GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Friday 24 July 2009

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 Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY THIRTY-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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INDEX

A

JANE ANN BARTON, Re-called

THE CHAIRMAN: Welcome back everyone. I am sorry that we have taken rather longer in our preparations than I had anticipated.

Before we move on to the Panel questions, I had asked the Panel Secretary to photocopy and pass to the parties pages from the 1997 edition of the *BNF* to give you forewarning of the fact
B that a member of the Panel would wish to ask the doctor a question or questions in relation to something that is on one or more of those pages, and to give you the opportunity to indicate if you did not wish that to happen or if you had observations. Although the *BNF* 1997 edition is in part already before us as an exhibit, this is a part that is not, and so there is the issue of whether you felt that we were going beyond that which was before us and whether you had views on that. It is on that which I am inviting observations at this point.

C MR LANGDALE: There is no difficulty.

MR KARK: I agree. Indeed, it is appropriate to put it on the transcript that the document has been circulated and there cannot be any objection.

THE CHAIRMAN: I am most grateful for that. It will follow that at some point in the questioning the panellist who wished to ask that question will indeed put the question and
D we will all hear then what it is.

Doctor, I am not going to trouble you with introductions to all the individuals. You are well aware of who we all are. I am going to begin by asking Ms Joy Julien if she has any general questions rather than patient-specific questions.

Questioned by THE PANEL

E

MS JULIEN: Good afternoon, doctor. My questions are general questions. They are questions that ask you to look retrospectively at the issues. The first question relates to your working conditions. You have told us that you were working between 1996 and 1999 in very difficult circumstances, mainly due to lack of resources, lack of sufficient supervision ratios, staffing ratios, and that that had an impact on your ability to write more detailed notes. You told us that you raised these issues informally, and I am just wondering now, with hindsight,
F whether you feel you should have raised them formally and at an earlier stage. I wanted to get your view on that.

A That is a very pertinent question, because I knew that the Trust for which I worked, the Healthcare Trust, was short of money. I knew there would not be money flowing to replace me or to add to the medical cover that I provided and I was sufficiently old-fashioned a GP to feel that the job in my community needed to be done, that I had been doing it for a number of years, and that while I could still continue to do it I would continue, albeit
G finding it increasingly difficult. Although my note-keeping suffered, I tried very hard to make sure that my clinical care of my patients and my staff did not suffer in the same way.

Q Now that you are here and you have been answering questions on these issues, where we are today, what is your view? Would you have done anything differently?

A No. I loved the job, I loved the people I was working with, I got great satisfaction from it, and I think it was only when the complaints began that I really realised that the job
H was beyond me.

Q Are you saying you would not have even formally raised the issues in writing?
A Of course I should have formally raised the issues in writing. Of course I should have made it obvious that it was becoming increasingly difficult for me and that I expected my consultants to do more to cover me and to help me. Of course I should.

Q You should have. At what stage do you now say that you should have raised it?
A 1998/99, when Dr Reid took over as clinical director, was the obvious time to do it, because there was a year without proper medical cover on Dryad ward where things became extremely difficult.

Q Still keeping with the retrospective view in terms of the individual patients, you have been giving evidence, you have been asked questions about the actions that you have taken and decisions you would have made, you have been criticised by Professor Ford on quite a few of the cases, and you have been specifically asked whether you consider your actions to be appropriate. You have answered throughout. You have said, yes, you felt they were appropriate. Really it is the same question: In retrospect, would that still be your answer in terms of all the cases? Would there be anything you would do differently?
A In the case of those 12 patients?

Q Yes.
A In the days and hours of their dying, I would have done nothing differently.

Q Nothing at all. There would be nothing that you would ----
A If I had had more medical cover, if we had had one-to-one nursing staff (as it sounded as if Professor Ford's unit had had), maybe we could have organised the terminal care in a slightly different fashion. But with what we had at that time and the way we did terminal care at that time, I have no regrets about the medication that any of those patients received.

Q So you would not have adjusted any prescription, you would not have referred a patient or asked for a second opinion.
A No.

Q In none of those 12 cases.
A No.

Q Even though you faced the criticism from Professor Ford, that is still your position.
A I have felt throughout that Professor Ford's criticism has been perfectly appropriate with the benefit of hindsight and looked at by a secondary care specialist with tertiary specialisation in palliative care – not a community hospital run by a part-time jobbing general practitioner: a completely different world of nursing, medical, everything treatment. I could not have provided the sort of care that he had at his fingertips in my cottage hospital.

Q Okay, putting aside Professor Ford's specific criticism, generally speaking is there anything now you have been going over these cases where you think, "Oh, well, maybe I should not have quite done that like that"? Is there anything?
A Nothing at all.

MS JULIEN: Nothing. Thank you very much.

MR PAYNE: Good afternoon, doctor. Can you see me okay?
A I can, thank you.

Q Because of Mr Langdale's boxes.
A I know. His wall. (Pause)

MR PAYNE: Yes, his defences, I think.

THE CHAIRMAN: Perhaps I could say for the transcript that the defence ramparts have moved six inches in the direction of Mr Langdale, opening up a clearer line of view between the witness and the Panel member.

MR PAYNE: I can say that because of your answers a couple of my questions are no longer relevant, which cuts the amount of questions I have down considerably. Could you turn to the transcripts of Day 25. Mr Langdale asked you a question and at the time I thought the answer did not fit the question, so then I looked it up on the transcript and I still felt that that answer did not quite fit the question. Would you turn to page 19E, where there is a bit of preamble before the question, and read it through and perhaps the question before. (Pause for reading)
A Yes.

Q I am going to ask you the question again, because I felt as though you answered the question and Mr Langdale carried on responding to that answer but I do not think the answer was the answer that the question should have prompted. "Was it always possible to think of a precise plan at that time or provide a precise plan?"
A The first part of my answer remains exactly the same: there were a few patients in which it was patently obvious what the plan was to be.

