeping colleagues well informed when sharing the care of patients;
- ensure suitable arrangements are made for her patients' medical care when she is off duty;
- prescribing only the treatment, drugs or appliances that serve patients' needs;
- being competent when making diagnoses and when giving or arranging treatment;
- keeping up to date;
- maintaining trust by:
    - listening to patients and respecting their views;
    - treating patients politely and considerately;
    - giving patients the information they ask for or need about their condition, treatment and prognosis;
    - giving information to patients in a way they can understand;
    - respecting the right of patients to be fully informed in decisions about their care;
    - respecting the right of patients to refuse treatment;
    - respecting the right of patients to a second opinion;
- abusing her professional position by deliberately withholding appropriate investigation, treatment or referral.

Further, Dr Barton failed to recognise the limits of her professional competence.

The Panel has already commented at length on Dr Barton's defective prescribing practices, her inadequate note taking and her failures with regard to consultation, assessment, examination and investigation. It does not refrain from emphasising and holding her to account for creating the risks and dangers attendant upon such conduct and omissions.

As a consequence of the Panel's findings of fact as outlined above, Dr Barton's departures from *Good Medical Practice* as outlined above, and the attendant risks and dangers previously commented on, the Panel has concluded that she has been guilty of multiple instances of Serious Professional Misconduct.

The Panel then went on to consider, in the light of those findings, what, if any action, it should take. The Panel considered:

- the submissions made by both counsel;
- the advice of the Legal Assessor;
- the facts found proved;
- the aggravating and mitigating features of those facts;
- the passage of time between the events giving rise to the complaint and the determination of the issues;
- Dr Barton's good character and other matters of personal mitigation including the bundle of testimonials submitted on her behalf.

Punishment

The Panel accepted the advice of the Legal Assessor that it is neither the role of this Panel nor the purpose of sanctions to punish, though sanctions may have that effect.

Proportionality

The Panel accepted the advice of the Legal Assessor that "This is a balancing exercise", where Dr Barton's interests must be weighed against the public interest in order to produce a fair and proportionate response.

The public interest

Both the Legal Assessor and Mr Kark addressed the Panel on the meaning to be ascribed to the phrase, "the public interest". The Panel accepted that the public interest includes:

- the protection of patients;
- the maintenance of public confidence in the profession;
- the declaring and upholding of proper standards of conduct and behaviour;
- on occasions, the doctor's safe return to work, but bearing in mind that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors.

The ambit of enquiry

The Panel accepted the Legal Assessor's advice that its task is to make judgments in the case against Dr Barton alone. It is no part of this Panel's role to make findings in respect of other persons who might have been the subject of criticism during the course of the evidence.

The Panel further accepted the Legal Assessor's advice that Dr Barton's actions should not be judged in isolation. An injustice would occur were she to be judged the scapegoat for possible systemic failings beyond her control. Her actions must be judged in context. The Panel has had the benefit of hearing a great deal of evidence in that regard, and is well placed to define that context. This in no way detracts from Dr Barton's own personal responsibilities as a medical practitioner however.

Looking to the future

The Panel accepted the advice of the Legal Assessor that where the Panel has found Serious Professional Misconduct it must look forward when considering the appropriate response to those findings, and is open to the criticism that it is exercising retributive justice if it fails to do so.

Matters found proved

As indicated above, the Panel made multiple adverse findings of fact in respect of Dr Barton's prescribing practices, note keeping, consulting colleagues, assessments, examinations and investigations. Further, the Panel concluded that she had been guilty of multiple instances of Serious Professional Misconduct.

Aggravating and mitigating features

In accordance with the Legal Assessor's advice the Panel went on to consider both the aggravating and the mitigating features of the facts found proved. It took into account also the evidence contained in the testimonials and character evidence called.

i. Aggravating (offence)

- Although Dr Barton conceded that, with hindsight, she should have refused to continue to work in a situation that was becoming increasingly dangerous for patients she insisted that, in the circumstances of the time, her actions had been correct.

- She told the Panel that were the situation and circumstances of the time to repeat themselves today, she would do nothing different.

- The Panel concluded that this response indicated a worrying lack of insight. It was particularly concerned by Dr Barton's intransigence over matters such as the issue of balancing the joint objectives of keeping a patient both pain-free and alert.

- This, combined with her denigration of senior colleagues and guidelines, produced an image of a doctor convinced that her way had been the right way and that there had been no need to entertain seriously the views of others.

ii Mitigating (offence)

- The Panel noted that the nature and volume of Dr Barton's work and responsibilities increased greatly between the date of her appointment and the time with which this Panel is concerned.

- In particular, the Panel notes that increased and often inappropriate referrals from acute wards to her own put Dr Barton, her staff and resources under unreasonable pressure.

- The Panel noted that Dr Barton was operating in a situation where she was denied the levels of supervision and safeguard, guidance, support, resources and training necessary to ensure that she was working within safe limits. Even when there was Consultant cover it was often of a calibre which gave rise to criticism during the course of evidence.

- The Panel accepted Mr Langdale's submission that the response of hospital management and senior colleagues to complaints against Dr Barton was such that she did, quite reasonably, feel that she was acting with the approval and sanction of her superiors.

- Dr Barton's practice of anticipatory prescribing of variable doses of diamorphine for delivery by syringe driver was validated by a protocol evidenced in a letter from Barbara Robinson, Senior Manager at Gosport War Memorial Hospital dated 27 October 1999.

iii Personal mitigation

- Over a period of ten years since the events in question Dr Barton has continued in safe practice as an NHS GP;

- She has already been under what has been described by GMC counsel as her "own voluntary sanction" for eight years, and for the last two years under formal conditions imposed by the Interim Orders Panel of the GMC;

- The bundle of testimonials from colleagues and patients as to her current working practices and her positive good character.

The passing of time

In considering the appropriate response to its findings of Serious Professional Misconduct the Panel recognised that it was faced with a most unusual set of circumstances:

- There had been a gap of ten years between the events in question and the date of this hearing;
- during that period Dr Barton had continued in safe practice as a GP in the community;
- for the first eight of the ten years she practised under self-imposed conditions of her own devising; for the latter two years, under conditions directed by the GMC's Interim Orders Panel;
- the Panel had received a large bundle of testimonials on Dr Barton's behalf which attested to details of her safe working practice in that period.

In the circumstances the Panel considered it to be important that it receive advice on the appropriate weight that should be attached to the issue of elapsed time, the principles to be applied to its consideration in these circumstances and whether any binding authority could be found. None was.

Mr Kark submitted that the Panel should follow the *Indicative Sanctions Guidance* and that no party should be disadvantaged by reason of the delay.

You submitted that:

- The Panel should consider the misconduct in the context of the guidance and standards applicable at the time.

- Dr Barton's working conditions at the relevant time differed from any that a hospital doctor would be expected to accept today. You suggested that clinical governance has moved on dramatically since then and that the Panel could conclude that in that respect Dr Barton could no longer pose any risk to patients.

The Legal Assessor advised that the passing of time served the Panel well in that it provides a context in which Dr Barton's attitudes and practices could be viewed and judged. It allowed the Panel to judge the efficacy of conditions as a workable sanction by opening a ten year window through which to view it.

Response

The Legal Assessor advised that in determining the appropriate response to Dr Barton's Serious Professional Misconduct the Panel should consider:

- the aggravating and mitigating features of the facts found proved;
- the passing of time between the events which gave rise to the findings against her and the date of this hearing;
- her performance during that time;
- the *Indicative Sanctions Guidance*;
- the protection of patients and the public interest.

i. No action or Reprimand

- Having found that Dr Barton has been guilty of multiple instances of Serious Professional Misconduct, the Panel considered whether in all the circumstances it would be sufficient, appropriate and proportionate either to take no action or to issue her with a reprimand.

- The Panel had no hesitation in concluding that given the seriousness and multiple instances of her professional misconduct it would be insufficient, inappropriate and not proportionate either to take no action or to issue her with a reprimand.

ii. Conditions

The protection of patients

Mr Kark submitted that Dr Barton has demonstrated neither remorse nor insight in respect of the matters found proved and that her departures from the principles set out in *Good Medical Practice* were particularly serious. He submitted that, in those circumstances she presented a continuing risk to patients, and urged the Panel to conclude that, despite the long delay, her case should be dealt with by way of erasure.

Mr Langdale submitted that:

- Dr Barton presents no continuing risk to patients. He said this was proved by her safe practice as a GP throughout the ten years since her departure from the Gosport War Memorial Hospital.

- This view was further supported by the many testimonials of both patients and professional colleagues who commented on her current working practices as well as her qualities as a GP.

- The authors of the nearly 200 written testimonials were informed in that they were aware of the allegations against Dr Barton, the findings of the Panel, and indeed the adverse publicity this case has attracted.

The Panel accepted that it was unrealistic to consider that Dr Barton could ever again find herself in the situation she faced at the Gosport War Memorial Hospital.

Given the seriousness of the Panel's multiple findings against Dr Barton and the aggravating features of those findings noted above, in particular her intransigence and lack of insight, the Panel was unable to accept that she no longer posed any risk to patients.

However, the Panel did accept that in the light of the mitigating features listed above, and the fact that she has been in safe practice for ten years – with eight of them operating under conditions of her own devising and two under conditions imposed by the GMC's Interim Orders Panel – it might be possible to formulate conditions which would be sufficient for the protection of patients.

The maintenance of public confidence in the profession.

Mr Langdale submitted that public trust and confidence in the profession meant the trust and confidence of the informed public. He said that while the authors of the testimonials received by the Panel were informed members of the public, this case has attracted much media attention and that there have been ill-informed and unjustified media comparisons with an unrelated but infamous case involving a doctor accused of deliberately causing multiple patient deaths.

The Panel wishes to make it clear that this is not such a case. However, the GMC have alleged and the Panel has found proved that there have been instances when Dr Barton's acts and omissions have put patients at increased risk of premature death.

The Panel takes an extremely serious view of any acts or omissions which put patients at risk. It had no hesitation in concluding that Dr Barton's Serious Professional Misconduct was such that it is necessary, even after ten years of safe and exemplary post-event practice, to take action against her registration in order to maintain public confidence in the profession.

The Panel considered that taking action against Dr Barton's registration would send a message to the public that the profession will not tolerate Serious Professional Misconduct.

The declaring and upholding of proper standards of conduct and behaviour.

For the same reasons and having carefully considered all the circumstances, the Panel is satisfied that it might be possible to formulate a series of conditions which would be sufficient both to maintain public confidence in the profession and uphold proper standards of conduct and behaviour.

The public interest in preserving the services of a capable and popular GP.

The Panel was greatly impressed by the many compelling testimonials which detailed Dr Barton's safe practice over the last ten years and the high regard in which she is held by numerous colleagues and patients.

The Panel noted Mr Langdale's assurance that the authors of the testimonials were either colleagues and/or patients who were aware of the allegations against Dr Barton, this Panel's findings on facts, and the media coverage of the case.

The Panel was mindful of the fact that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors. However, the Panel was satisfied that there is an informed body of public opinion which supports the contention that preserving Dr Barton's services as a GP is in the public interest.

Order

The Panel has formulated a series of conditions. In all the circumstances, the Panel is satisfied that it is sufficient for the protection of patients and is appropriate and proportionate to direct that Dr Barton's registration be subject to conditions for a period of three years.

The following conditions relate to Dr Barton's practice and will be published:

1 She must notify the GMC promptly of any post she accepts for which registration with the GMC is required and provide the GMC with the contact details of her employer and the PCT on whose Medical Performers List she is included.

2 At any time that she is providing medical services, which require her to be registered with the GMC, she must agree to the appointment of a workplace reporter nominated by her employer, or contracting body, and approved by the GMC.

3 She must allow the GMC to exchange information with her employer or any contracting body for which she provides medical services.

4 She must inform the GMC of any formal disciplinary proceedings taken against her, from the date of this determination.

5 She must inform the GMC if she applies for medical employment outside the UK.

6. (a) She must not prescribe or administer opiates by injection. If she prescribes opiates for administration by any other route she must maintain a log of all her prescriptions for opiates including clear written justification for her drug treatment. Her prescriptions must comply with the BNF guidelines for such drugs.

(b) She must provide a copy of this log to the GMC on a six monthly basis or, alternatively, confirm that there have been no such cases.

7. She must confine her medical practice to general practice posts in a group practice of at least four members (including herself).

(There was a general outcry of disapproval from members of the public who then left the hearing chamber)

(The Chairman continued)

8. She must obtain the approval of the GMC before accepting any post for which registration with the GMC is required.

9. She must attend at least one CPD validated course on the use of prescribing guidelines within three months of the date from which these conditions become effective and forward evidence of her attendance to the GMC within one week of completion.

10. She must not undertake Palliative Care.

11. She must inform the following parties that her registration is subject to the conditions, listed at (1) to (10), above:

    (a) Any organisation or person employing or contracting with her to undertake medical work;
    (b) Any locum agency or out-of-hours service she is registered with or apply to be registered with (at the time of application);
    (c) Any prospective employer or contracting body (at the time of application);
    (d) The PCT in whose Medical Performers List she is included, or seeking inclusion (at the time of application);
    (e) Her Regional Director of Public Health.

