FITNESS TO PRACTISE PANEL
Applying the General Medical Council Preliminary Proceedings Committee and Professional Conduct Committee (Procedure) Rules 1988

8 JUNE – 20 AUGUST 2009 and 18 – 29 JANUARY 2010

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

Name of Respondent Doctor:	Dr Jane Ann BARTON
Registered Qualifications:	BM BCh 1972 Oxford
Area of Registered Address:	Gosport, Hampshire
GMC Reference number:	1587920
Type of Case:	New case of alleged serious professional misconduct
Panel Members:	Mr A Reid, Chairman (Lay) Ms J Julien (Lay) Mrs P Mansell (Lay) Mr W Payne (Lay) Dr R Smith (Medical)
Legal Assessor:	Mr F Chamberlain (8 June – 20 August 2009) Mr D Smith (18 - 29 January 2010)
Secretary to the Panel:	Miss C Challis Miss O Babatunde (21 – 31 July 2009)

Representation:

The GMC was represented by Mr Tom Kark, Counsel, and Mr Ben Fitzgerald, Counsel, instructed by Field Fisher Waterhouse.

Dr Barton was present and was represented by Mr Timothy Langdale QC and Mr Alan Jenkins, Counsel, instructed by the Medical Defence Union.

ALLEGATION

"That being registered under the Medical Act 1983, as amended,

> '1. At all material times you were a medical practitioner working as a clinical assistant in elderly medicine at the Gosport War Memorial Hospital ("GWMH"), Hampshire; **Admitted and found proved**

'2. a. i. Patient A was admitted to Dryad Ward at the GWMH on 5 January 1996 for long term care, **Admitted and found proved**

ii. between 5 and 10 January 1996 you prescribed Oramorphine 5mg 5 times daily, as well as Diamorphine with a dose range of 40 - 80 mg over a twentyfour hour period to be administered subcutaneously ("SC") on a continuing daily basis, **Admitted and found proved**

iii. on 11 January 1996 you prescribed Diamorphine with a dose range of 80 - 120 mg and Midazolam with a range of 40 - 80 mg to be administered SC over a twentyfour hour period, **Admitted and found proved**

iv. on 15 January 1996 a syringe driver was commenced at your direction containing 80 mg Diamorphine and 60 mg Midazolam as well as Hyoscine Hydrobromide, **Admitted and found proved**

v. on 17 January 1996 the dose of Diamorphine was increased to 120 mg and Midazolam to 80 mg, **Admitted and found proved**

vi. on 18 January 1996 you prescribed 50 mg Nozinan in addition to the drugs already prescribed, **Admitted and found proved**

b. In relation to your prescriptions described in paragraphs 2.a.ii and 2.a.iii.,

i. the lowest doses prescribed of Diamorphine and Midazolam were too high,
Found proved in relation to head 2a ii in relation to the Diamorphine only as Midazolam not prescribed.
Found proved in relation to head 2a iii in relation to the Diamorphine.
Found proved in relation to head 2a iii in relation to the Midazolam.

ii. the dose range was too wide,
Found not proved in relation to heads 2a ii and 2a iii

iii. the prescription created a situation whereby drugs could be administered to Patient A which were excessive to the patient's needs, **Admitted and found proved**

c. The doses of Diamorphine administered to the patient on 15 and 17 January 1996 were excessive to the patient's needs, **Found not proved.**

d. Your prescription described at paragraphs 2.a.vi.in combination with the other drugs already prescribed were excessive to the patient's needs, **Found proved.**

e. Your actions in prescribing the drugs as described in paragraphs 2.a.ii., iii., iv., v., and vi. were, **Amended to read:** Your actions in prescribing the drugs as described in paragraphs 2.a.ii., iii., iv., v., and**/or** vi. were,

i. inappropriate,
Found proved in relation to heads 2a ii, 2a iii and 2a vi.
Found not proved in relation to head 2a iv and 2a v.

ii. potentially hazardous, **Admitted only in relation to head 2a iii and found proved.**
Found proved in relation to heads 2a ii, iv, v and vi.

iii. not in the best interests of Patient A;
Found proved in relation to heads 2a ii, 2a iii and 2a vi.
Found not proved in relation to heads 2a iv and v.