Q Yes.
A And that was the lady with carcinoma of the bronchus who had come to receive palliative care. There was a whole other number of patients who, having made my initial assessment of them, I needed to give a little time, to see what they were capable of. I knew what they had come to me for; for example, the people with a fractured neck of femur who had been offered the chance of gentle rehabilitation. On my initial assessment of them, that did not seem very likely, but I needed to give them time to get over the transfer and the journey and settle them into the ward before making a further assessment of them.

Q Was that your practice, then, that on initial entry to the hospital you made one assessment and then two days later or three days later ----
A A few days.

Q Whenever you felt it was appropriate, you made ----
A I felt we could then go back to the patient. The nurses then knew the patient, the patient had settled into the ward, and it became much more apparent what their potential and their capabilities were.

Q With that in mind – and I had crossed these questions off – there were times when you wrote the anticipatory prescription on the day.

A Because it was obvious that they were not going to be able to be rehabilitated. They were really very seriously ill even when they arrived, and I was looking at them at some stage in the future needing palliative and terminal care.

Q With the greatest of respect, the prescription was 20-200 mg in virtually all the cases.
A Yes.

B Q Like one-size-fits-all.
A But subsequently one size did not fit all, because subsequently I altered the prescription. Or in large numbers of cases that you have never looked at and never seen, the prescription was never used.

Q So this was not a blanket coverage for every patient that you ----
A Absolutely not.

C Q It just so happens that it is these 12 patients – well, about ten of them.
A You are looking at these patients because they are out of the ordinary. They are out of the run of work that we did on the ward.

Q Thank you for that.
A Do you remember that Professor Ford said that on an acute medical ward he thought
D that between 30 and 50 per cent of people died on opiates?

Q I remember the reference to 30 to 50 per cent dying.
A I think that probably our figures were much the same. We had large numbers of patients who passed away very peacefully and gently without needing any opiates, without needing any anticipatory prescribing at all. These were 12 very difficult cases.

E Q Thank you. That is very helpful. The second question I have for you is on when patients were transferred to you. If you look at page 20H, at your answer there, you talk about imaginative scoring from the people sending the patients to you.
A Yes.

Q Also, at page 22D, you talk with regard to the patients' relations and their expectations. Quite frankly, I think you would agree with me that if somebody says to you,
F and you are a member of the family, that they are going for rehabilitation, you would literally believe them, surely.
A Of course. But it was not the truth.

Q And you have said that it was totally unrealistic.
A Yes.

G Q My question is: did you ever officially complain?
A No. To whom?

Q First of all, I would assume that you could go through your consultant or perhaps you could complain to the consultant of those wards that ----
A It was a time, if you remember, when continuing care was coming to an end. The National Health Service was going into a period of internal markets and prices for everything,
H and the acute beds in our district general hospitals were really stretched. They were really

pushed. They needed those beds desperately, so they passed patients on sooner and iller than they should have been to us. We understood why, but we then had to pick up the pieces and make a relationship with the relatives and explain that what they had in fact been told was not correct. I do not think that it would have been possible, even had I complained to everybody, to change the culture in the acute wards in the district general hospitals.

Q Thank you very much. There were some transfers back when people needed, perhaps, to be returned because they were not right; you could not handle the situation that they were in. You talked about being on an A&E trolley while they waited for a bed. Did you actually know that was a fact; that that was going to happen with every case - that was necessary? Could it not have been the fact that you could have bypassed that situation just by contacting the ward and saying: "Can we send this person straight back to you?"
A If it had been imperative that any patient needed to go back, like the lady who dislocated her hip, we could make the arrangements, but we knew that on the morning of discharge from an acute ward these elderly people were put into what was called the Discharge Lounge, on a chair, on a wheelchair – sometimes on a trolley – to wait for their transport down to us and while they were waiting for the transfer to us somebody else was in their bed.

Q So the situation was that acute at ----
A The situation, at times, was quite dire, so that you had to be absolutely certain that that patient was well enough to cope with a transfer back up through A&E and the waiting that would involve, and that it was appropriate for them to go at all. We did it, but it was not appropriate, again, for any of these people.

Q You just said, once again, "through A&E", but was that a necessity?
A There was no bed; their bed was gone; the bed was full.

Q You would not know that unless you enquired.
A I knew because each morning the bed bureau up at the acute hospital was asking how many beds we had; how many people they could transfer. That was not the situation of a hospital with beds sitting empty waiting for our patients to go back.

Q My experience of hospitals is relatively new but I was under the impression that that situation, where they asked what each individual ward had beds spare, happened on a daily basis throughout every ward.
A Yes.

Q And they would say: "We have three spare beds", or "We have no spare beds", or whatever. So that then they could hold the record of what beds were available.
A Yes.

Q My last question to you: could you tell me what the signs and symptoms of a midazolam overdose are?
A I am sorry?

Q Could you tell me what are the signs and symptoms of a midazolam overdose?
A Respiratory depression; over-sedation. It is a benzodiazepine and it is a relative of valium; if you give someone too much valium the picture would be the same; they would be unconscious and their respiration could be depressed.

Q Is it a serious medical situation?
A Well, an overdose of anything is a serious medical situation. It is quite quickly metabolised in the body, apparently, so that the amount in a syringe driver would reach a steady state quite quickly and remain at a fairly stable level.

Q It could go as far as a coma, though?
A If you gave a large dose inappropriate for what that patient needed it could.

MR PAYNE: Thank you very much indeed. Those are my questions.

THE CHAIRMAN: Thank you, Mr Payne. Mrs Mansell?

MRS MANSELL: Hello, Dr Barton. I just want to pick up on a question that Mr Payne actually asked you. This is regarding the rehabilitation, and a diagnosis or assessment about rehabilitation made by the one ward and then referred to you. You say sometimes they are over-optimistic and are giving the patient's relatives an over-optimistic view. However, they actually did not need to do that, did they?
A How do you mean "they did not need to do that"?

Q Because previously you had been very much into palliative care, terminal care, continuing care, so it could have been that they were saying to the relatives that the patient was moving to you for palliative care.
A They could have done, and that would have made life considerably easier for us.