In deciding on the length of conditional registration, the Panel took into account the fact that Dr Barton has been practising safely in general practice for the past ten years. During that time she has complied with the prescribing restrictions which she initiated and which were subsequently formalised by the GMC's Interim Orders Panel. This Panel is satisfied, looking forward, that the conditions it has directed provide further safeguards for the protection of patients, and therefore concluded that it was appropriate and proportionate to impose the conditions for the maximum period.

Shortly before the end of the period of conditional registration, Dr Barton's case will be reviewed by a Fitness to Practise Panel. A letter will be sent to her about the arrangements for that review hearing. Prior to the review hearing Dr Barton should provide the GMC with copies of her annual appraisals from the date of this hearing.

The effect of the foregoing direction is that unless Dr Barton exercises her right of appeal her registration will be made subject to conditions 28 days from the date on which written notice of this decision is deemed to have been served upon her.

Dr Barton is the subject of an interim order of conditions. The Panel proposes, subject to any submissions to the contrary, in accordance with Rule 33A of the 1988 Rules, to vary the existing order by substituting its conditions with the conditions contained in this determination.

Mr Fitzgerald, do you have any submissions on that subject?

MR FITZGERALD: No, sir.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: Nor I sir, thank you.

THE CHAIRMAN: That is what will happen and that concludes the case. Thank you all very much indeed for your attendance.

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday, 28 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-SIX)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was not present.

(Transcript of the shorthand notes of T A Reed & Co. Ltd.
Tel No: 01992 465900)

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(STRANGERS HAVING PREVIOUSLY WITHDRAWN, THE PANEL CONTINUED TO DELIBERATE IN CAMERA)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday, 27 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-FIVE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was not present.

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(STRANGERS HAVING PREVIOUSLY WITHDRAWN, THE PANEL CONTINUED TO DELIBERATE IN CAMERA)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday, 26 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-FOUR)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was not present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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(STRANGERS HAVING PREVIOUSLY WITHDRAWN, THE PANEL CONTINUED TO DELIBERATE IN CAMERA

(STRANGERS HAVING BEEN READMITTED)

THE CHAIRMAN: Welcome back, everyone. Before we commence with the main item, which is the Panel's request for assistance, I regret that the Panel must also make a necessary correction, this time to the findings of fact set out in the agenda dated 15 January 2010. The agenda currently records that heads 15(a) and 15(b) were found not proved in relation to all 12 patients, whereas of course from a reading of the Panel's determination you will recall that in the case of Mrs Alice Wilkie, Patient D, the Panel did find those heads proved. So the Panel will amend the record on the findings of fact, and I apologise that there was a second typographical error.

Mr Kark, so far as the second matter is concerned ---

MR KARK: Sir, we are grateful for that correction and I am grateful for the time you have given me. As you know, I am in a slightly difficult position, and I am grateful that you delayed this hearing slightly as a result.

Sir, we have been advised that the Panel wishes to be advised on the specific question of the time that has elapsed and the events that have occurred since the matters giving rise to the allegation, and the date of this hearing. You were advised that you could take into account the elapsed time, and you have asked what weight is to be allocated and what principles should be applied, and is there any authority on the subject.

Sir, the position is this, that I spoke to your learned Legal Assessor this morning and gave him my views both orally and in manuscript. Having come out of the other hearing, I have now been provided with a copy of what I think I can properly call a supplemental draft legal advice, which has been put together I suspect with the assistance of Mr Jenkins. I do not entirely agree with it, and I think it would be helpful if really both sides addressed you briefly, and then your learned Legal Assessor, if he wishes to, could have an opportunity of considering what we have both said.

Obviously it is preferable if we can all come to an agreement, but it may be that in this case, as sometimes happens, we will simply have to address you, you will have to receive your legal advice, and then you will have to, frankly, make of it what you will. I do not know if that is appropriate, or if you want go give us more time to see if we can come to a compromise.

THE CHAIRMAN: I think all you have said must be right. In the ideal circumstances, a single agreed view would obviously be the easiest for the Panel. If it is the feeling of the three of you that a little more time might enable you to reach that point, then I am sure we would give it; but if the view is that that is unlikely to happen, then we will have to bite on the bullet and recognise, as you say, that we would have to hear from each of you – in fact three of you, because also the Legal Assessor's view – and then decide for ourselves where that left us.

MR KARK: I hesitate to say this, but I think it may be that we are coming at this – this is still an adversarial system, of course, and we may be coming at this from rather different

angles, or not wholly different, and it may be important in any event for me on behalf of the GMC to record on the transcript what the GMC's submissions would be. So I would propose to do that, with your leave, in any event.

THE CHAIRMAN: Then I do not see that there is any point in spending further time in attempting to find an agreed version, so we will start with yourself.

MR KARK: Sir, the answer to your question so far as we are concerned – and you will bear in mind of course that any submissions I make to you are merely submissions by the GMC, of course – the question of time elapsed between the events giving rise to a finding of serious professional misconduct and the hearing itself at which that finding may be made can, we accept, be relevant to the issue of sanction. It is not relevant, we would submit – and have submitted previously, and this was accepted by Mr Langdale on Dr Barton's behalf – it is not relevant to the issue of whether the behaviour as you found it to be in fact amounted to serious professional misconduct.

So the first step obviously is to consider whether the facts alleged and found proved give rise to a finding of serious professional misconduct. If you do find Dr Barton guilty of serious professional misconduct, then of course you have to consider what sanction to impose. As you know, you must follow the *Indicative Sanctions Guidance* as a model for consideration of that issue. I will not repeat the actual paragraphs, but as you know, *Indicative Sanctions Guidance* sets out the purposes – and that is what we would invite you to have regard to – of imposing a sanction at paragraphs 18, 19 and 20. You also had of course this learned Legal Assessor's advice at his paragraph 9. Mitigation, of which delay can be a part, is dealt with at paragraph 26. Again, I am not going to read it all out to you, but it ends with this sentence:

> "Features such as these should be considered and balanced carefully against the central aim of sanctions, that is the protection of the public and the maintenance of standards and public confidence in the profession."

I would say this: neither side, neither the GMC nor certainly Dr Barton, should, as it were, be punished, if that is the right word, for the delay. You must consider to what extent the delay is important when you consider the fundamental questions posed by *Indicative Sanctions Guidance*. It has been said, of course, that there has been a change in Dr Barton's circumstances in the sense that she has been – and this has been revealed to you already – under IOP orders almost since the time of these events. In fact the IOP orders were imposed later, but Dr Barton was under her own voluntary sanction, as it were, not to prescribe diamorphine.

There is however, of course, a significant difference, and that is that Dr Barton has now been found to have acted in the way alleged, by you. So despite the delay – and I am not saying you should ignore it – but despite the delay you still have to ask yourselves the same questions: what does the protection of patients in the future require? How can we best maintain public confidence in the profession? And how do we declare and uphold proper standards of conduct and behaviour?

I am sorry if all of that is obvious, but it does flow from your question. I am not going to repeat my address to you now, but I did in fact, if you recall, deal with the issue of delay and deal with it in terms very much as I have now – that you still have to come back to the fundamental questions that are posed by *Indicative Sanctions Guidance*.

So there is no law specifically on this, other than the fact that you are allowed to take delay into account. But of course it may be very often more relevant to cases where you are considering an issue of impairment. But I do not mean by saying that to detract from the submission that delay can be a part of mitigation if it affects one of those fundamental principles. That is how I would put it.

THE CHAIRMAN: Our concern was that if there were an authority on the effluxion of time, we would very much like to have it pointed out to us; but I take it from what you have said that the GMC at least are not aware of a pertinent authority that covers that area.

MR KARK: There are all sorts of authorities about delay, but none specifically, as far as I am aware, on this very point.

THE CHAIRMAN: We have not been looking at the effluxion of time as delay, as such, but as effluxion of time in which things have happened.

MR KARK: By which I mean the same thing, I accept.

THE CHAIRMAN: It means that there is not and has not been in our minds at all any criticism of anybody, for that effluxion. It is merely that, it having happened, what significance, what weight should be applied to it, and is there an authority? I understand from your point of view that the view is that we should look no further than the *Indicative Sanctions Guidance* because there is nothing beyond it that is relevant to assist us.

MR KARK: To the specific question that you have asked, that would be my submission. I am sorry if that is not very helpful.

THE CHAIRMAN: Thank you. Can we get any further help from the other side of the room?

MR JENKINS: Whether it is help is a matter for you, but it is for me to address you briefly. I agree entirely that there is as yet no authority on the question of delay and what weight you should give it in your deliberations. The guiding principle plainly is one of proportionality.

I have four points to make, if I may. Firstly, as to the question of serious professional misconduct, the Panel must ensure that the GMC guidance and standards that were applicable in 1996-1999 are applied. The delay has given rise to a large number of further documents and items of guidance given by the GMC. Plainly in your training as panellists you will have concentrated on the more recent guidance, but it would be wholly wrong for you to apply that more recent guidance or to appear from your determination to apply any of those more recent standards than those which applied at the time of the events that you have considered.

I make that point briefly because you have already been addressed by the learned Legal Assessor and properly advised in relation to that.

The second point I make is that the conditions of working for Dr Barton during the period with which you are concerned, 1996-1999, are very different perhaps from any that a doctor may be asked to work in now. I would suggest that clinical governance has moved on dramatically, as certainly the medical member will be aware. No doctor would be placed

today in the position that Dr Barton was during the period with which you are concerned. That a job should change rapidly in the way in which it did, that there should be bed blocking of the surgical units and patients being transferred early when not fit properly to be transferred, that would not happen today.

You need to remind yourselves of the correspondence you have at D6, which is Dr Barton's correspondence about the position she found in January 2000 as almost intolerable, because of the circumstances in which the job had changed. Intolerable for her and the nursing staff. Those are all matters that have changed over time.

Allied to that point, your functions, if you get to looking at sanction, include plainly declaring and upholding standards, maintaining public confidence.

To the extent that you are declaring and upholding standards, you cannot be looking at the guidance of today; you must be looking at the standards that were applicable back in 1996-1999. You will ask yourselves: "To what extent should we as a Panel be declaring today the standards of 1996-1999?" The clinical situation has changed; again, clinical governance – no one would be put in Dr Barton's position. What I would suggest is that because of the delay and the changing clinical and professional regulatory guidance picture, the burden on you to declare and uphold standards is reduced. If you were looking at conduct let us say ten years later than that which you are looking at, conduct perhaps between 2006 and 2009, then there would be the normal burden on you to declare and uphold standards, because they are the same standards. But that is not the position.

The third point I make is that Dr Barton should not be at a disadvantage by reason of the passage of time since these events. As you know, there have been a number of significant changes in the medical regulatory picture. Following the case of Dr Shipman clearly there were reports following an inquiry chaired by Dame Janet Smith. As a result of her reports and some reflection, the General Medical Council saw fit to seek new rules, and those are the 2004 rules. Plainly those rules involve looking at the fitness to practise of the doctor as it is at the time of the hearing. Under the old rules that you are looking at in this case, you are looking back. If this were a case, looking at the events again of 2006-2009, you would be looking at "Well, what is the doctor's position today, at the time of the hearing?". It would be forward looking on the question of fitness to practise, and to that extent a panel would be looking at "Well, what should we be doing today with regard to this doctor's registration?"

They are difficult issues, I agree, on the one hand saying "You are governed by the old rules, and these are the rules you must follow", and yet knowing that the picture has changed. It is clear from the Dame Janet Smith inquiry and the GMC's changing of the rules that the appropriate way of analysing matters is "Let's look forward from today". That was what brought about the change.

Again, difficult issues for you to look at the two, but you must reflect on the change that has come about, and ensure that Dr Barton is in no way prejudiced by the change in the rules. She should be in no worse position.

The last point I make, given the effluxion of time, is if you are looking at specific sanctions, plainly you have to consider the question of conditions. When looking at conditions you will have to consider a number of factors, one of which clearly is the issue of whether conditions can be formulated, and whether they are workable. There are other considerations too; but

just on the question of whether conditions can be formulated and whether they are workable, you know very well that Dr Barton has adhered to conditions for eight years. Eight years is a significant time – clearly one that you have to reflect on when looking at those questions.

Sir, I do not add to what I have just said by way of points. Clearly I have had a discussion both with Mr Kark and indeed your learned Legal Assessor, and you will find some of the points that I have just made I think highlighted in the advice that you are just about to receive. Thank you.

THE CHAIRMAN: Thank you very much for that.

Legal Assessor, are you in a position to advise us, in particular in relation to some of the points that have been raised by the defence?

THE LEGAL ASSESSOR: No, sir, not at the moment, the reason being that when Mr Kark was doing the work, he gave me the document from which he read. With that, and with Mr Jenkins, we put together a document to which he has referred. We did not have the opportunity, the three of us, to discuss it and distil it, and therefore, so as not to offend either side, I would welcome the opportunity of attempting at least to put an advice which will accommodate everybody's views. That may be just a little bit of fine-tuning, or it may be more, but may I suggest that if we meet again after the short adjournment I may be in a position to give some advice. Whether it is in line with what I have had previously proposed or not, I do not know, but if you would give me that facility it would be helpful.