'3. a. i. Patient B was admitted to Daedalus Ward at the GWMH on 22 February 1996, **Admitted and found proved**

ii. on 24 February 1996 you prescribed the patient Morphine Slow Release Tablets (MST) 10 mg twice a day, **Admitted and found proved**

iii. on 26 February 1996 you increased the prescription for MST and prescribed Diamorphine with a dose range of 80 mg - 160 mgs and Midazolam with a dose range of 40 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iv. on 5 March 1996 you prescribed Diamorphine with a dose range of 100 - 200 mg and Midazolam with a dose range of 40 mg - 80 mg over a twentyfour hour period to be administered SC and a syringe driver was commenced containing Diamorphine 100 mg and Midazolam 40 mg, **Admitted and found proved**

b. In relation to your prescriptions for drugs described in paragraphs 3.a.iii. and iv.,

i. the lowest commencing doses prescribed on 26 February and 5 March 1996 of Diamorphine and Midazolam were too high, **Found proved in relation to head 3a iii in relation to Diamorphine and Midazolam.**

Found not proved in relation to head 3a iv in relation to the Diamorphine.
Found proved in relation to head 3a iv in relation to the Midazolam.

ii. the dose range for Diamorphine and Midazolam on 26 February and on 5 March 1996 was too wide, **Admitted and found proved**

iii. the prescriptions created a situation whereby drugs could be administered to Patient B which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 3.a. ii., iii. and/or iv. were,

i. inappropriate,
Found not proved in relation to head 3a ii.
Found proved in relation to heads 3a iii and 3a iv.

ii. potentially hazardous,
Admitted only in relation to head 3a iii and iv and found proved.
Found not proved in relation to head 3a ii.

iii. not in the best interests of Patient B,
Found not proved in relation to heads 3a ii
Found proved in relation to heads 3a iii and 3a iv.

d. In relation to your management of Patient B you,

i. did not perform an appropriate examination and assessment of Patient B on admission, **Found not proved.**

ii. did not conduct an adequate assessment as Patient B's condition deteriorated, **Found proved.**

iii. did not provide a plan of treatment, **Found not proved.**

iv. did not obtain the advice of a colleague when Patient B's condition deteriorated, **Admitted and found proved**

e. Your actions and omissions in relation to your management of patient B were,

i. inadequate, **Found proved.**

ii. not in the best interests of Patient B; **Found proved.**

'4. a. i. on 27 February 1998 Patient C was transferred to Dryad Ward at GWMH for palliative care, **Admitted and found proved**

ii. on 3 March 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20-80mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 4.a.ii.,

i. the dose range of Diamorphine and Midazolam was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to the patient which were excessive to the Patient C's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraph 4.a. ii. were,

i. inappropriate, **Found proved.**

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of your patient; **Found proved.**

'5. a. i. on 6 August 1998 Patient D was transferred to Daedalus Ward at GWMH for continuing care observation, **Admitted and found proved**

ii. on or before 20 August 1998 you prescribed Diamorphine with a dose range of 20mg - 200mg and Midazolam with a dose range of 20mg - 80mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs as described in paragraph 5.a. ii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient D which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs as described in paragraph 5.a.ii. were,

i. inappropriate, **Found proved.**

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of Patient D; **Found proved.**

'6. a. i. Patient E was admitted to Daedalus Ward at GWMH on 11 August 1998 after an operation to repair a fractured neck of femur at the Royal Haslar Hospital, **Admitted and found proved**

ii. on 11 August 1998 you prescribed 10 mg Oramorphine 'prn' (as required), **Admitted and found proved.**

iii. on 11 August 1998 you also prescribed Diamorphine with a dose range of 20 mg - 200 mg and Midazolam with a dose range of 20 mg - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 6.a.iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient E which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraph 6.a. ii. and/or iii. were,

i. inappropriate,
Found proved in relation to heads 6a ii and 6a iii.

ii. potentially hazardous, **Admitted only in relation to head 6a iii and found proved.**
Found proved in relation to head 6a ii.

iii. not in the best interests of Patient E;
Found proved in relation to heads 6a ii and 6a iii.

'7. a. i. Patient F was admitted to Dryad Ward at GWMH on

18 August 1998 for the purposes of rehabilitation following an operation to repair a fractured neck of femur at the Royal Haslar Hospital, **Admitted and found proved**

ii. on 18 August 1998 you prescribed Oramorphine 10 mg in 5 ml 'prn' (as required), **Admitted and found proved.**

iii. between 18 and 19 August 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twenty-four hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 7.a.iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient F which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 7.a. ii. and/or iii. were,

i. inappropriate,
Found not proved in relation to head 7a ii.
Found proved in relation to head 7a iii.

ii. potentially hazardous, **Admitted only in relation to head 7a iii and found proved.**
Found proved in relation to head 7a ii.

iii. not in the best interests of Patient F;
Found not proved in relation to head 7a ii.
Found proved in relation to head 7a iii.