Q I am interested in how those different assessments actually developed.
A I cannot help you with what was going on in the minds of the clinicians in the acute wards when they transferred people to us.

Q No, but you were not interested, then, to establish why you had this different view to how they were assessing somebody; what they were seeing that told them that this person could be rehabilitated, whereas when you were seeing them that was blatantly not obvious, as you have said. It was blatantly not obvious in some cases.
A I felt that it was possibly a cop-out on the part of the staff transferring the patient because is it not easier to tell a family: "Oh, we will send you to the Gosport War Memorial Hospital and they will get your mother back on her legs in no time" – is that not easier than saying: "I'm sorry; there's nothing further we can do; your mother's condition is likely to deteriorate over a period of time and she may well die"?

Q I accept that but could it, conversely, have been that you were overly pessimistic about a patient and their chances?
A I hope not. I hope that in all the thousands we looked after we were always neither optimistic nor pessimistic about anybody's chances until we were actually faced with their medical condition.

Q I think we have looked at cases where you have actually had your view as being slightly more pessimistic than the consultant's view who has agreed to their admission.
A Yes, and the consultant saw them in each of these cases before the admission and with the information that they were given by the ward looking after them at that time, and what I saw was what was in front of me when they arrived on my ward. So there was a difference.

Q As it is such a very critical decision whether someone is moving to palliative care and terminal care, would you not have felt, at times, it was in their interests to actually discuss that and check it out with other people who had seen something else in the patient other than you had?
A Yes, but at the end of the day you could discuss the patient with the previous clinician all you liked; but what you had was the patient there in front of you in the bed.

Q I am interested in how your assessment of that patient became challenged in any way or how you challenged yourself that you had got it right.
A You were constantly thinking to yourself: "Is this the right medication for the patient? Is this the right place for this patient? Are we doing the right thing for this patient?" You did that every day when you went round the ward and looked at each of the patients. That is the constant discipline you practise.

Q Then you go on to say that with some of the patients, although it might not have been the right place for them - although you may have been thinking that - nothing actually happened to change that situation.
A No. They could not go anywhere else at that stage; we must do our best and look after them.

Q You have said in your evidence that although you knew the guidelines of the *BNF* and the Wessex manual, etc, they were not necessarily followed. I think we have got quite a number of cases here where they were not followed in relationship to specific patients, because you looked at the patient and you knew that they needed additional opiates. What steps did you put in place to ensure a patient was not given too high a dose of opiates?
A Because the patient was being constantly monitored by experienced nursing staff who would be turning them, seeing to them, probably at hourly intervals during the day, and who would have noticed and remarked had there been any obvious, to them, side-effects of the medication. There was one example, Mr Pittock, where one of the experienced senior nurses felt that he was getting too much haloperidol, at which point she contacted the duty doctor and they agreed to stop it and change the medication for something slightly different. These were very experienced nurses constantly assessing those patients 24/7; I could only go in once, twice a day and hear what they had to say and make my own snapshot assessment of a patient.

Q Sometimes that situation, though, can generate of itself a degree of risk, can it not, in that people get so familiar with situations that it is sometimes difficult to stand outside and look objectively at the situation. What was being done to make sure those effective challenges were in place?
A I think the nurses went on training courses; I went on training courses. We are always taught, despite the fact that we are caring for a patient, to be objective about their care; we are always standing back and looking at what we are doing as we are doing it. That is part of the profession.

Q I was thinking more of the training on a day-to-day basis, really.
A By our discussion at hand-over and by discussion when I came on to the ward: "Are we doing the right thing? Are we giving the best medication?"

Q When I look at, say, Mr Pittock, for instance, I can really see that there was a real commitment to very high quality nursing care for the patient.

A A Very much so.

Q Talking about the mouth-washing, the gentle care, turning, etc, etc. But the patient is gradually moving up quite significantly in the dosages of opiates.
A Because he is dying.

B Q I guess my question is: does it matter whether there is an overdose of opiates if a person is dying?
A That is a very good question, is it not? If you believe that and you think that is true, why am I here?

Q I am asking you to tell me.
A Because I am accused of overdosing these people who were dying with opiates, and I think probably overdosing anybody with anything is wrong, is incorrect and is
C unprofessional. I think we did our best, at all times, to aim to get the level appropriate for that particular patient at that particular moment in time, as they were dying.

Q I think that was why it goes back to Mr Payne's question as well of you: how did you actually recognise when there was that overdose? Because I understand that, within people with dementia and end-of-life care, that judging is actually quite difficult.
A Extremely difficult because they cannot tell you.

D Q That is why I was asking you those previous questions as to the safeguards that you were able to put in place.
A Yes.

Q And how you might, from time to time, actually challenge each other.
A Yes.

E Q I am looking for when those challenges occurred, because as I look through the nursing notes and the clinical notes I am not actually seeing those challenges there.
A I think, perhaps, "challenge" is the wrong expression to be using; this is not an adversarial process ----

Q No, absolutely not, and I am not meaning it that way.
F A ---- "Why did you give that diamorphine? Why did you give that midazolam?" I think, in discussion on ward rounds, seeing to the patient, we constantly had a dialogue about whether what we were doing was appropriate and the best thing for that patient at that time. We constantly had the patient in the front of our minds as being our prime directive – the appropriate treatment was everything at that stage, during the dying process.

MRS MANSELL: Thank you.
G
THE CHAIRMAN: Thank you, Mrs Mansell. Dr Roger Smith.

DR SMITH: Hello, Dr Barton. Can I pick you up, first, on something you said to Ms Julien. You said this was a community hospital. That was not quite my understanding. You said it was a cottage hospital. That was not my understanding either. I understood that in another part of the hospital, at least when it had been redeveloped, Sultan Ward, I think, was the
H community hospital where you looked after your own patients.

A Yes. Those were called the GP beds, but it was still – in that there was no resident medical staff, there were no resident consultants and there were no theatre or resus facilities – it was still, to my mind, a community or cottage hospital – a glorified nursing home, not a district general hospital.

Q That is what you thought of it?
A That is what I knew; I worked there.