MR KARK: Sir, may I just raise the issue of timing. I am meant to be back next door at two. We are in the middle of some extremely complex evidence from Professor Compston, an expert witness, and I wonder if we could have time to discuss with the Legal Assessor and sit slightly early to hear his advice.

THE CHAIRMAN: When we contemplated the potential to return with questions we did fully understand that you were engaged elsewhere, with the obvious difficulties, but I had understood that your junior would be available to assist in the circumstances of your not being ---

MR KARK: You are absolutely right, and I accept the implied criticism if there is any, but unfortunately Mr Fitzgerald is in the Court of Appeal today, and that does take precedence over even what I want him to do; so he simply cannot be here. I will contact him and, if he is available, no doubt he will be on his way.

THE CHAIRMAN: Yes. I cannot know what is in the Legal Assessor's mind at the moment, but if I may so, in an effort to say at least where I am, it seems to me that there was not any new issue in your advice; there was not anything that we had not already heard; whereas in the new advice we had from Mr Jenkins there were at least two very interesting points, which I do not think have been ventilated before. I think it is important if, as we had previously agreed, we would have to take on board all of the advices and then decide where they would take us – I do think it is very important that the Legal Assessor has the opportunity to fully consider those new points, and to give us such advice as he is able, in terms of what we should make of those.

I suppose what I am saying is, of course you would want to hear what he has to say in due

course; but it may be that the areas where he is going to need to be considering matters are more areas where he might consider discussion with Mr Jenkins, rather than yourself.

MR KARK: Yes.

THE CHAIRMAN: I think if we do this: we allow him to get on as best he can, and we seek to have any final advice from himself tendered at a time when perhaps there is a natural break in your own proceedings, or when you have the mid-afternoon break.

MR KARK: If you are prepared to wait until then.

THE CHAIRMAN: I think we should, because we asked for the advice because we felt the need for some assistance. We have been given some advice, and I think it is important that we hear the Legal Assessor's take on that; but you of course must be given the opportunity to see whether that is something on which you would have to comment. Therefore we should hear that at a time when you are available. But it may be that a note can go through to you at some stage with what the proposal is, and then obviously we would then have to wait until you were free to join us. It is unfortunate, but these are too important matters to relax, and I think we should make sure that we do them properly, do them justice.

MR KARK: Certainly.

THE CHAIRMAN: Very well; we will break now and we will return at a time that will be determined later. Mr Jenkins, I am sorry, that means we need you to be around, and by the sound of things possibly to be available to discuss things further with the Legal Assessor.

MR JENKINS: That is all right; I am not double-booked.

(The luncheon adjournment)

THE LEGAL ASSESSOR: Thank you, Chairman, for the time. I have discussed over the short adjournment with both Mr Kark and Mr Jenkins the advice, and I think we are largely at one on this, so here is the advice supplemental to that which I gave two days ago.

During its in-camera discussions the Panel sought further advice as to how it is to take into account the passage of time between the facts giving rise to the allegation of serious professional misconduct and the determination of the issues. To elaborate on the advice I have already given, I would invite the Panel to bear in mind the following matters:

Firstly, the advice given earlier in relation to serious professional misconduct, which I do not repeat here.

Secondly, the purpose of sanctions which, to repeat, is the protection of patients present and future; the upholding of proper standards of conduct and behaviour; and the maintenance of the reputation of the profession.

Thirdly, can I repeat, have regard to the *Indicative Sanctions Guidance* (2009) amended edition.

Fourthly, any message going out to the public and the profession as of today but based on old factors must continue to have a relevance to the aims and objectives of sanctions. Insofar as historical misconduct is found proved, the sanction must accurately reflect contemporary opprobrium lest it runs the risk of being regarded as retributive.

Fifthly, neither party ought to be placed at a disadvantage by the passage of time.

Sixthly, the extent to which the culture pertaining at the time of the matters complained of has altered during that period of time gives the Panel the opportunity to examine in context document D6 and the sentiments expressed in it by Dr Barton.

Seventhly, the likelihood that, in the future, a doctor would find him- or herself in the position the Panel found Dr Barton to have occupied in terms of clinical governance, is a matter to be borne in mind.

The passage of time serves the Panel well in that it provides a context in which Dr Barton's attitudes and practices can be viewed and judged. It allows the Panel to judge the efficacy of conditions as a workable sanction, by opening an eight-year window through which to view it.

Once a finding of serious professional misconduct has been made (if it has) then the discretionary application of a sanction must have a forward-looking purpose.

I disagree with Mr Jenkins' final submission to you before the short adjournment that there is a reduced burden to uphold standards. Those standards are those expected of doctors today, tomorrow and the days which follow.

I hope that supplemental advice has been of some assistance to you.

THE CHAIRMAN: Thank you, Legal Assessor. Mr Kark, do you have any observations on the advice just tendered?

MR KARK: No, I do not; thank you.

THE CHAIRMAN: Mr Jenkins, do you have any observations on that advice?

MR JENKINS: Not beyond what I said to the Panel before.

THE CHAIRMAN: Yes, indeed. Thank you very much indeed, everybody. Dr Smith?

DR SMITH: A clarification, if I may, from the Legal Assessor. He referred to "contemporary opprobrium". Can you please explain what "contemporary" means. Is it contemporary to then or contemporary to now?

THE LEGAL ASSESSOR: To now.

THE CHAIRMAN: Good question. I should say for the purpose of completeness, if either counsel have any observation arising out of that question --- (None indicated.)

Very well, the Panel will go back into camera to further consider, and we will let you know in

due course, but it will be some considerable time still, I would say. Thank you very much, both of you.

(STRANGERS THEN, ON DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Monday 25 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-THREE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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(STRANGERS, BY DIRECTION FROM THE CHAIR, HAVING PREVIOUSLY WITHDRAWN, THE PANEL CONTINUED TO DELIBERATE IN CAMERA)

(The Panel adjourned to Tuesday 26 January 2010 at 12 p.m.)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday, 22 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-TWO)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

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(STRANGERS, BY DIRECTION FROM THE CHAIR, HAVING PREVIOUSLY WITHDRAWN, THE PANEL CONTINUED TO DELIBERATE IN CAMERA)

(The Panel adjourned to Monday 25 January 2010)

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Thursday, 21 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY-ONE)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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A THE CHAIRMAN: Welcome back everyone. We left matters yesterday at the point when I was about to invite the Legal Assessor to provide us with his advice and you will recall that Mr Langdale indicated that the doctor would not be able to be present herself but was content for us to continue in her absence.

Mr Jenkins, I take it that you are going to stand in, as it were, for Mr Langdale today?

B MR JENKINS: I am, sir, yes.

THE CHAIRMAN: Very well, then I will invite the Legal Assessor to provide us with his advice.

THE LEGAL ASSESSOR: Thank you, Chairman.

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1. I wish to make it abundantly clear that matters of judgment and discretion are entirely outside the boundaries of the advice and assistance that I am required to give to the Panel. For the avoidance of doubt, the Panel is the judge of the law. I advise on matters of law to assist the Panel in the discharge of its functions. I will advise only. I will not give directions. To do so might create in the mind of the informed observer a suspicion of improper influence. Should any hint of a suspicion arise in the Panel's mind that any advice I give breaches the boundaries or exceeds the limits imposed
D upon all legal assessors by The General Medical Council (Legal Assessors) Rules 2004 the Panel must be equally assiduous to resist and challenge such an intrusion into what is and remains the Panel's sole domain.

2. The Panel, exercising its own independent judgment, must now consider whether it judges Dr Barton to have been guilty of serious professional misconduct based on the facts found proved. This is an exercise in making a judgment without reference to
E any burden or standard of proof. Serious professional misconduct, if found to have been committed is an historical fact unlike the new concept of impairment fitness to practise.

3. On 6th August last, my predecessor, Mr Chamberlain, gave advice to the Panel as to what constitutes serious professional misconduct and, as it has been commended by Mr Kark without demur from Mr Langdale, I do not propose to repeat it as the Panel
F has a written copy of that advice to refer to.

4. I would emphasise, however, the need to judge Dr Barton's actions not with the wisdom of ten years' hindsight and the advantage of modern approaches to palliative care, but in the context of the culture prevailing at the time of the events in respect of which findings have already been made. Context is important because the Act requires the Panel to consider whether Dr Barton has been guilty of serious
G professional misconduct.

5. The Panel ought not to lose sight of the fact that it is the GMC case against Dr Barton which it is trying and not a hypothetical case against any other practitioner in respect of whom, in the course of the evidence, it might have been tempted to be critical. This is not to say, however, that her actions are to be judged in isolation. An injustice would occur were she to be judged the scapegoat for possible systemic failings

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beyond her control. Her actions must be judged in context. The Panel has had the benefit of hearing a great deal of evidence and is best placed to define that context.

6. It is a requirement of the rules that reasons be given for the decision taken. The extent of the reasoning was, in part, the subject of the appeal in the case of *Phipps v General Medical Council [2006] EWCA Civ 397; [2006] Lloyd's Rep Med 345* in which Wall LJ said:

> "85 ... [E]very Tribunal (including the PCC of the GMC) needs to ask itself the elementary questions: is what we have decided clear? Have we explained our decision and how we have reached it in such a way that the parties before us can understand clearly why they have won or why they have lost?
>
> 86. Very grave outcomes are at stake...Respondents to proceedings before the PCC of the GMC are liable to be found guilty of serious professional misconduct and struck of the Register. They are entitled to know in clear terms why such findings have been made."

7. As Sir Anthony Clarke MR put it in *Meadow v General Medical Council [2006] EWCA Civ 1390; [2007] 1 QB 462:*

> "In short, the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past." (para 32).

8. I refer to this passage not because this Panel is required to make a judgment on the statutory concept of impairment of fitness to practise, but because Mr Langdale used the phrase "fitness to practise" in his submissions. A Fitness to Practise Panel proceeding under the old rules, and following a finding that a practitioner has been guilty of serious professional misconduct must, in the exercise of its discretion as to sanction, look forward to avoid the criticism that it is exercising retributive justice.

9. The purpose of sanctions is not to punish even though their effect might be and often is punitive. Their purpose is to provide protection to the public interest. The public interest includes amongst other things the following four:
   a. Protection of patients
   b. Maintenance of public confidence in the profession
   c. Declaring and upholding proper standards of conduct and behaviour
   d. It may, on occasion, also include the doctor's safe return to work but bear in mind that neither the GMC nor the Panel has any responsibility for the rehabilitation of doctors.

10. In his submissions Mr Langdale made reference to the question of public trust and confidence in the profession. He submitted that this means properly informed public trust and confidence. He said it did not mean the view of members of the public who have relied on uninformed, biased and/or inflammatory reports in the media. If the Panel adopts this valid submission it may be assisted by part of the dictum of Lord Hope in the Scottish case of *Helow –v- Secretary of State for the Home Department and Another [2008] UKHL 62*. Their Lordships were dealing with an appeal against the refusal by a judge, a member of the International Association of Jewish Lawyers and Jurists, to recuse herself from hearing a case involving a Palestinian litigant. Lord Hope said:

> "Then there is the attribute that the observer is "informed". It makes the point that, before she takes a balanced approach to any information she is given, she will take the trouble to inform herself on all matters that are relevant. She is the sort of person who takes the trouble to read the text of an article as well as the headlines. She is able to put whatever she has read into its overall social, political or geographical context. She is fair-minded, so she will appreciate that the context forms an important part of the material which she must consider before passing judgment..."

11. To practise safely, doctors must be competent in what they do. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly.

12. Doctors have a respected position in society and their work gives them privileged access to patients, some of whom may be very vulnerable. A doctor whose conduct has shown that he/she cannot justify the trust placed in him/her should not continue in unrestricted practice while that remains the case.

13. The public is entitled to expect that their doctor is fit to practise and follows the GMC's principles of good practice by ensuring the following:

a) The provision of good clinical care;
b) The maintenance of good medical practice;
c) The maintenance of good relationships with patients and with colleagues;
d) Honesty and trustworthiness;
e) Their own health does not endanger patients.

14. Consider both the aggravating and the mitigating features of the case. Take into account also the evidence contained in the testimonials and character evidence called. The watchword, as ever, is "proportionality".
15. This is a balancing exercise. It requires the Panel to balance the competing interests. On the one hand is the public interest, on the other there are the interests of the practitioner.
16. The interests of the practitioner include:-
    a. Returning immediately to unrestricted practice;
    b. Consideration of her character and all personal mitigation available to her. It is at this stage that the Panel should consider the time that has elapsed since the matters giving rise to these proceedings.
17. Only such sanction as is necessary to provide these safeguards should be imposed.

18. That the GMC makes submissions as to the appropriate sanction to impose is not to be taken as binding upon the Panel's determination. The Panel's discretion and judgment is unfettered save by the application of proper principles I outline in this advice.