'8. a. i. Patient G was admitted to Dryad Ward at GWMH on 21 September 1998 with a painful sacral ulcer and other medical conditions, **Admitted and found proved**

ii. on 21 September 1998 you prescribed Diamorphine with a dose range of 20 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iii. on 25 September 1998 you wrote a further prescription for Diamorphine with a dose range of 40 - 200mg and

Midazolam with a dose range of 20 – 200mg to be administered subcutaneously over a twenty-four hour period on a continuing daily basis, **Admitted and found proved**

b. In relation to your prescriptions for drugs described in paragraphs 8.a.ii. and/or iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient G which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 8.a.ii. and/or iii. were,

i. inappropriate, **Found proved in relation to heads 8a ii and 8a iii**

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of Patient G, **Found proved in relation to heads 8a ii and 8a iii**

d. You did not obtain the advice of a colleague when Patient G's condition deteriorated; **Admitted and found proved**

'9. a. i. Patient H was admitted to Dryad Ward GWMH on 14 October 1998 for ongoing assessment and possible rehabilitation suffering from a fracture of the left upper humerus, liver disease as a result of alcoholism and other medical conditions, **Admitted and found proved**

ii. on 14 October 1998 you prescribed Oramorphine 10 mg in 5 ml, with a dose of 2.5 ml to be given every four hours thereafter as needed, following which regular doses of Oramorphine were administered to the patient, **Admitted and found proved**

iii. on or before 16 October 1998 you prescribed Diamorphine with a dose range of 20 mgs - 200 mgs to be administered subcutaneously over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iv. on or before 17 October 1998 you prescribed Midazolam with a range of 20 mgs - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

b. In light of the Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. was, **Amended to read:** In light of Patient H's history of alcoholism and liver disease your decision to give this patient Oramorphine at the doses described in paragraph 9.a .ii. was,

i inappropriate, **Found proved.**

ii. potentially hazardous, **Found proved.**

iii. likely to lead to serious and harmful consequences for Patient H, **Found not proved.**

iv. not in the best interests of Patient H, **Found proved.**

c. In relation to your prescription described in paragraph 9.a. iii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient H which were excessive to the patient's needs, **Admitted and found proved**

d. Your actions in prescribing the drugs described in paragraphs 9.a. ii., iii. and/or iv. were,

i. inappropriate, **Found proved in relation to heads 9a ii, 9a iii and 9a iv.**

ii. potentially hazardous,
Admitted only in relation to heads 9a iii and iv and found proved.
Found proved in relation to head 9a ii.

iii. not in the best interests of Patient H.,
Found proved in relation to heads 9a ii, 9a iii and 9a iv.

e. You did not obtain the advice of a colleague when Patient H's condition deteriorated; **Admitted and found proved**

'10. a. i. Patient I was admitted to Dryad ward at GWMH on 26 March 1999 following her treatment for a fractured neck of femur at the Haslar Hospital, **Admitted and found proved**

ii. on 12 April 1999 you prescribed Diamorphine with a dose range of 20 - 200 mgs and Midazolam with a dose range of 20 - 80 mgs to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

iii. on 12 April 1999 a syringe driver with 80 mgs Diamorphine and 20 mgs Midazolam over twenty-four hours was started under your direction but later the dose was reduced to 40 mgs by Dr Q, **Admitted and found proved**

b. You did not properly assess Patient I upon admission. This was,

i. inadequate, **Found not proved.**

ii. not in the best interests of Patient I, **Found not proved.**

c. In relation to your prescription for drugs described in paragraph 10.a.ii.,

i. the dose range was too wide, **Admitted and found proved**

ii. the prescription created a situation whereby drugs could be administered to Patient I which were excessive to the patient's needs, **Admitted and found proved**

d. Your actions in prescribing the drugs described in paragraph 10.a. ii. were,

i. inappropriate, **Found proved.**

ii. potentially hazardous, **Admitted and found proved**

iii. not in the best interests of Patient I, **Found proved.**

e. The dosage you authorised/directed described in paragraph 10.a. iii. was excessive to Patient I's needs. This was,

i. inappropriate, **Found proved.**

ii. potentially hazardous, **Found proved.**

iii. not in the best interests of Patient I; **Found proved.**

'11. a. i. Patient J was admitted to Dryad Ward at GWMH on 23 August 1999 following his treatment at the Queen Alexandra Hospital where the patient had been admitted as an emergency following a fall at home, **Admitted and found proved**