B

Q Something has been puzzling me about some of the expressions you have used while you have been giving us evidence. For instance, you referred to "my nurses; my patients; my ward". Does that fit into the similar understanding of your position - that it was your ward? You were looking after patients who were "your patients" because it was a community hospital.
A Yes. I was the clinical assistant. I was under the supervision of consultants but the consultants were not on site and they were not there very often. I came to look upon them as "my wards; my patients; my nurses".

C

Q Did it go as far as you thinking, perhaps, the consultants advised on an exception basis?
A I am sorry – on a?

Q On an exception basis. They advised you.
A I think that with the geographical difficulties and their time constraints they left a lot of the major decisions to me; I think they trusted me to make appropriate decisions for the management of the patients. So, in a way, they did act in an advisory capacity because they physically could not be there. If we had had a daily consultant visit, presence, in the hospital, as I understand that they have now, the day-to-day management of the ward would probably have been very different. Those major decisions that we have talked about in these 12 patients would probably not have been made by me, but that was the way it worked because of the geographical problems.

D

E

Q So did you see yourself, really, as a semi-autonomous doctor?
A You are either autonomous or you are not autonomous. I was not autonomous but I did see myself in charge day-to-day. It said that in my job description; that I was responsible for the running of the day-to-day ward and the care of the patients and the staff. That was how I saw myself doing the job since 1989.

F

Q Just to finish that theme then, the nursing was staffed, as I understand it (please correct me) to a hospital level; not a nursing home level, a hospital level.
A Do you know, I think, in many ways, it was staffed much more to a modern nursing home level than it was a district hospital. There are certainly no training nursing posts there; these were all people who were fairly long in the tooth, like myself, and had been there a long time; it was much more analogous to a nursing home.

G

Q Let us change tack completely. We have heard a theme, as well, of variability in patients' status and condition, and that variability that has been explored has been physical variability (we have heard about one patient graphically being described as "up and down, up and down") and other patients as "mentally up and down". First of all, do you generally agree that patients do tend to take variable courses; that something wrong with them today might be better tomorrow?
A Yes.

H

Q Some things.
A Some things, yes.

Q Conceding, of course, that in the background there is a longer-term course in both physical and mental conditions.
A Which, in the case of these people, who were not particularly well when they came to me, was a general, overall downhill course towards death – some quicker, some slower, some taking plateaus as they went. But, generally, these patients that you are looking at, downhill.

Q Yes, so downhill with an "up and down" on it.
A Yes.

Q Rather like the Stock Market.
A Yes.

Q So you have a patient in pain. The patient complains of a pain – a pain – and you try to control it with Oramorph and you progress into MST, maybe, or you may progress into a fentanyl patch. For some reason, there comes a point at which they cannot take tablets, so you are looking for something that is not oral – or they cannot take liquid and you are looking for something that is not oral. Our impression on the generality of it is they go on to a syringe driver. I want to ask you, as others have, but just to try and crystallise this: why was there no possibility of the intermediate route; the route where they got intramuscular or subcutaneous doses on an "as required" basis? You did tell us a little bit about why you would not want to do that. Can you enlarge on that for us, why you would not do that?
A Because the intramuscular dose would be very uncomfortable and intrusive and the patient would constantly be suffering peaks and troughs of medication. The advantage of a syringe driver was that, once it had reached its steady-state level, you were giving them a steady rate of pain relief. I am not looking at a pain that the patient is just suffering from, a pain in isolation; we were also making the overall assessment of that patient, that they were going downhill, they were deteriorating. They were not going to be able to come off the analgesic medication. That was our understanding. So we wanted to give it in a steady-state form so that they were not hurt or drifting in and out of the palliative relief they were getting from pain while they waited for another injection. It would be fine for an acute pain but it would not be suitable for ongoing terminal pain.

Q So it is because you have decided that they are on a terminal pathway?
A Yes.

Q There cannot be an intermediate way of treating their pain, distress, because they are at the end of their lives?
A Yes, these particular ones that you have been looking at; yes. But of course you say, "Why are you using only the oral route and then the syringe driver?" but of course you have mentioned fentanyl and that is the ideal intermediate route that does not involve injections and does not involve oral treatments, which we tried and used quite successfully in a number of patients, not quite so successfully in the two you are looking at. There is not really anything else between oral tablets, oral liquid, and the subcutaneous administration in a nice steady-state level. It is not a death warrant. It is not putting you on the death pathway *per se*. You are on it because you are dying.

Q Mr Farthing, Mr Cunningham's step-son, asked if you could stop the driver or pull back so he could speak to his father. I think the word you used was that you would find that abhorrent to pull back on the dose because he would be in pain?
A Yes.

Q Why should not the answer be "but, how do you know he is going to be in pain?"
A If I stopped the ---

Q Yes?
A Well, for a start, he would get a very unpleasant withdrawal reaction stopping it. Both the diamorphine and the midazolam if withdrawn, or if you gave an antidote to it, would give very unpleasant pain ---

Q That is a very fair answer but what about reducing the dose so he could lighten up?
A Because we were only just able, from the note that I remember writing in the notes, to control the symptoms that he was having on the level of diamorphine and midazolam he was having at that time. Any lowering of the dosage would have caused him distress and agony.

Q How do you know that?
A I made that clinical judgment. I was looking after him. I felt that that was appropriate for the patient.

Q Is that your philosophy as a doctor or is that a judgment about that patient?
A Do not do harm is my philosophy as a doctor. So anything that involved even the potential for doing that patient harm by reducing the analgesia, I would not agree to.

Q But what about the challenge that there is potential for variability in the opposite direction, that having controlled the cause symptom ---
A But we had not. He was still, in the next clinical entry in the notes, getting pain.

Q But is it not true that you will never know?
A No, and I do not want to know.

Q You do not question that in your own mind at all?
A No, I do not.

Q On the same theme of variability, the same graph of dementia with acute episodes of confusion, would you agree that that is a typical pattern in confused old ladies? They have their days?
A Yes.

Q Sometimes quite violently have their days?
A Yes.