19. Should the panel judge Dr Barton to have been guilty of serious professional misconduct, it must first determine whether it would be sufficient to take no action following its finding that she has been guilty of serious professional misconduct. This power is regarded as appropriate only in exceptional cases.

20. Should there be a finding of serious professional misconduct and the Panel does not think it sufficient to conclude the case by taking no action, a reprimand is a course that can be adopted. A reprimand is not a sanction proper, it is not empowered by the legislation. It is an expression of the Panel's opinion about the conduct of a practitioner. The Panel has the guidance to refer to.

    I would say, as a rider at this stage, that the guidance to which you have been referred, and which you should refer should you require further elaboration, is the amended 2009 edition of the Indicative Sanctions Guidance.

21. The correct approach to the imposition of sanctions is to consider them in turn beginning with the least onerous, namely the sanction of applying conditions to the practitioner's registration.
22. Conditions can be imposed up to a maximum of three years. The purpose of imposing conditions is protection of patients. Conditions should be appropriate, proportionate, workable and measurable. It is required that the problem is amenable to improvement through education and that the objectives of the conditions are clear
23. Only if this sanction fails to provide the required protection will the Panel go on to consider the power to suspend. This power is limited to suspension for a period of 12 months. If either conditions or suspension are imposed, then the Panel is empowered to order a review of both or either order.
24. Finally, Erasure only takes effect should suspension fail to provide the protection required.

Sir, that is the advice that I give at this stage. If there are any matters which members of the Panel would wish assistance on specifically, then, again, if they could raise them with me, I will do my best to assist them.

THE CHAIRMAN: Thank you, Legal Assessor. I will take that final invitation first. Is there anything that members of the Panel wish to raise at this point? No? Very well. Mr Kark, do you have any observations on the advice just tendered?

MR KARK: No, thank you very much.

THE CHAIRMAN: Mr Jenkins, do you have any observations?
MR JENKINS: Nor I, thank you very much.

THE CHAIRMAN: Thank you very much indeed.

Very well, what will happen now is that the Panel will go into camera to consider the matters now placed before it. I would expect this to take some considerable time and, as I indicated

yesterday, I am not going to put any marking by way of likely timetable down. However, so far as visitors and members of the public are concerned, I will undertake that we will not return to read our determination until a sufficient period of notice has been given. In other words, for example, if on Wednesday we were to conclude that we would be ready to read on Thursday, we would notify members of the public and press through the usual channels that we would be expecting to read the following day, so we will attempt to give as near to as we can at least a full day's notice. I should say to members of the bar that, as always, there is the potential, while the Panel is in camera and in discussion, that it may find it requires further advice from the Legal Assessor and/or indeed from the advocates themselves, and if that happens, what we will do is cease discussion at that point and, using the numbers that I understand the Panel Secretary has, we will let the parties know that we do require such advice and we will then make arrangements for that advice to be tendered and indeed for you to make such comments as you might wish on that. It may or may not happen, sometimes it does, sometimes it does not. We understand Mr Kark is going to be in the building anyway.

Mr Jenkins, are you going to be within a reasonable time call away?

MR JENKINS: Yes.

THE CHAIRMAN: Very well, that is what we shall do then..

Ladies and gentlemen, we are going into camera now and you will next hear from us when we are ready to resume. Thank you very much indeed, ladies and gentlemen

STRANGERS THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Wednesday 20 January 2010

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Andrew Reid, LLB JP

Panel Members: Ms Joy Julien
Mrs Pamela Mansell
Mr William Payne
Dr Roger Smith

Legal Assessor: Mr Duncan Smith

CASE OF:

BARTON, Jane Ann

(DAY FIFTY)

MR TOM KARK of counsel and MR BEN FITZGERALD of counsel, instructed by Field Fisher Waterhouse, Solicitors, appeared on behalf of the General Medical Council.

MR TIMOTHY LANGDALE QC and MR ALAN JENKINS of counsel, instructed by the Medical Defence Union, appeared on behalf of Dr Barton, who was present.

(Transcript of the shorthand notes of T A Reed & Co Ltd.
Tel No: 01992 465900)

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THE CHAIRMAN: Welcome back, everyone. Before we start, Mr Langdale, Mr Kark, I should say it has come to the Panel's attention that in our determination on facts dated 20 August 2009 we inadvertently failed to record Dr Barton's admission and our finding regarding one of the facts alleged. The head of allegation in question is 13(c) in relation to Mrs Jean Stevens, Patient L. The determination has therefore been amended to include the relevant admission and finding, and copies of the revised determination are available for all should anybody wish to have it, and the Panel assistant will have those available to distribute should anybody needs one. Mr Kark.

MR KARK: Sir, as you know you had delivered your determination on the facts on 20 August last year, and the stage which these proceedings has now reached is the stage which is governed by rules 28 to 31, which provide as follows, so far as rule 28 is concerned:

> "the Committee have recorded a finding, whether on the admission of the practitioner or because the evidence adduced has satisfied them to that effect, that the facts, or some of the facts, alleged in any charge have been proved, the Chairman shall invite the Solicitor or the complainant, as the case may be, to address the Committee as to the circumstances leading to those facts, the extent to which such facts are indicative of serious professional misconduct on the part of the practitioner, and as to the character and previous history of the practitioner."

As you know, this is now, so far as you are concerned, a single stage process, but there are two important features of it: the first is that you must decide whether Dr Barton is guilty of serious professional misconduct; the second, and that would take you through to rules 30 and 31, is if you do find that she is guilty of serious professional misconduct, you then have to decide what, if any, direction to make so far as sanction is concerned.

The issue of whether or not the doctor is guilty of serious professional misconduct is of course to be tested by reference to those charges found proved and therefore by reference to her behaviour at the time to which the charges are relevant. To that extent the test is not the same as the issue of whether a doctor's fitness to practise is impaired. You, I know, will be well aware of that, but it does bear mentioning, because of course as a modern Fitness to Practise Panel you will be well used to applying the rules so far as impairment is concerned, but it is important to underline that this is an old rules case. Whereas you would, were this an impairment case, look at the question 'What is the position now?' in respect of the doctor's fitness to practise based on the Panel's findings, serious professional misconduct is viewed historically, and you must consider and determine whether, in relation to the facts found proved, and having regard to any evidence adduced under the rules, you consider the practitioner to have been guilty of serious professional misconduct.

Now, the Legal Assessor as was, Mr Chamberlain, who has now of course been replaced by Mr Smith, gave you directions which we would respectfully encourage you to re-read. They were given on Day 39, starting at page 43. That of course is not said to undermine anything that your present Legal Assessor will say to you, but Mr Chamberlain did set out the test when he was giving you advice in relation to the issue which you then had to consider, whether the facts then found proved were incapable of amounting to serious professional misconduct. He drew your attention to the cases of *Roylance* and *McCoan* and *Doughty*, and you will recall that there is in fact no definition of serious professional misconduct, but the test that we would respectfully invite you to test yourself, and the question you may wish to ask yourself is this: looking at all of the facts which have been admitted and found proved, is

Dr Barton guilty of conduct which amounts to a serious falling below of the standard which might be expected of a doctor practising in her field in similar circumstances?

Now, whilst employed at the Gosport War Memorial Hospital as a clinical assistant between 1996 and 1999, you have found that Dr Barton offended certain basic medical principles in her treatment of the patients who were under her care at that hospital. I am going to set them out, if I may, in order of topic rather than by patient, and I am going to set out the nature of the criticisms which were in fact set out in the heads of charge. I am going to spend a little more time, not very long I promise you, but a little more time than perhaps I would have done if I were addressing you immediately after a hearing in August of last year, although we know that you have spent the last two days reviewing the material in this case and no doubt reminding yourselves of the facts.

There is, as you will appreciate, not only interest in these proceedings by some of the relatives of those patients, but there is also considerable public interest, and so it is appropriate that I should address you, albeit briefly, on the criticisms that you found of Dr Barton.

First, you expressed your concern in your determination that nurses were enabled to use their own discretion to start at a high dose of diamorphine and midazolam, and thus effectively they were enabled to start these patients on what was termed the terminal pathway. You found that Dr Barton's practice of prescribing in the way that she did was neither safe nor prudent. You noted with concern her apparent assumption, when prescribing on an anticipatory basis, that the required dose would increase, despite not knowing when that increased dose might be administered, nor by whom.

You found that although Dr Barton was well aware of the principles of applying the analgesic ladder, the BNF, and the Wessex Protocols (about which we heard much), she accepted in effect ignoring them, in the sense that she routinely prescribed outside the guidelines, even though Professor Ford and her own expert Professor Sikora both stated that the guidelines could not be ignored simply because a patient was on the terminal pathway, and that departures from the guidelines should be the exception rather than the rule. When Dr Barton did depart from the guidelines, you found that she had made no note as to why she had done so, nor provided any written justification.

In relation to each of the patients for whom Dr Barton prescribed opiates by way of anticipatory prescription on occasions, prior to the time when the patient actually needed any analgesic at all, it was in such wide variable quantities that they offended what you termed in your determination Professor Ford's one hundred per cent rule, which allowed, as you will recall, for one hundred per cent increase from lowest to highest, and so you found that Dr Barton's prescriptions were in those cases inappropriate, potentially hazardous and not in the best interests of those patients. You found that those prescriptions created the situation where drugs could be administered, and on occasion were administered, which were excessive to the patient's needs, and in some cases the drugs administered caused the patients to lose consciousness, become unrousable, and that was both unnecessary and caused considerable distress to some of those nearest and dearest to them.

You found that Dr Barton's practice of doubling up the dose greatly increased the risk of over-sedation and the adverse side effects. You found that Dr Barton evinced a marked reluctance, as I think you put it, to titrate doses before commencing patients on syringe

drivers, which marked the beginning of the terminal pathway. Titration was, Dr Barton accepted, a basic standard medical principle, but she said in evidence, "I was not taught it, I was not familiar with using it. It was not practical or feasible".

In respect of Patients A (Leslie Pittock), B (Elsie Lavender), J (Geoffrey Packman) and K (Elsie Devine), the Panel determined that even the lowest dose which Dr Barton prescribed of either diamorphine and/or midazolam were too high when looked at in conjunction with each other, and, in respect of Leslie Pittock, when Nozinan was added, and so you found that Dr Barton's prescriptions in this respect were inappropriate for those patients, potentially hazardous to them and not in the best interests of those patients.

Particularly in the case of Patient K (Elsie Devine), you specifically found that given that fentanyl was already in that patient's system, that even the lowest doses of diamorphine and midazolam as prescribed by Dr Barton would have had a profoundly sedating effect, would put the patient at severe risk of respiratory depression, coma and premature death. This lady, as you will remember, slipped into unconsciousness soon after the syringe driver was started and remained unconscious until her death two days later.

You found that syringe drivers were on occasion attached to patients unnecessarily and prior to the time when they needed it.

In respect of Mr Wilson (Patient H), Dr Barton appears to have ignored the feature which should have been of significance to her prescribing, which was his alcohol-related liver disease, and you found in that case that not only was her prescription for him potentially hazardous, but it had the potential to lead to serious and harmful consequences for him, even though you could not be sure that it was likely to do so.

In terms of preliminary assessment in the case of Patient D (Alice Wilkie), prior to the prescribing of opiates you found that Dr Barton had not performed an adequate assessment and that this failure was not in the patient's best interests.

On a similar but different topic, you found that in respect of Mr Geoffrey Packman the doctor failed to obtain further advice as his condition worsened and made no further investigations, and your view was that Dr Barton should have done both prior to starting this patient on a syringe driver.

Throughout all of this period in relation to these patients Dr Barton was failing to make relevant and necessary notes. Of course, *Good Medical Practice* does not require that everything should be written down, and we do not suggest that it would always have been practicable for her to do so, or to make a full note, but there was in evidence here, we submitted then and now, a culture of making no notes; notes which would have been highly relevant to the patient's care and management. Not only was there a failure to make notes in relation to assessment, reassessment and management, but you also found that there was a failure to make a proper note of the drug regime, which meant that nurses had no guidance as to how to apply these excessively wide and high prescriptions.

Can I take you to the relevant *Good Medical Practice* guidance, which you will find in your files at tab 2, and it should be that which was issued in 1995. If you look at page 13, you should find the date stamp of October 1995, just to make sure we are all looking at the right document. I just pause to make sure everyone has a copy. I am going to make reference to a

number of pages and a number of references. It is a matter for you, as it were, how you apply them, but I am going to draw your attention to those which may be relevant, it seems to the General Medical Council, to your decision.

We start as ever with the first paragraph, which provides that:

> "Patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence, good relationships with patients and colleagues and observance of professional ethical obligations."

I am going to be selective, as it were, from now on.

> "Good clinical care .....
>
> This must include:
>
> - an adequate assessment of the patient's condition, based on the history and clinical signs including, where necessary, an appropriate examination;
> - providing or arranging investigations or treatment where necessary;
> - referring the patient to another practitioner, when indicated.
>
> In providing care you must:
>
> - recognise the limits of your professional competence;
> - be willing to consult colleagues;
> - be competent when making diagnoses and when giving or arranging treatment;
> - 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;
> - keep colleagues well informed when sharing the care of patients .....
> - prescribe only the treatment, drugs, or appliances that serve patients' needs."