Q And the next day they are all light and smiles?
A You are talking about Mrs Devine?

Q No, I am talking in general.
A You are absolutely correct; in general terms, that can happen, yes.

A Q So they have a variability, or they may have a variability?
A They may have a variability superimposed upon a general downhill path.

Q And so when you treat a very acute, and in Mrs Devine's case a very aggressively acute, episode of confusion, there are two alternatives. You went for the fentanyl patch?
A I did.

B Q Which, rightly or wrongly – I am not making a judgment on that at the moment – might have been or might not have been the right kind of treatment for confusion, but, nevertheless, you chose for an acute episode a long-acting treatment. Why did you not take the course that you did the next day and give her a single dose of an antipsychotic?
A Because the difference between her behaviour on the two days was chalk and cheese. The previous day, the day she was seen in the afternoon by elderly psychological ---

C Q Dr Taylor.
A Dr Taylor – her behaviour was manageable, controllable. She was not in any great distress. She was not being of any great bother to herself or anyone else. The following morning when I came on to the ward, we had an acute psychiatric emergency. Chlorpromazine is not a drug that I would choose to use for anything other than an acute psychiatric emergency. It is an unpleasant drug to use; it is a dirty drug and it was what I had available in the drug cupboard on that day when presented with that problem, but I would not
D have continued to use it.

Q No, it was a very peculiar, very almost dangerous position.
A Yes.

Q I understand that. There is certainly an analogy with the opiates. Was there not a half-way house? She was spitting out tablets, that is true?
E A Yes.

Q But do you have to go from tablets to a quite potent patch?
A Or a syringe driver.

Q Or a syringe driver. Is there nothing in the middle?
A No. Rectal administration?
F

Q What is to say, for instance, that another oral administration might work like some syrup?
A You could not take the risk that she would spit it all over the nurses and we would be back in the same situation of not being able to control her behaviour, poor soul. She needed relief from her acute anxiety, fear, aggression, all this spectrum of behaviour. In my clinical judgment, it was the best I could come up with on that day and the following day.
G

Q Two doctors saw her that day: Dr Taylor who --- Let us accept, for the sake of argument, that she was a bit better by the time Dr Taylor saw her, she was not as wandering, as much of a nuisance, because these people can be a nuisance.
A Six or eight hours into the treatment she was much more comfortable and seemed happy, yes.

H Q And it may be the treatment or it may be naturally variability. We do not know that.

A A Yes.

Q But she made the judgment: we will take her to Mulberry when there is a bed.
A I did not see her, I did not speak to her that day, but I do not think, from the entry she made in the notes, that she knew about the creatinine and I do not think she realised that Mrs Devine was terminal.

B Q Terminal what?
A She was entering the terminal phase of her life.

Q Terminal phase of what part of her life?
A Because of the combination of the very high creatinine and the deterioration in her dementia, she was going to die very soon.

C Q A creatinine of 300 – terminal?
A It was a very rapid rate of change in this particular lady. She had been running along in a quite stable fashion and it had gone up very quickly. I felt, in my clinical judgment that day, that Mrs Devine was becoming terminally ill and I had to control this psychotic, aggressive, dangerous behaviour. So then I had no choice, if I felt the fentanyl was not controlling the aggression side of it, to go for the midazolam together with an equivalent dose of diamorphine.

D Q Terminal renal failure with a creatinine of 300?
A I know it is not colossally high but that was in a very elderly person with pre-existing renal disease. I felt that she was coming to the end stage.

Q Let us just look at the other side of her, and that is why I said "terminal side of what". The term "terminal dementia" has cropped up.
E A Yes, but her behaviour had deteriorated quite markedly overall during the time she had been with us on the ward, but even more so during those last few days.

Q Terminal dementia as a term, what does that mean, to you?
A It means that some of their more fundamental brain functions are beginning to break down.

F Q But where does the "terminal" come in? It is a worrying word to me, "terminal". I do not quite understand what it means. What does "terminal dementia" mean to you?
A It means that something about the dementia means that she is going to die soon. I do not really understand the psycho-pharmacology of what happens but people do die of dementia and I thought that she was dying.

Q They do die of dementia but sometimes it can be very slow, can it not?
G A And sometimes it then accelerates and becomes very much quicker.

Q What is the scale of dementia? How do you measure it as a clinician?
A The tools that we have are very crude and can only measure cognitive function. We cannot measure what else the brain is controlling, which we know is all the bodily functions.

Q What I am getting to, I suppose, is the suggestion that if you have a mental test score
H of nil, is it not true that you can live for quite a long time?

A A You could.

Q Years?
A Provided the other more basic lower functions in your brain were carrying on in their usual fashion, but once those start to break down, then you are in trouble.

Q Yes, like in at least one of the patients we saw where there was weight loss and loss of
B interest in life – not dementia itself but depression as well. OK. Most of my questions are not really general and they are not really specific patients; they go across the boundary. The other generality that I wanted very briefly to explore is "too ill to move". You could draw all sorts of spectra of "too ill to move" from the sublimely stupid, somebody dying at the roadside is too ill to get to a hospital and that would be completely wrong, to too ill to move in the case of somebody like Mr Packman, or an old lady with a hip problem that has become very complicated. Too ill to move depends upon a balance of risks I think you said.
C A Yes. It is not only would they survive the actual mechanics of the journey but would it be possible to do anything other than palliation when they arrived at the other end of the journey to where you were transferring them.

Q And so if you had firmly in your mind that an orthopaedic procedure was out of the question, you would take that view and say "too ill to move, it is not worth it".
A I would.
D

Q But if it is a matter of making a difference in a life and death decision, that is to say end of life or not end of life, can you explain to me why going down a corridor and lying on a trolley in your own hospital is out of the question because it is too much of an imposition?
A Are you talking about Mrs Spurgeon with what we thought was the infected hip? To be more specific about it, I would only subject a patient in a lot of pain towards the end of their life to that procedure if I felt there was some purpose to it, if there was some reason for
E doing it. Now I did not order that X-ray and I did not have anything to do with whether it was done or not done and whether I felt that it was appropriate to do or not is nothing to do with what my consultant decided to do. I personally would not have put her through that procedure anyway because I would not have felt that a look at the X-ray would alter my management of her at that time.