Under the heading "Keeping up to date", paragraph 5:

> "You must maintain the standard of your performance by keeping your knowledge and skills up to date throughout your working life."

Would you go to page 4, and the heading is "Maintaining trust: professional relationships with patients." Paragraph 11:

> "Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- Listen to patients and respect their views;
- Treat patients politely and considerately;
- ...
- Give patients the information they ask for or need about their condition, its treatment and prognosis;
- Give information to patients in a way that they can understand;
- Respect the right of patients to be fully involved in decisions about their care;
- Respect the right of patients to refuse treatment ..."

Over the page, page 5:

> "Respect the right of patients to a second opinion."

Paragraph 12:

> "You must not allow your views about a patient's lifestyle [etc] age, social status ... to prejudice the treatment you give or arrange".

Paragraph 17:

> "You must not abuse your patients' trust. You must not, for example ..."

I go to the last bullet point:

> "Deliberately withhold appropriate investigation, treatment or referral."

At page 8 it deals with working in teams and specifically delegating care to non-medical staff and students: 28:

> "You may delegate medical care to nurses and other health care staff who are not registered medical practitioners if you believe it is best for the patient. But you must be sure that the person to whom you delegate is competent to undertake the procedure or therapy involved. When delegating care or treatment, you must always pass on enough information about the patient and the treatment needed. You will still be responsible for managing the patient's care.
>
> You must not enable anyone who is not registered with the GMC to carry out tasks that require the knowledge and skills of a doctor."

At 30, "Arranging cover": "You must be satisfied" – and I only mention this in the context of the evidence that was given on occasion as to why these prescriptions were written in advance:

> "30. You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective handover procedures and clear communication between doctors".

As I say, it is a matter for you as to how much that guidance assists you, but that is what we submit may be relevant to your considerations.

In short, none of these failings, plainly, were in the patients' best interests and many were, frankly, positively harmful to their welfare, and on behalf of the GMC we submit that there is overwhelming evidence of serious professional misconduct.

I now turn to the issue of sanction, which we deal with at the same time, as it were, although, of course, it is a quite separate decision.

The question of what sanction you apply is, of course, a matter for you as an experienced Panel applying your experience and your knowledge of this case, and what I say to you now is, of course, merely a submission by the General Medical Council as to what in this particular case the appropriate sanction should be. The sanction that the General Medical Council submits is appropriate in this case is one of erasure from the register.

A critical issue in all proceedings in regulatory tribunals, particularly, perhaps in the General Medical Council, is the issue of insight, and it is the General Medical Council's submission that Dr Barton has demonstrated, frankly, almost no insight into her failings at all. This is despite the fact that in 1991 she had the clearest warning that her practice needed to be reviewed. Even now, having heard all the evidence, and having sat and listened to the evidence of Professor Ford, and no doubt pondered upon his reports, Dr Barton told you that with the benefit of hindsight she would not have done anything differently. I am going to specifically cite her evidence.

It has been clear, and I expect there will be reference to this by the defence, that there were serious management failings and that Dr Barton could and should perhaps have received better support and guidance from those senior to her medically, and in the management of the hospital where she worked. But you may feel, having heard from Dr Barton giving evidence over many days that her character played a significant part in the fact that she was in effect left to her own devices in the management of the patients at the Gosport War Memorial Hospital. In any event, Dr Barton has personal responsibility for the prescriptions which she wrote. She allowed a system to continue where there was a lack of appropriate controls and systems to ensure that patients did not come to harm. Responsibility was on occasion devolved to nurses which was beyond their skills, their teaching or their experience.

You heard evidence about the change of patients coming into the Gosport War Memorial Hospital during the 1990s. That may also be mentioned, I do not know, but you also have to bear in mind that that was something that was apparently happening across the UK and other clinical assistants in other community hospitals do not appear to have adopted the same approach as was taken by Dr Barton.

I have mentioned the issue of insight, and I just want to remind you of a few passages of evidence which go to that issue just before I turn to the indicative sanctions guidance because, as you will see in Indicative Sanctions Guidance, the question of insight is a theme running through every sanction that you have to consider. I will give you the references so you can in due course check if you wish to that I have got the quote right.

Dealing with the 1991 issue Day 25 page 58, being examined in chief, Dr Barton said this:

> "I felt that by holding a meeting, and by reiterating to the staff that we were available and willing to answer their queries, there had hopefully been the opening of a

A

> sufficient dialogue [to avoid the feeling of them being excluded] ... I felt the problems had largely been allayed."

A few days later, when asked about that specific topic by me she said, and agreed, the practice did not in fact change one jot.

On anticipatory prescribing, using syringe driver, day 25 page 63 she said:

B

> "I do not think there was a practical alternative ... So the patient could well be waiting several hours to receive adequate [pain relief] ... It was unrealistic to expect [the on call] doctors ... to prescribe appropriately and sensibly."

In relation to Patient A, Leslie Pittock (day 25/85) Dr Barton said: Having heard Professor Ford's criticism, I have not altered my view as to what I thought was appropriate at the time.

C

In relation to Patient E, Gladys Richards (day 27/14) she said: There is nothing I would change about my view and judgment as to how she was cared for by me as her doctor.

In relation to Patient F, Ruby Lake, she said (day 27/24): Does the evidence of Professor Ford cause me to review or question my actions in relation to the Patient? Not at all.

D

Patient G, Arthur Cunningham (day 28/page 13): I totally stand by what I did for Mr Cunningham that week.

Patient J, Geoffrey Packman (day 28/48): With regard to the criticisms by Professor Ford, I totally stand by my course of action during the time with this patient.

In general areas – I will have to check the reference – she was asked at the end of her cross-

E

examination: If you had more time would it have affected your decisions in relation to any of these patients? Answer: No.

She was asked questions by the Panel, day 31/1 and she answered: With hindsight, having heard the evidence and the criticisms, would I have done anything differently? No. Of course, I should have formally raised the issue of workload in writing but in relation to the 12 patients, in the days and hours of their dying I would have done nothing differently. If I had

F

more medical cover and one-to-one nursing care maybe we could have organised the terminal care in a slightly different fashion, but with what we had at the time I have no regrets about the medication that any of those patients received. I would not have adjusted any prescription or referred any patient or asked for a second opinion.

She was asked by Ms Julien, who I think was asking these questions specifically: In none of those 12 cases? Answer: No.

G

She was asked this: Putting Professor Ford aside, is there anything going over these 12 cases where you think, 'oh well, maybe I should not have done it quite like that'? Her answer was: Nothing at all.

Can I take you now to *Indicative Sanctions Guidance* and for this you will need to have the latest version, which is that issued in April 2009 and then revised in August 2009.

H

THE CHAIRMAN: It is behind tab D in the blue folders.

MR KARK: The first few paragraphs of the guidance set out the aims of *Indicative Sanctions Guidance*, which is to promote consistency, etc., and I will not spend time on those. Can I take you to paragraph 18, please, on page 6:

> "The *Merrison Report* stated that the GMC should be able to take action in relation to the registration of a doctor ... in the interests of the public, and that the public interest has 'two closely woven strands', namely the particular need to protect the individual patient, and the collective need to maintain the confidence of the public in their doctors.
>
> Since then a number of judgments have made it clear that the public interest includes, amongst other things:
>
> (a) Protection of patients.
> (b) Maintenance of public in the profession.
> (c) Declaring and upholding proper standards of conduct and behaviour."

I read on from paragraph 20:

> "The purpose of the sanctions is therefore not to be punitive but to protect patients and the wider public interest, although they may have a punitive effect. This was confirmed in the judgment of Laws LJ in the case of *Raschid and Fatnani v The General Medical Council* [2007]1 WLR 1460, in which he said:
>
> > 'The Panel then is centrally concerned with the reputation or standing of the profession rather than the punishment of the doctor'."

He then cites part of *Gupta* and I was going to deal just with the last half, which actually is then in turn referring to Sir Thomas Bingham, Master of the Rolls, in *Bolton v Law Society*:

> "... where his Lordship set out the general approach that has to be adopted. In particular he pointed out that, since the professional body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction. And he observed that it can never be an objection to an order for suspension ... that may be an example that the practitioner may be unable to re-establish his practice when the period has passed."

There is a section headed "Proportionality" and I am just going to read paragraph 21 and the first few words of paragraph 22:

> "In deciding what sanction, if any, to impose, the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. The Panel should consider the sanctions available starting with the least restrictive.
>
> Any sanction and the period for which it is imposed must be necessary to protect the public interest ..."

Going over to paragraph 23:

> "The Panel must keep the factors set out above at the forefront of their mind when considering the appropriate sanction to impose on a doctor's registration. Whilst there may be a public interest in enable a doctor's return to **safe** practice, and panellists should facilitate this where appropriate in the decisions they reach, they should bear in mind that the protection of patients and the wider public interest (i.e. maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour) is their primary concern."

The mitigating and aggravating factors are deal with at paragraph 25, and it deals with how to deal with mitigation:

> "Mitigation might be considered in two categories:
>
> (a) Evidence of the doctor's understanding of the problem, and his/her attempts to address it …

And

> (b) Evidence of the doctor's overall adherence to important principles of good practice …"

Paragraph 26:

> "The Panel should also take into account matters of personal and professional mitigation which may be advanced, such as testimonials, personal hardship and work related stress. Without purporting in any way to be exhaustive, other factors might include matters such as lapse of time since an incident occurred, inexperience or a lack of training and supervision at work. Features such as these should be considered and balanced carefully against the central aim of sanctions, that is the protection of the public and the maintenance of standards and public confidence in the profession."

Can I straightaway say something about the lapse of time? These events we recognise were a very long time ago. You will have to consider, however, whether there is evidence of such deep-seated problems and such a lack of insight that despite the passage of time and good behaviour, no doubt, since these events, nevertheless erasure is in fact the appropriate sanction.

At paragraph 36, which follows immediately from expressions of regret and apology – and I draw your attention to the importance of evincing regret and apologising where things have gone wrong – then I read paragraph 36:

> "Awareness of and sensitivity to these issues are important in determining the following:
>
> (a) How a doctor frames his/her 'insight'.
> (b) Whether or how a doctor offers an apology.
> (c) The doctor's demeanour and attitude during the hearing.

A

37. The main consideration for the Panel therefore, is to be satisfied about patient protection and the wider public interest and that the doctor has recognised that steps need to be taken, and not the form in which this insight may be expressed."

Can I then turn to the sanctions which you will have to consider? Of course, you start at the lowest upwards. I am not, frankly, going to bother dealing with no sanction at all, because I B do not think that is realistic in a case like this, although you will have to consider it. Can I go to page 17, which deals with conditional registration? I am really drawing your attention to it in order to indicate why on behalf of the GMC we submit that it would not be appropriate in this case. You know obviously your powers in relation to imposing conditions. Paragraph 57 says:

C "Conditions might be most appropriate in cases involving the doctor's health, performance or following a single clinical incident or where there is evidence of shortcomings in a specific area or areas of the doctor's practice. Panels will need to be satisfied that the doctor has displayed insight into his/her problems, and that there is potential for the doctor to respond positively to remediation/retraining and to supervision of his/her work."

Paragraph 61 provides:

D "The objectives of any conditions should be made clear so that the doctor knows what is expected of him or her and so that a Panel, at any future review hearing, is able to ascertain the original shortcomings and the exact proposals for their correction."

Before imposing conditions, you must satisfy yourselves that:

E "The problem is amenable to improvement through conditions ...."

The objectives of the conditions are clear.

A future Panel will be readily able to determine whether the objective has been achieved and whether patients will or will not be at risk."

F We would respectfully submit that even if you were to apply conditions in a case like this, for instance, not to use opiates, there would come a time when those conditions lapsed inevitably and you have to bear in mind the doctor's responses which I have reminded you of.

Paragraph 62 we say is important when you are considering conditions:

G "When deciding whether conditions might be appropriate the Panel will need to satisfy itself that most or all of the following factors ... are apparent having regard to the type of case ... This list is not exhaustive."

Then the very first bullet point:

"No evidence of harmful deep-seated personality or attitudinal problems.

H - Identifiable areas of the doctor's practice in need of assessment or retraining.

A - Potential and willingness to respond positively to retraining ..."

Then the penultimate bullet point:

> "Patients will not be put in danger either directly or indirectly as a result of conditional registration itself."

B I turn briefly to suspension, which is dealt with at paragraph 69, which provides:

> "Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner ..."

I miss the next line; it mentions it has a punitive effect.

C

> "Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that the Panel considers that the doctor should not practise
D again either for public safety reasons or in order to protect the reputation of the profession). This may be the case, for example, where there may have been acknowledgement of fault and where the Panel is satisfied that the behaviour or incident is unlikely to be repeated. The Panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions."

Paragraph 70 provides that you will want to consider:

E

> " ...where there is evidence that he/she has gained insight into the deficiencies and has the potential to be rehabilitated if prepared to undergo a rehabilitation programme."