Q Forgive me coming back to an old theme at that point. What then is the relationship
F between you, your consultant and the patient?
A I am responsible for the day-to-day care of that patient.

Q He wants an X-ray?
A He ordered it. It was booked for the following afternoon. As far as I am aware, it was done. I have no idea.

G Q You did not think it was necessary?
A But I would not have cancelled it and I would not have countermanded it and I would not have hidden it so that he could not see it.

Q And you would not have gone to look for it either?
A No, because I knew he was coming back on the ward round to look at it on the Monday and the nurses would have made it available to him to look at. That was part of their
H duty.

Q I do not want to divert into that area really. Mr Packman: I would like just to pinpoint this, that you had in mind that he had suffered a myocardial infarction?
A I did.

Q And he was grey round the mouth and you were called to see him. You came to see him because he was grey round the mouth; he was not at all well. You thought he was having a heart attack.
A I did.

Q He was 67 and he had all his faculties?
A His chronological age was 67 but his age with regard to his co-morbidities was considerably older than 67 and there was a case of a gentleman that I felt, even if he survived the trauma of a transfer, difficult as that was going to be, the chances of them doing anything definitive for him at the other end, other than pure palliation, were remote.

Q Why would they not give him thrombolysis?
A Because he bled and they had stopped the Clexane to prevent the DVTs because he had had a bleed. I do not think they would have considered him for thrombolysis, even if we had had it available routinely in those days.

Q I think you are absolutely right, but why would they not have given him intensive cardiac care for arrhythmias for 24 hours?
A And then?

Q You tell me what is the mortality rate in the first two hours of the onset of a myocardial infarction?
A It is very, very high and it was going to be even higher for him and putting him in an ambulance and transferring him 10 miles up the road to get to the nearest coronary care unit was probably going to be his last journey.

Q But if you took that view for other patients in the community, you would not send anybody to hospital?
A But I did not take that view for other patients in the community. This was this particular patient in front of me. This was this particular man and his particular problems and his particular co-morbidities. That would be quite different from how I would react to a young, fit, 67 year old marathon runner who collapsed in my surgery and I thought was having a heart attack. The management of him would be totally different, of course, but this man was very seriously ill. He was dying.

Q Was he dying when he came to you?
A Probably.

Q Is that what really made up your mind?
A Yes.

DR SMITH: That is all I have for general questions.

THE CHAIRMAN: I am sorry, did you not have a specific question in relation to ---

DR SMITH: Not with regard to specifics.

THE CHAIRMAN: This refers to an individual patient? In that case, no, I do not because we are on generalities. Dr Barton, I am sure your head is reeling. Mine is. Are you fit to go on for a bit longer before we take our break?

A Thank you.

Q Okay. We are still on general and I am the last of the 'generals'. As you know, I am not a medic. I have been struggling to get some understanding as to the relative positions that appear to have been taken up by Professor Ford and yourself in regards to the way in which patients are to be treated towards the end of their lives. You have spoken to us at the beginning of your testimony about how when you started off at Gosport there was a hospice-style operation underway and you were able to give that hospice-style treatment to those who were terminally ill. I need to understand whether all the answers you were giving to Ms Julien about how you would do things were based on the circumstances in which you found yourself, and whether it would differ if you were in the sorts of circumstances you have told us Professor Ford has the luxury of operating from. Does that make sense?

A I am sure one's whole outlook on palliative care could be very different working in a specialised tertiary unit. He talked about one-to-one nursing care, he talked about hourly observation, he talked about being able to titrate the doses of his opiates. I am sure I could have practised different palliative care under those circumstances, but this was what I had. This was what I had available to me, this was the level of cover that I had, and this was the sort of hospital that we worked in. I had to tailor my palliative care to what I had available.

Q Right. If we look specifically at the two ends of the spectrum of alertness and lack of pain, is your general view that there should always be a total elimination of pain as the prime objective? Or do you allow for in your own thinking a balance, where you might accept that a patient might be willing to accept an element of pain in exchange for an element of alertness?

A I think that would be the ideal: sufficient pain relief, so that when dressings were being done or when basic nursing care was being given that the patient was not suffering.

Q An alertness that would allow ----

A Proper nursing care.

Q Yes. And, also, as a part of the general dying process as one would see in your earlier days of the hospice-type operation, where the terminally ill person is able to spend their last days free of pain or relatively free of pain but able to spend them in a state of consciousness in terms of their enjoyment of their last moments with their families, saying the things that needed to be said and so on.

A That would be a perfect end-of-life palliative care pathway. That would be what you were always aiming for.

Q Thank you. I am pleased to understand that is where you are. In terms of this particular hospital at these particular times with these particular patients, what Professor Ford appeared to be saying was that by reason of the prescriptions that you wrote up and that the nurses administered, patients were not given the opportunity of alertness that they should have had and which you indicate in the ideal world you would wish them to have too.

A I think that he cannot make that judgment (a) with the benefit of hindsight and (b) because my notes were so inadequate and the nursing notes were on occasions equally

A sketchy. I think it is very difficult, looking back at that remove of time, to be able to say, "Did they achieve on that unit what they were aiming with each of these patients?" and my suggestion would be that, mostly, yes we did. We gave patients comfort and dignity and relief from some of their more distressing symptoms and we did our best to make sure they were as alert as we could keep them at the same time.

Q As you say, the lack of notes and the sheer distance in time make it difficult both for
B Professor Ford to advance his view and also for you to unhappily advance your view.
A Certainly.

Q Had you the notes, you would be able to look, find it, and say, "It is very clearly there." One of the things that he was talking about was the view he had that you were going too quickly on to the syringe driver and Dr Smith has talked with you briefly about the alternatives between the time when, let us say, the oramorph option ceased to be viable
C because a patient could not swallow and the kind when you chose to go on to the driver. The question that he was asking you was why not for a time have PRN, for example, diamorphine injections. From the point of view of the nurses, first of all, would that have been particularly difficult to achieve?
A In that you have to have two trained nurses to remove from the cupboard and sign to administer each dose to that patient every four hours, it would take two of your trained staff away from the ward for that length of time, and they had 22 other patients to look after and
D the phone ringing and all the other admin. But that is not a good argument. That is not the argument you make for the patient. The argument for the patient would be that you would get peaks and troughs in their pain relief and they would already be starting to suffer pain at the point when you decided you must go to the cupboard and get them another injection, because they are going down all the time and then you put in another peak.

Q I understand that very clearly and I can see from a long-term point of view that that
E would be highly inappropriate.
A Yes.

Q But when we are looking at the perspective which he appeared to be advancing, that we need to find out what is the appropriate level of opiate to be giving to this patient, so that when one does perhaps move into the syringe driver situation you have it right ----
A Yes, but you have put that patient through 48/72 hours of comfort/discomfort,
F comfort/discomfort in order to find yourself a level at which you are going to set the syringe driver.

Q If it takes that long. Presumably it might equally ----
A When you saw the sort of doses that some of these patients needed, you would need to escalate the injections quite quickly or you would take a long time to find out what your steady state was going to be, and I think that for some of these patients that sort of coming in
G and out of pain would be unacceptable – to me.

Q Yes. To you.
A Yes.

Q In many cases it would not be possible to ask the patient, but in evaluating that as a potential route, assuming that it was something on which a patient or indeed their close
H family would have views, would you seek those views or would you feel that ---

A My priority was totally to the patient and the comfort of the patient. I would not be looking at the views of ----

Q Of family?
A Of family.

Q Very well. But dealing with the patient, I think we have agreed that there might be occasions when a patient would be prepared to accept some level of pain in exchange for relief from drowsiness.
A I think that would be acceptable with the consent, the full consent of the patient, and with the option that if that became too unpleasant and uncomfortable for them then you could move on to subcutaneous analgesia. It is the patient who is always at the forefront of your decision making.

Q So far as the suggestions from Professor Ford that by going into the driver scenario you also ran the risk of masking the true causes of matters such as agitation and restlessness: as you have pointed out, they might very well be simply a part of that terminal process, but as he pointed out, they might also be as a direct result of the prescription of the particular medication at that level.
A You always have to accept when using these drugs that there is the double effect. But if you start from the initial premise that these patients were dying and that was the process that was going on, then it was perfectly acceptable to give sufficient doses of the drugs to control their distressing symptoms and accept that controlling those symptoms might in some way shorten their life.

Q The suggestion as I understood it from Professor Ford was that there might be occasions when the distressing symptom was not present until the high level of a particular drug or combination of drugs had been administered and that you were not then in a position, to use your word, to "untangle" whether that symptom had been caused by the drug itself or by the inevitable terminal process.
A I think that would be very difficult to entangle, again, without the patient in front of you in the clinical situation. I do not think you could do it with the benefit of hindsight.

Q If the process were slowed down, so that instead of going directly from, say, the Oramorph – which then becomes impossible – onto the syringe driver, you employed that middle stage which he appeared to be advocating, do you think that might have made any difference towards not having what might ultimately be an entanglement?
A No. I do not because I think the entanglement is largely caused by the process of dying. I do not think that titrating the drugs, as he suggested, would have made any difference to that at all.

Q That is very helpful to me. We have come to the end of the general questions. I wonder if this would be a convenient moment for you to take a break and I will then ask the Panel if they have any specific patient questions to put to you.
A Thank you.

THE CHAIRMAN: Fifteen minutes, please, ladies and gentlemen.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back everyone. Doctor, have you managed to get some refreshments?
A Thank you.

Q You feel okay to "chonk" on for a bit longer.
A Thank you.

THE CHAIRMAN: Very well. We will turn now to questions from the Panel with regard to specific patients. I will just mention the patient's letter and invite questions, and then go on through in that way.

First of all does anybody have any questions related to Patient A? Patient B? Patient C? Patient D? Patient E? Patient F? Patient G? Patient H?

Dr Smith.

DR SMITH: Dr Barton, Patient H is Mr Wilson. You felt that he had heart failure. He was the man who had gained a considerable amount of fluid. Fourteen kilograms, I think it was.
A Eleven kilograms.

Q You said he was verging on the edge of heart failure and that when he became "bubbly" that was a sign of heart failure.
A He was examined, was he not, by one of my partners?

Q Yes.
A Who described him as "bubbly". I imagine that when his chest was examined he had creps at both bases, which is what he described as "bubbly".

DR SMITH: You are quite right, it was another doctor who examined him. I will leave that.

THE CHAIRMAN: Very well. Patient I? Patient J? Patient K?

Dr Smith.

DR SMITH: And this is the last you will hear from me!
A Elsie Devine.

Q Elsie Devine – so graphically described by one of the nurses. I want to contextualise by taking you through fentanyl and chlorpromazine again. It is not a criticism of using a fentanyl patch, it is not a criticism of using chlorpromazine in an acute, very aggressive, very dramatic episode; it is to contextualise what happens. We have heard about the fentanyl patch. We have heard from the extensive drug company manual on it. It was put on on the previous day to what we are calling "the episode," on the 19th, the Thursday, and by the time 7.30 came around – that was when all the drama was going – it had been on for 24 hours or so. It was removed at 12.30.
A Yes.

Q I had to go back on the evidence to prove that to myself and it is indeed on a prescription on page 279, "Removed at 12.30," and I think it is Sister Hamblin's signature.
A Yes.

Q In talking you through it, Mr Kark put it to you – and I am not sure if it was from the *BNF* or that manual – that there may in the elderly be reduced clearance or prolonged half-life and the elderly may be more sensitive. You pointed out that that was in the context of an intravenous study.
A Yes.

Q First of all, I wonder if you can explain this. Having achieved a certain blood level, does it matter which way the drug has got into you what happens to the half-life?
A No. But the reason for stopping the fentanyl and starting the subcutaneous analgesia was that patently the fentanyl was not controlling her distress and aggression and agitation.