Again there is reference in the bullet points under paragraph 75 to you wanting to see evidence that there is no evidence of harmful, deep-seated personality or attitudinal problems
F and that the doctor does not pose a significant risk of repeating the behaviour.

I turn finally to erasure, which is the sanction which the GMC submits is appropriate. Paragraph 77 provides:

> "The Panel may erase a doctor from the register in any case - except one which relates solely to the doctor's health - where this is the only means of protecting patients and
G the wider public interest, which includes maintaining public trust and confidence in the profession."

I know you will know the following words well, which are probably cited to you in almost each case that you hear, Lord Bingham's words in the case of *Bolton*, but can I just remind you of the very last words:

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

The *Gupta* judgment is set out briefly in paragraph 79:

> [The case] emphasised the GMC's role in maintaining justified confidence in the profession and, in particular, that erasure was appropriate where, despite a doctor presenting no risk: *"..the appellant's behaviour demonstrated a blatant disregard for the system of registration which is designed to safeguard the interests of patients and to maintain high standards within the profession".*

We do not concede, I am afraid, that in fact it can properly be said that Dr Barton does not present a risk. Paragraph 82 finally:

> "Erasure may well be appropriate when the behaviour involves **any** of the following factors (this list is not exhaustive):
>
> - Particularly serious departure from the principles set out in *Good Medical Practice* i.e. behaviour fundamentally incompatible with being a doctor.
> - A reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.
> - Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients ..."

Lastly, there is the issue of abuse of position/trust. The very last bullet point there, just above paragraph 83:

> "Persistent lack of insight into seriousness of actions or consequences."

Sir, the GMC exists to protect the public and to ensure that there is public confidence in the profession. Despite the age of these matters, these events have caused not only great anguish to many relatives of those who died at the Gosport War Memorial Hospital whilst under Dr Barton's care, but also serious public concern about the methods of an individual doctor who had considerable power at her local hospital. Each of these patients were under Dr Barton's care, as she accepted, and they and their relatives trusted her with their well-being and indeed with their lives.

The regulation of the medical profession is entrusted to the GMC and you, as a Panel, have a duty to do what you can to ensure that the right message is sent not only to other doctors about what are acceptable standards of practice and what are not, but also the message has to go to the public that they are safe when their care is entrusted to a doctor.

The GMC's submission is that the failings, acts and omissions by Dr Barton which you have found proved were entirely unacceptable and she has not demonstrated remorse or insight. The failures demonstrated in this case are so serious that, despite the passage of time, the only sanction which would ensure the protection of the public and public confidence in the profession is one of erasure.

Those are my submissions, unless I can assist you further.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Mr Kark and Mr Langdale, it occurs to me that I was perhaps remiss at an earlier stage in not noting, as Mr Kark very correctly did, that there has been a change in Legal Assessor. Noting that there are members of the public here today who have attended on previous occasions, I should say that there is nothing unusual about the change of Legal Assessor mid-case, especially in very long cases.

In this particular instance, I am happy to be able to tell you that Mr Chamberlain was given a judicial appointment at the end of our last session and so is no longer available to assist us. However, we are very fortunate that a very experienced Legal Assessor has been willing and able to join us in the form of Mr Smith. So there is nothing odd or unusual about it at all.

Mr Langdale, I know you are anxious to start, but I think what we are going to do is take a short break now to ensure that everybody is fully fresh before you do. Ladies and gentlemen, we will take a 15-minute break now.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. I should say that in the break we have had the technical services department in to attempt to increase the volume of the speakers at the back of the room and I hope that will make things easier for you. But if during the course of proceedings if at any time anybody is unable to hear, please raise a hand and try and catch my eye and I will make sure that we remedy it.

A MEMBER OF THE PUBLIC: I have come without my hearing aid, but do not worry about me, because there is someone who can relay it to me. As long as they can hear, that is fine.

THE CHAIRMAN: We do have a loop facility here. I do not know if it will work, but ---

A MEMBER OF THE PUBLIC: I can pick up bits and pieces, but someone else is writing notes.

THE CHAIRMAN: We are going to arrange for a pair of headphones to be provided to you. They may or may not assist, but we will certainly try that.

A MEMBER OF THE PUBLIC: Thank you for your consideration.

THE CHAIRMAN: Not at all. Mr Langdale?

MR LANGDALE: Sir, in addressing the Panel at this stage, I must make it clear, as you would expect, that I bear in mind the findings that the Panel has made and I bear in mind the GMC's *Indicative Sanctions Guidance*. If I fail to deal with anything in particular, it is not as a result of ignoring either of those pieces of material.

A lot of what I am going to say goes to the issue of whether there should be a finding of serious professional misconduct in the circumstances of this case. A lot of what I seek to say also goes to the question of what action or sanction the Panel thinks it appropriate to take or to impose.

May I say right away, I entirely accept, because he is obviously right, what Mr Kark has said about the judgment to be made in relation to serious professional misconduct, because this case is "under the old rules". There is no dispute between us about that. I accept also the test he has propounded for your consideration as to what amounts to or may amount to serious professional misconduct. I am not going to separate those two issues into discrete parts, because so much of the material to which I shall be referring overlaps or in fact has a bearing on both issues. It is you, the Panel, who decide whether the findings of fact that you have made and the submissions made to you on behalf of the GMC and on behalf of Dr Barton justify a finding of serious professional misconduct.

Although I am going to place before you a body – almost a lever arch file – of testimonial evidence, which will take a little time for you to digest, I should also make it clear that I do not seek to address you in this phase, as it were, at any great length. That is for two reasons. Firstly, you have heard weeks of evidence, you have heard detailed submissions made to you about the evidence, you have had the opportunity to read yourselves back into the case. The second reason is that although the hearing itself took many weeks, a great deal of time, the issues that have been canvassed before you have been very similar in terms of the patients concerned. Each patient is different, but the issues you have had to address and we have had to address you about are not widely dissimilar in any sense.

May I just say something in relation to the file of evidence that I will be asking you to receive and consider at the end of what I seek to say to you? That file has been provided to the GMC and has been available for some time. There has been a slight change to its content, because, as I will explain later on, those instructing me have made every effort to contact those who provided the testimonial material to make sure they still stood by what they were saying in the light of your findings and the nature of the case. So what you are going to be getting is in relation to people who are aware of those matters. Therefore some, because they are untraceable, have been left out from the original bundle.

May I start by saying something about the *Indicative Sanctions Guidance*? I do not need to go into it in any detail, because Mr Kark has already covered the most material items or paragraphs of the guidance. Obviously there is no dispute about the public interest – this is paragraph 19 to which he referred you – including the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour. All my remarks addressed to you, as the Panel, are fully aware of that. I do not seek to say anything to the contrary.

Paragraph 21, another one of the paragraphs which Mr Kark mentioned, is that the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. Paragraph 23 in particular states that there may be a public interest in enabling a doctor's return to safe practice. The protection of patients and the wider public interest is the primary concern, for obvious reasons. You could not have a doctor being permitted to return to safe practice unless you were satisfied that patients would be protected, but it is there in black and white.

I would just say in relation to that consideration, that guidance, you are dealing here with a doctor who, since she left the Gosport War Memorial Hospital in the year 2000, has been in safe practice for nearly ten years.

Paragraph 36 to which my learned friend referred you in relation to insight and so on and the recognition of the need for steps to be taken. I am going say a little bit more about that in a moment or two, because my submission is that it has not been – I am not going to use the word "fair", because my learned friend has been consistently fair in this case – needs further elaboration and examination before the Panel could properly accept the way he has put it.

May I also turn to the matters to which Mr Kark has referred you in relation to the issues with regard to erasure? You have these in front of you; I am not going to repeat them all. It is absolutely right that what is said in the guidance should be followed. Those are matters which are not matters of dispute between myself and Mr Kark in any way at all, but you will be paying no doubt careful attention to the wording of what is said there, I am sure. Again, I am not going to repeat to you the cases that are cited.

In relation to paragraph 82, which deals with where erasure might be appropriate, it sets out that it might be appropriate when the behaviour involves any of the following factors, the list not being exhaustive. We submit on behalf of Dr Barton that when one looks at each one of those indicators – they are not exclusive – the answer to the question: did the behaviour involve any one of these, would properly be no.

Reckless or particularly serious departure from the principles set out in Good Medical Practice, i.e. behaviour fundamentally incompatible with being a doctor. Of course there is an acceptance on behalf of Dr Barton that she did depart from a principle, by way of example, the principle about proper note keeping, but the mere fact that there was that departure does not mean that it is particularly serious. The Panel will remember the evidence about it and the evidence from more than one professionally trained and competent person, how note taking in those days was rather different and how in some cases her note taking was rather better than in the case of others. I say that by way of example and the need for the Panel, as I am sure the Panel will observe in any event, to look at the wording in relation to these examples.

"A reckless disregard for the principles": nobody has suggested ever that Dr Barton was recklessly disregarding anything, or indeed was reckless in her conduct. "Doing serious harm" and so on. As I say, we suggest that on the evidence and your findings, each one of those, if the question was asked "Did the behaviour involve any of these factors?" the answer would be "No", and I bear in mind the very last point which Mr Kark stressed to you, as it were, the last of the bullet points, "Persistent lack of insight into seriousness of actions or consequences". I will be saying something more to you, if I may, about that.

May I just lastly say something to you in terms of the guidance as to the expression that is used, and it is justifiably used, and it is absolutely critical, the question of public trust and confidence in the profession. May I just stress this: that means properly informed public trust and confidence. It does not mean the view of members of the public who have relied on uninformed, biased and/or inflammatory reports in the media. Nor does it mean the view of relatives whose understandable emotions have, again understandably, clouded their perception of the case. Those reactions or emotions are not to be dismissed, but in considering the question of public trust and confidence in the profession it means properly informed trust and confidence without bias, whatever may have brought about the bias.

Perhaps the central question to be asked is really in two parts: first of all, and this is applying obviously to this case, would the protection of patients be adversely affected if Dr Barton

remained in practice as a GP? I will come on to the question of conditions in due course. We submit that there is proof positive that, subject maybe to conditions, the protection of patients would not be adversely affected.

The second part of the question that has to be asked in relation to this issue of public trust and confidence: would public trust and confidence in the profession not be maintained if Dr Barton remained in practice? We submit that although that concept is a little bit more elusive than the concept of the protection of patients, public trust and confidence would be maintained if Dr Barton, again maybe subject to conditions, remained in practice, bearing in mind that it is not part of the Panel's function to punish the doctor for any failings on her part that the Panel may have found, and bearing in mind the factors, to which I shall turn in a moment in more detail, which could be summarised in this way: (1) the area of practice in which she was engaged at Gosport War Memorial Hospital; (2) the conditions in which she was operating; (3) the particular failings which the Panel have found to have taken place; (4) the fact that it is accepted that whatever those failings may have been, Dr Barton was at all times acting as she saw it, genuinely saw it, in the best interests of her patients; (5) the fact that she has not practised in that area of medicine for some ten years, nearly ten years now, coupled with the fact that she has shown herself to be, and is, we suggest, on the evidence as opposed to comment, a very conscientious, caring and indeed esteemed GP.

Having said that by way of general comments about the guidance with regard to possible sanctions, may I turn to first of all briefly general background mitigation material. Again, I am keeping this short because the Panel heard from Dr Barton in evidence, as well as indeed from evidence from others, about her background and so on. It is clear the Panel can be satisfied, we suggest, that she is a hard working doctor of great integrity, a doctor who was a good doctor – people have not suggested she was a bad doctor – taking into account the failings that the Panel have found, that she had an unblemished medical career over many years, qualifying in 1972, beginning as a trainee GP in 1974, and a partner in her present practice since 1980. There has been high praise of her from those who worked with her. You will be seeing, from the evidence I shall place before you in due course, she has extraordinarily high praise from her patients.

Immediately leading on from that, by way of general background, may I tackle a particular aspect of this case that counsel on behalf of the GMC has laid great stress upon: the suggestion that she is a doctor who lacks insight, and indeed my learned friend has gone far enough to say or to suggest to you that there is some evidence of a deep-seated – these are the words used – personality or attitudinal problem. We suggest on behalf of Dr Barton that that assertion cannot be justified when one looks at the matter in the whole.

My learned friend cited, by way of example of her lacking insight, that it was clear in 1991 that her practice needed review, and he suggested that the evidence showed that she has, as it were, ignored that. That, with great respect, just is not justified. The Panel will remember all the evidence that was heard about the contretemps that developed in the early 90s; the views of some nurses and so on and so forth about whether these prescriptions were justified; those who thought they were only justified in terms of patients who were suffering from cancer, and so on. The Panel will (a) remember it, I am sure, in general terms, and you can remind yourselves of it in detail if necessary, but the picture is very clear: Dr Barton did not stand alone as some figure asserting something that was contrary to the practice of others, or somebody who ignored what was being said by the nursing staff. There were meetings (in the plural), and her medical, if you like, superiors, the consultants involved, as well as senior

nursing staff, did not suggest to her that she should change her practice. Dr Logan, the consultant at the time, did not say to her, "Dr Barton, you really must review what you are doing", or suggest for a moment that what she was doing was wrong, or not in accordance with what he regarded as acceptable practice. We suggest that that sort of assertion should be looked at by the Panel extremely closely before accepting that the events of the early 1990s somehow show Dr Barton to have been somebody who possessed no insight or was ignoring red flags being waved in front of her face.

"Where does this suggestion come from?" is the question that one has to ask. It comes from Dr Barton's own evidence. If she was somebody, and again perhaps this goes to the question of her integrity apart from anything else, if she was somebody who was trying to give an easy ride for herself in some way, she could very easily have taken a certain course. For her to maintain, as she has done, and you have been reminded of particular passages, that what she did at the time she stands by, does not indicate of itself somebody who lacks insight, somebody who is not ready to change, somebody who is unduly arrogant, nor, again with respect to my friend, does it justify a suggestion that she has some deep-seated (again I quote the words) personality or attitudinal problems, which my friend then seeks to build on to suggest to you that (a) she should be erased if you find serious professional misconduct, and you should not properly consider allowing her to remain in practice subject to conditions. She said in her evidence that in her view, looking back and bearing in mind the circumstances in which she had to operate, her decisions were made correctly, and that the conditions of the patients concerned justified the treatment she gave them. She has maintained, for example, that her decision at Mr Packman's bedside, that he was not fit for transfer back to the hospital, was in her judgement correct. That, we submit, is not arrogance, nor does it justify a conclusion that Dr Barton is not ready to learn, or that she is not ready to change to meet developing medical practice. That is why I am stressing the circumstances in which she was operating at the time.

She has acknowledged – this seemed to almost pass the GMC by – failings from the start of these proceedings. Her inadequate note-taking, accepted by her from the start; particularly, the inadequacy of her note-taking with regard to the rationale for her decisions in certain cases. She acknowledged from the start the dose ranges of her anticipatory prescriptions were not appropriate, because they carried with them a risk that they might provide a basis for an improper administration of opiates.

It is not, we suggest, an appropriate process of thought to conclude that the fact that Dr Barton still considers that her judgement was right, and I underline these words, as it were, in these cases, that that means she is indifferent to changes in methods and practice, and that is the leap that is made, unjustified intellectual leap. The Panel will bear in mind, in considering Dr Barton's stance, "I was there. I made the judgement I thought was right at the time and I do not think my judgement was wrong", that stance does not mean that she is somebody who can be regarded as possessing a deep-seated personality or attitudinal problem.

It is worth bearing in mind too, in relation to this area of medicine, the difficulties that faced not only Dr Barton but any doctor in this particular field with these often difficult judgements. You have made findings that in certain cases the prescription was not in the best interests of the patient. I am summarising obviously. She is somebody who in her view at the time, looking at the patient and considering the patient, thought that it was justified in the context, because anticipatory prescriptions were accepted.

You will also bear in mind that a lot of the findings you have made against her relate to the risk rather than the fact that a patient's situation was actually harmed. May I just remind you of these matters in considering certain assertions made about the patients and the allegations against them. Leaving aside the question of risk, or inappropriate, or not in the patient's best interests because it was inappropriate or there was a risk, it was suggested on behalf of the GMC that many were, actually were, harmful. Again, I invite the Panel to remind itself – it hardly probably needs reminding as they are your findings and you have refreshed yourselves of them in any event – but may I remind the Panel and ask you to consider this, that in fact the findings of the Panel as to whether these prescriptions were harmful, not surprisingly, because of the difficulty of establishing whether in fact it was the opiate which contributed improperly to the problem or the dying process itself, you actually found, I think in relation to two patients, a specific finding that, as it were, harm had been caused. In relation to Enid Spurgin, you found that the dosage, in the particular dosage that you were concerned with, was excessive to the patient's needs. That is a finding of fact that you made. In relation to Elsie Devine, the lowest doses which she prescribed would have been likely to induce a very powerful sedative effect with a consequent risk of respiratory depression, and in your finding you coupled with that the fact that she was on fentanyl – and you will remember this case no doubt – at the time that the syringe driver process was started; the fentanyl would have had, I am stressing that word, a profoundly sedating effect. You found in her case the prescription put the patient at severe risk of respiratory depression, coma and premature death.

You also noted, again Mr Kark referred to this particular case, that she had lapsed into unconsciousness shortly after the commencement of the syringe driver. May I just say this, and it does not alter the impact of the finding I do not think, it does not alter the gist of what I am seeking to say to you now, in fact in that case she did not lapse into unconsciousness until she died. You may remember that her daughter, I think it was Code A gave evidence that in fact although the nursing staff on duty, or one of the nurses, thought she would not get a response, the patient Code A did squeeze her hand. She was not in fact unconscious throughout. I am just saying that as a matter of fact because that point was specifically mentioned by my learned friend.

That, we suggest, needs to be looked at and considered very much in the context of the suggestions being made that Dr Barton saying, "I stand by what I did. I could see the patient. I was using my experience and my judgement to prescribe as I did in the context of anticipatory prescribing, and to make the judgements that I did, that in fact, for example, in Mr Packman's case", I am putting it bluntly, "that there was no point, it was not in his best interests to be returned to hospital". That fact does not indicate, cannot be used, and I stress this as much as I can, as a proper basis for concluding that Dr Barton lacks insight, or that she lacks an ability to change and adapt in the year 2010 to changed medical practices and views, if she was ever to go back into the field of palliative care medicine, because she has no intention or desire to go back into that field. If it was the case, the Panel can be safe in concluding obviously she would ensure that she received training with regard to the latest methods, principles and procedures, and she would ensure that she implemented those approaches and methods under suitable consultant supervision: or is this is a bizarre example of a doctor who in every other respect in terms of her training, her methods, her procedures and her actions is subject to no criticism whatsoever, nobody suggests she has an attitudinal or personality problem as a GP, quite the contrary, a bizarre example of somebody who somehow exhibited these features in connection with the particular field of medicine she was operating in over 10 years ago, it does not, we suggest, make sense.

You will be considering, I hope, amongst the material that I will be providing you with, the latest appraisal of her by a doctor – I will refer you to it later if I may – which makes it clear that in fact – and you will remember this from the evidence you have heard in the course of the hearing – the Liverpool Care Pathway material, something which she has seen and considered and taken an interest in, not exhibiting the slightest sign of somebody who is just saying, "Well I know it all; I don't need to bother to look at that".

Dr Barton has been in practice now for over 30 years, and in practice for nearly 10 years since she left the Gosport War Memorial Hospital. It has not been suggested from any quarter, but most importantly by any medical practitioner, that she is somebody who does not apply up to date procedures and learning. The Panel will also bear in mind in relation to this suggestion that is made, that we are concerned with 12 patients treated by Dr Barton out of hundreds who were treated by her at the Gosport War Memorial Hospital.

Another general heading, if I may, with regard to the approach we suggest the Panel should take in this case, and that is to consider what the context was in which she operated and in which she failed in the way the Panel have found the context. It is perhaps a vital consideration affecting the course the Panel decides to take as a consequence of its findings.

I am not going to go into this at any great length. The Panel will remember the evidence, but it can fairly be said that these 12 cases were treated in accordance with her normal prescribing practice. It is not a case, perhaps I can say in parenthesis, that she was somebody who ignored – that is the word that was used – the guidelines in that she paid no attention to them. Dr Barton was aware of the guidelines. She made her own judgment based on the condition of the patient she was dealing with. So it is not a case that she ignored them. You found there was a failure in some cases to observe the guidelines when that would have been appropriate but it is not a case of a doctor saying, "To hell with the guidelines, they make no difference to me". She was aware of them; she applied her own judgment about them.

Her practice was known to all consultants, one of whom was also the Medical Director, Dr Reid. Those consultants included Dr Logan and Dr Grunstein, and must indeed have included Dr Wilkie, whose name surfaced at certain periods earlier on. They did not question her practice and did not criticise it. Of course it is right for the Panel to say, as you did, that as a medical practitioner she retained ultimate responsibility for her own actions. That is something that Dr Barton would not resile from for a single moment, but she could properly, and we suggest did properly, feel she was acting with approval and sanction. She was not a doctor operating in a vacuum. She was entitled to expect, and did expect, that they would provide her with guidance and advice if they felt that she needed it. One can add too in terms of the context other doctors also saw her patients on occasion. Dr X, Dr Knapman, Dr Beesley and Dr Briggs: none, from what they saw – admittedly they were not carrying out day to day treatment of the patients, but from what they saw – none of them concluded that Dr Barton was doing anything that they would query.

In terms of the consultants, perhaps it is also worth bearing in mind that there was an agreed protocol in relation to the question of prescribing in the way she did, which was defence document D4. You will probably remember it was produced in the course of the evidence called by the defence.

If I can add to the doctors and the consultants the nurses: generally it was clear from the nurses that they did not criticise or query what Dr Barton was doing, but it is notable in general terms, apart from the generality, it is notable that those nurses, who were quite capable of complaining if they had concerns, you may remember Nurse Giffin, Nurse Turnbull, Nurse Tubritt, and in a rather different category Nurse Hallman, they were all people who were quite capable of complaining if they felt there was a need to complain. None of them at any time, either when any of these 12 patients were receiving treatment, or afterwards when they made statements either to the police or to the GMC, none of them voiced any concerns about what was prescribed or administered to these 12 patients. Indeed, they, the nurses I have referred to specifically by name, like all the nursing staff, found Dr Barton to be a good doctor, with the interests of her patients at heart.

Again, with regard to the nurses one has to consider the difference between a risk, a risk that should not have been run but a risk and the actuality, bearing in mind the nature of your findings in many cases – we abide by them, obviously, because they are your findings – that it was the risk, the potential for harm that meant that they were not in the best interest of the patients, and in addition to the consultants, the doctors and the nurses, may I also remind you of the evidence about the pharmacist, again somebody who was in a position to check on, criticise, discuss with Dr Barton what she was prescribing, the combinations and so on. Leave aside the question as to whether in fact, looking back at it, or a different consultant might take a different view, that was the context in which Dr Barton was operating.

Also in that context, as you know, Dr Barton placed great reliance on the nursing staff and their judgment, and, indeed, had good reason to do so. Not one non-nursing witness suggested that Dr Barton was not entitled to place great reliance on that, but it did mean that she could not herself be making her own judgments about the condition of patients 12 or 24 hours a day – you will remember the evidence about that – far from it.

A further consequence of the conditions under which she was operating was the fact that certain procedures, which might be possible or available in a fully staffed hospital or a teaching hospital, were not possible or available to her at Gosport. Titration and so on: I do not need to go over the evidence. You will remember the evidence about it.

Her note-taking, as you know, and, indeed, that of her staff, suffered. She has accepted that failing, but in mitigation of that failure, which was not brought about by laziness or sloppiness, it can fairly be said that there was no case amongst the 12 patients in this case of that failure causing any problem at all – these 12 patients – to any consultant, nor to any nursing staff. Somebody has suffered as a result of that failure, and that is Dr Barton. She has to face the consequences for her failure.

I have already mentioned, but may I remind you in this context, of the evidence about note-taking at that time and the evidence of Dr Tandy – I can give you the reference, day 18/48 about note-taking generally and her view that in some instances Dr Barton's note-taking was better than some other. Then this too in terms of the context: the lack of consultant cover. A lack of medical input. I am touching here in a way on management issues. If there had been more consultant cover and medical input then the burden on her would be less. Furthermore, the consultants did not expect her to come to any of them to seek their sanction with regard to treating a patient with palliative or end of life care. She was not expected to seek their sanction. If she made a clinical decision that a patient was not suitable for return to the hospital from which the patient had originally come and therefore not suitable for further

intervention: it may seem a bit much, quite frankly, to somehow blame Dr Barton's character. That is what was being suggested, for the failure of consultants to do more, for their failure to indicate to her, if they thought it, there was something wrong with what she was doing. How it can possibly be suggested that somehow her character is at fault in that regard is perhaps difficult to understand. No consultant has suggested how he or she was frightened of Dr Barton: "I didn't dare challenge Dr Barton. I would not possibly go against anything she said". Of course they respected her experience and her judgment, but to suggest that somehow her character is to blame, as I say, does not perhaps stand up to close examination.

Of course Dr Barton has to take responsibility for any findings the Panel have made which are adverse to her, but when assessing the impact of those findings it has, we suggest, to be borne in mind, she was not receiving adequate medical supervision, guidance and advice. This was not a situation of her making. She got on with what she had got. There was a failure of management generally. I do not think there is any dispute about this, because my learned friend Mr Kark has acknowledged that there were failures. If the management had set things up so as to provide effective clinical governance then this problem would not have occurred. Anticipatory prescribing would not have taken place in the way that it did. Titration would have been possible. There would have been audit, annual appraisals and so on. There would have been multi-disciplinary team meetings, no doubt, and sufficient time for Dr Barton to maintain proper records. There would have been challenges, as it were, within the system. It is not her fault that those features were absent. What response did she get when she spoke to consultants and management about concerns? The response was: I see your point, but there is nothing really I can do about it, and no doubt the Panel, when these criticisms are made of Dr Barton, will bear in mind what happened when she resigned, for perfectly proper and understandable reasons. Instantly matters changed and management made sure that greater resources were put in to cover the same job that Dr Barton was doing.