Q I accept that that was your reasoning behind that.
A I could have continued with the fentanyl and I could have left the patch on, but I would have still been looking at using a syringe driver to give her the necessary relief from the restlessness and the agitation and the fear.

Q I am not looking as to reasons or motives for using it.
A All right.

Q It is just contextualising the whole scenario that we have a drug which has a long half-life, and indeed it was not taken up until some hours after chlorpromazine.
A I think the calculation was that she would have received an extra 10 mg of diamorphine during that time.

Q Indeed the 17 hours that it takes to clear may well be longer than that.
A Yes.

Q Then chlorpromazine and that is why I have asked if I can use these photocopies of the *BNF*. It is the relevant *BNF* of 1997 and I want to take you to page 163 in the top right-hand corner. It is where chlorpromazine is described, halfway down on the right-hand side.
A Yes.

Q It talks about cautions in cardiovascular and cerebrovascular disease, and then, four lines down, in renal impairment.
A Yes.

Q It says, "caution in the elderly".
A Yes.

Q Right down at the bottom, its side effects include drowsiness, and then over the page, on page 164, about five lines down on the left-hand side, respiratory depression.
A Yes.

Q Under "Dose", albeit it says "*by mouth*" a few lines down it says: "ELDERLY third to half adult dose."
A Yes.

Q Would you agree, if it is not a specific about any other way of giving it, that it is a caution.

A A Yes.

Q About the drug.
A Yes.

Q Then: "*By deep intramuscular injection,* 25-50 mg every 6-8 hours."
A Yes. 25-50 mg and she was only ever going to get the one.

B

Q Yes. I absolutely do not criticise your giving it. I absolutely do not criticise that. If you go back to page 161, which is behind that frontage piece, here is advice on anti-psychotic drugs from the Royal College of Psychiatrists. Number 2 says:

> "Bear in mind risk factors, including obesity – particular caution is indicated in older patients especially those over 70."

C

This lady was that group, I think.
A Yes.

Q Then if you go further down:

> "Important: When prescribing an antipsychotic … on an emergency basis, the [IM] dose should be lower than the corresponding oral dose … particularly if the patient is very active …"

D

This patient was very active; her muscles were really active.
A Yes.

Q Then:

E

> "(increased blood flow to muscle considerably increases the rate of absorption)."

All that is to contextualise. You said in your evidence that you thought that by lunchtime it would have been wearing off.
A Yes.

F Q Do you think that is right, in the light of that information?
A You are suggesting that, perhaps, I was being a bit optimistic by the rate at which it would wear off? So supposing you said four o'clock, having given it at eight – eight hours later - by which time the level of the midazolam would be slowly increasing and the level of the diamorphine and the fentanyl crossing over, so that, hopefully, she would have a level of comfort and relief from her symptoms.

G Q What I am putting to you is: with this retrospectoscope, the fentanyl is at its peak but Chlorpromazine in this old lady is probably at a higher level than you may have suggested in your evidence.
A Yes.

Q Is that fair to say?
A Yes.

H

A Q She has had a start dose of opiate, and she is now on a syringe driver.
A Yes.

Q With the retrospectoscope ----
A Would I have given 25mg?

B Q No, I am going one stage further than that: would you reconsider whether you thought that the drugs contributed to her demise?
A I would not reconsider that the drugs contributed to her demise. I consider that she needed each of those drugs to control the severe distress and agitation and discomfort she was in, and that they were all appropriate.

C Q At the risk of repeating myself from my earlier discussion with you, you have no doubts that that might have been a single, acute outburst which might have been controlled ----
A It was an acute, single outburst but it was superimposed on a gradual level of behavioural change and a rapid change in renal function. So the downward slope was well under way.

DR SMITH: That is all I wanted to ask you. Thank you.

D THE CHAIRMAN: Very quickly, on Patient K: why not then keep her on the fentanyl?
A And then put up a syringe driver?

Q With just midazolam.
A Yes.

E Q And the answer is?
A It was possible to do that but it seemed rather inappropriate to be running a fentanyl patch for three days and monitoring a syringe driver as well. It was much easier to combine the two at an equivalent dose in the syringe driver to make monitoring much more easy.

F Q But it means a risk because you are now having to remove the fentanyl patch and start the diamorphine with the resultant potential for difficulty.
A Yes, but I knew that the rate of decline of the level of fentanyl was over a period of 24 hours, and I knew that the level of the diamorphine in the syringe driver was going to gradually build up. I was confident that there would be a reasonable cross-over point, which would not give her any distress.

G THE CHAIRMAN: Thank you. Now it is Patient L. Does anybody have any questions on Patient L? No. That concludes questions from the Panel. It is twenty-past four. I do not know whether counsel would wish to go on and ask any questions they may have arising out of the Panel's questions, or whether there are going to be so many that they will require further time. We are in your hands. Mr Kark?

MR KARK: I do have questions and I could certainly start, but I cannot tell you, at the moment, how long I am going to be, I am afraid.

THE CHAIRMAN: So you might not finish today?

H MR KARK: I might not finish today.

MR LANGDALE: Can I invite Mr Kark to make himself very popular and suggest that he starts on Monday? It will not mean Dr Barton is unnecessarily kept in the witness box over the weekend because I have a number of questions – not very many but enough to mean that between the two of us she would not finish at a sensible time today.

THE CHAIRMAN: Mr Kark, how does popularity sit with you?

MR KARK: I am always seeking popularity. I am very happy to start on Monday.

THE CHAIRMAN: Very well. We will break now. Thank you very much indeed. Doctor, I think, it is probably best to give you a chance to recharge your batteries after what must have been quite an intense afternoon for you. So Monday it is, ladies and gentlemen. We are starting, as normal, at 9.30 on the Monday, but bearing in mind that on the Tuesday we will be starting at 11.30. Thank you very much indeed.

(The Panel adjourned until 9.30 am on Monday 27 July 2009)