You will remember the fact that it was the case I think that a staff grade doctor was put in place, working full-time, with out of hours cover also being provided in relation to something like tripling of the amount of time and direction that Dr Barton had been able to give in the circumstances in which she was placed.

This as a further sub-heading which we invite the Panel to bear in mind very much when considering whether what she did amounts to serious professional misconduct and, if it does, what the consequences should be. That is the area of practice in which she was engaged. A difficult area, and one which operated rather differently to the way it does now. You have heard evidence from Professor Ford and Professor Sikora about this: now everything is much more guided and monitored. I have mentioned the Liverpool Care Pathway and so on. Methods of administering and so on are, it seems, more uniform. Greater care is taken to inform patients and their relatives about the situation than was the case 10 to 15 years ago across the country.

It has to be said too, it is still an area of discussion and debate as to what was the appropriate course, what the appropriate approach should be for patients in this difficult, painful and troublesome time of their lives. Furthermore, it was an area where there were differing views and attitudes to palliative or terminal care, and about the proper doses to employ in such care.

You will remember that the BNF and the palliative care handbook did not attempt to give guidance in relation to patients being treated in that way. You saw examples of differing attitudes. Indeed, you took account (if I may say so perfectly properly of course) about the

divergence of view in the profession (paragraph 10 of your determination). Those nurses who expressed concerns about patients being put on syringe drivers when they were not suffering from cancer; different views as to what level of pain was to be tolerated by patients; different views as to what the administration or oral or subcutaneous morphine was appropriate. Those, who like Professor Ford, saw it as only appropriate if the patient was suffering from pain as opposed to distress and so on, and those like Dr Barton and Dr Logan who saw it as appropriate to administer to relieve distress and so on.

It is worth noting and you will remember, Professor Ford did find it acceptable in the case of patients who were suffering from cancer. You will remember too the evidence of Professor Sikora who also said that you might use properly the administration of subcutaneous morphine to relieve distress, fear of dying and so on. He also did not see that there should be a difference between the relief of pain, depending on what it was the patient was suffering from, no difference therefore between the cancer patient and the patient who was dying from some other cause, and suffering pain, distress, agitation and so on.

Perhaps one can say this: it is perhaps implicit in your findings that you found that Dr Barton came down too heavily on one side of the scales, that of her overriding concern to ensure that her patients did not suffer pain, and that coming down too heavily on that side of the balance – and it is a difficult balancing exercise, the evidence shows – that of course had the effect of there being an expense on the other side of the balance, which was that of trying to keep a patient in a reasonable state of alertness. You dealt with this in your finding, and you made it clear what you saw as Dr Barton's clear position. As I say, that was a balancing exercise and if that was an error of judgment on her part, as you have found, it was an error made in a difficult area and without any ill intent: far from it.

Before turning to what submissions I make in respect of what would be the appropriate order in this case, may I just mention one other feature of the case? We suggest it is a cardinal feature of the case and I have touched upon it already.

Underlying the essential features of Dr Barton's actions was a particular attitude – now we can talk about an attitude on an evidential basis – and concern that she had, in that she was endeavouring at all times to act in the best interests of her patients. It has not been suggested that she was quite categorically seeking to hasten the end of any patient under her care. That was her case throughout and the GMC did not suggest to the contrary.

It is important, we suggest, to lay great stress on that core element, not only because it will no doubt have considerable bearing on what the Panel thinks it appropriate to order so far as Dr Barton's professional future is concerned, but also to give the lie to some of the wilder and more exaggerated statements that have been made in the media, hinting darkly at Dr Shipman or claiming that Dr Barton was practising euthanasia. One comes back to the point I was making earlier on about when one considers public confidence and trust, it has to be informed public confidence and trust.

The central concern that Dr Barton had was to ensure that her patients did not suffer any unnecessary pain, agitation or distress at the time they entered the last phase of their lives. There was no desire to harm any patient. There was only a desire to care for them as best she could, as she judged the situation to be. You have found that in some instances that judgment was wrong, but you will not forget, I am sure, her motivation.

A What can we say about the appropriate order in this case? I am approaching this on the basis that if you have found there was serious professional misconduct, then this is the context in which you would have to consider this approach to the order. We suggest on the evidence she is demonstrably fit to practise. It is only in this difficult area that complaint has been made about her. It can fairly be said that a clear demonstration of her commitment and dedication to her work has been given by her continuing to provide excellent care to her patients, despite having had allegations of various kinds hanging over her head as well as the B strain of the proceedings before you, for some ten years. Since 2000, she has been in practice subject to a voluntary condition that she does not prescribe – and I am using the expression very generally – opiates. You heard the evidence in the course of the case.

As a result of an Interim Orders Panel in 2008 – and this is the condition she is currently operating under – missing out the concomitant conditions in relation to notifying the GMC and so on and so forth, condition 5 is that she must not prescribe diamorphine and she must C restrict her prescribing of diazepam in line with BNF guidance. One has to say that was I think a justifiable concern. What is the basis for suggesting that somehow the facts of this case demonstrate that if you thought it was appropriate, a condition or conditions should not be imposed? How can it be suggested in all conscience if, first of all voluntarily and then, following an order, an identical condition laid down by the Interim Orders Panel, in observing exactly what those conditions are, she has not been demonstrating in her practice some deep-seated personality or attitudinal problem such that she disregards what she has to D do, that she disregards current proper practice and so on? I invite the Panel to look at the facts when considering the suggestion made on behalf of the GMC that really, conditions are not appropriate in this case.

Furthermore, I invite the Panel to remember that when it has been suggested that there might be some sort of problem, because you can only impose conditions for three years and goodness gracious me, Dr Barton might suddenly, if that was done, in the fourth year, she E would start going haywire and somehow the protection of patients would be affected and public trust and confidence and would be affected. Really.

No doubt you will have in mind that if there was the slightest risk of that and indeed in any event, if that condition or conditions of that kind were imposed, they can be reviewed at the end of the period. Again, it is not a justifiable reason for saying that conditions would not be appropriate in this case. She will never be, to pursue the point that was being made on behalf F of the GMC, ever again in her life, conditions or no conditions, in the same situation as she was in the 1990s, nor would she be in that area of practice in the way that she was, save whenever aspects of her practice as a GP might involve dealing with somebody or treating somebody who was getting near to the end of their life. Nor will she ever be applying the approaches that applied in the 1990s. You can be satisfied, we suggest, absolutely that the situation would never be repeated and indeed there is no lack of insight with regard to the inadequacies of the situation that pertained in which she was operating then.

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I have already made the point that you cannot properly or sensibly in the case of Dr Barton make the jump that because she stands by what she did in 1996, 1997, 1998, 1999, whatever it was, she somehow is somebody who has no insight and would not follow proper procedures.

Subject to the condition I have mentioned, first voluntarily adopted by her and then applied H by the Interim Orders Panel in 2008, she has clearly been practising good medicine since she

left the Gosport War Memorial Hospital. It does not seem to be possible in all reason to suggest that she somehow poses a risk – that was the expression that was used – it was seriously suggested on behalf of the GMC that she poses a risk to patients. Is counsel on behalf of the GMC right and are those who know her and who have appraised her and made a professional judgment about her wrong? That is a matter for the Panel to consider on the evidence that first of all it has already heard and I hope on the evidence that I will be providing in a moment or two in regard to testimonials.

We suggest that – of course this is a matter for you, if you consider that a condition should be imposed – erasure is not the proper course and is not justified here, bearing in mind the standards you have to apply and that any properly informed person could have absolute confidence – and I am putting it as strongly as that – and trust in Dr Barton as a doctor and in the profession as a whole. She is a good, experienced, caring and conscientious GP who continues in practice and continues providing to the community an important and vital service.

Her fitness to practise we suggest, if necessary subject to the existing conditions, is not in doubt. In support of that contention I am going to ask that you receive a bundle of testimonials. One always feels like apologising when providing a lot of written material, but I am not going to apologise, because it is rather important so far as Dr Barton is concerned in terms of some of the suggestions that have been made, particularly today, about her.

Can I, rather than have a porter's job being carried out now, simply say something to you about its nature and then you can receive then and I by then will have stopped, because no doubt you will wish to consider the import and effect of them on some later occasion than this afternoon. Can I conclude in this way?

You will find – and I venture to suggest it is a pretty exceptional collection – that there are 184 testimonials in letter or report form from differing people: patients and so on and other professionals in the medical profession. I venture to suggest that it demonstrates overall her popularity with patients, the fact that they are ready to wait longer than normal in order to see Dr Barton at the practice, the range of illnesses and problems she has had to deal with, her sympathetic approach attested to by many and the fact that they bear out what I said earlier on by way of a contention made by counsel that she is a good, caring, conscientious doctor, indeed, an excellent family doctor, and somebody who is astute, trustworthy and ethically sound, absolutely contrary, we suggest, to the suggestion that there is some kind of deep-seated personality or attitudinal problem – this is the last time I am going to mention it – that is just not borne out. Are all these people wrong? Have they all missed something? The answer on a sensible basis, we suggest, for your consideration must be no, they have not.

In terms of the last four of these people, they are people who sent unsolicited testimonials about Dr Barton, that is, unsolicited by those instructing me. All of the people on this list have seen the heads of charge and the findings of fact and all have indicated, having been contacted by those instructing me, that they wish their letters or reports to be used. There are six who gave their authority this morning, or at least that is when it reaching those instructing me. So you have a very small bundle of six. You will find the appraisal that I referred you to, this is the latest appraisal by Dr Beale, at pages 266 and 267. Perhaps I can say this, again to avoid an unnecessary bulk of paper, we have provided you with the latest appraisal. There are earlier appraisals and there is no difficulty about providing those to you if you would find

them to be of help. I am reminded that the last four which I mentioned earlier on, as I understand it wrote directly to the GMC. That is how they came into the picture.

Sir, that is all I seek to say to the Panel. Thank you.

THE CHAIRMAN: Thank you very much, Mr Langdale. The Panel will receive the bundle of testimonials and mark it exhibit D8. (Same distributed) Mr Kark?

MR KARK: I am not rising to reply, because I do not have a further right to do so, but can I just give you the right reference which I had wrong earlier, if you remember. It was in fact Day 28/64 and 65.

Can I also mention this? I suspect the Panel will obviously want to read the material before receiving your advice from the Legal Assessor and that I presume will be given tomorrow. I myself unfortunately am engaged in another hearing, in fact in this building, and that Panel very kindly agreed not to sit so that I could attend today, but as you see, Mr Fitzgerald, who has been with me throughout the proceedings, will be here tomorrow and I gather we may have an opportunity of seeing the Legal Assessor's advice in advance in any event, so I hope you will not take it as any discourtesy if I am not here tomorrow, but I will make myself available for your final determination, providing I can square that, as it were, with my current Chairman in the other hearing.

THE CHAIRMAN: In the event that the Panel, having had advice and comments from parties, were to encounter the need for further advice, would we be calling upon yourself or Mr Fitzgerald?

MR KARK: As I say, the hearing is next door. If Mr Fitzgerald feels he needs me, then I will make sure that I can attend, but I am absolutely sure Mr Fitzgerald will be able to cope with anything that may arise.

THE CHAIRMAN: Of course. Thank you. Mr Langdale?

MR LANGDALE: I appreciate what my friend has said and I am grateful to him for indicating it. May I just say this? Obviously the timing is entirely a matter for you and the Panel as a whole. Dr Barton in fact would not be able to be here tomorrow – I am just pointing that out as a fact, so that you know.

THE CHAIRMAN: As long as Dr Barton is happy for us to continue, receive advice and so on, I anticipate that we will at some stage tomorrow be going into camera and I will leave it open-ended this time. I will not give any indication as to how long we are likely to be, other than to say that as soon as things become clear in terms of time, we will let everybody know, and that of course includes family and other visitors who may wish to be present to hear the reading of the determination when that happens.

MR LANGDALE: May we take it then, sir, if I may inquire, whether we should, as it were, be on the end of a telephone tomorrow and maybe thereafterwards?

THE CHAIRMAN: I think we can say that after we have read through that considerable bundle, we would then be expecting to hear from our Legal Assessor and we probably can attempt to put some sort of time on that now, if it would assist.

MR LANGDALE: It would, sir. (After a pause)

THE CHAIRMAN: I have taken the opportunity to confer with the Legal Assessor as to how long he is likely to need in any event and also for us to consider, as you have indicated, a weighty bundle that needs to be read with care. We are going to say two o'clock, if that assists.

MR LANGDALE: Thank you. It does.

THE CHAIRMAN: Very well. That is it for today. The Panel will be hear again tomorrow afternoon at two o'clock to hear the advice of the Legal Assessor. If parties are interested to attend for that, they are of course most welcome.

(The Panel adjourned until 2.00 p.m. on Thursday 21 January 2010)