ii. on 26 August 1999 you gave verbal permission for 10 mg of Diamorphine to be administered to Patient J, **Admitted and found proved**

iii. you saw Patient J that day and noted 'not well enough to transfer to the acute unit, keep comfortable, I am happy for nursing staff to confirm death', **Admitted and found proved**

iv. you did not consult with anyone senior to you about the future management of Patient J nor did you undertake any further investigations in relation to Patient J's condition, **Admitted and found proved**

v. on 26 August 1999 you prescribed Diamorphine with a dose range of 40 - 200 mg and Midazolam with a dose range of 20 - 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted and found proved**

vi. on 26 August 1999 you also prescribed Oramorphine 20 mg at night' **Admitted and found proved**

b. In relation to your prescription for drugs described in paragraph 11.a.v.,

i. the lowest doses of Diamorphine and Midazolam prescribed were too high,
Found not proved in relation to the Diamorphine.
Found proved in relation to the Midazolam.

ii. the dose range was too wide, **Admitted and found proved**

iii. the prescription created a situation whereby drugs could be administered to Patient J which were excessive to the patient's needs, **Admitted and found proved**

c. Your actions in prescribing the drugs described in paragraphs 11.a. ii. and/or v. were,

i. inappropriate,
Found not proved in relation to head 11a ii.
Found proved in relation to head 11a v.

ii. potentially hazardous, **Admitted only in relation to head 11a v and found proved.**
Found not proved in relation to head 11a ii.

iii. not in the best interests of Patient J,
Found not proved in relation to head 11a ii.
Found proved in relation to head 11a v.

d. Your failure to obtain medical advice and/or undertake further investigation described in paragraph 11.a. iv. was,

i. inappropriate, **Found proved.**

ii. not in the best interests of Patient J; **Found proved.**

'12. a. i. Patient K was admitted to Dryad Ward at GWMH for continuing care on 21 October 1999 from Queen Alexandra Hospital**.** She was reported to be suffering from chronic renal failure and multi infarct dementia, **Admitted and found proved**

ii. on admission you prescribed Morphine solution 10mg in 5 ml as required, **Admitted and found proved**

iii. on 18 and 19 November 1999 there was a deterioration in the Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch, **Amended to read:** on 18 and 19 November 1999 there was a deterioration in Patient K's condition and on 18 November 1999 you prescribed Fentanyl 25 µg by patch, **Admitted as amended and found proved**

iv. on 19 November 1999 you prescribed Diamorphine with a dose range of 40 - 80 mg Midazolam with a dose range of 20 to 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Amended to read:** on 19 November 1999 you prescribed Diamorphine with a dose range of 40 - 80 mg **and** Midazolam with a dose range of 20 to 80 mg to be administered SC over a twentyfour hour period on a continuing daily basis, **Admitted as amended and found proved**

b. The prescription on admission described in paragraph 12.a.ii. was not justified by the patient's presenting symptoms, **Found proved.**

c. In relation to your prescription for drugs described in paragraph 12.a.iv.,

i. the lowest doses of Diamorphine and Midazolam prescribed were too high, **Found proved.**

ii. the dose range was too wide,
Found not proved in relation to the Diamorphine.
Found proved in relation to the Midazolam.

iii. the prescription created a situation whereby drugs could be administered to Patient K which were excessive to the patient's needs, **Found proved.**

d. Your actions in prescribing the drugs described in paragraphs 12.a. ii., iii. and/or iv. were,

i inappropriate, **Found proved in relation to heads 12a ii, 12a iii and 12a iv.**

ii. potentially hazardous, **Found proved in relation to heads 12a ii, 12a iii and 12a iv.**

iii. not in the best interests of Patient K, **Found proved in relation to heads 12a ii, 12a iii and 12a iv.**

e. You did not obtain the advice of a colleague when Patient K's condition deteriorated; **Admitted and found proved**

'13. a. i. Patient L was admitted to Daedalus Ward at GWMH on 20 May 1999 following a period of treatment at the Haslar Hospital for a stroke, **Admitted and found proved**

ii. on 20 May 1999 you prescribed,

a. Oramorphine 10 mgs in 5 mls 2.5-5mls, **Admitted and found proved**

b. Diamorphine with a dose range of 20 to 200 mgs to be administered SC over a twenty-four hour period on a continuing daily basis, **Admitted and found proved**

c. Midazolam with a dose range of 20 to 80 mgs to be administered SC, **Admitted and found proved**

iii. you further prescribed Oramorphine 10 mgs in 5 mls 4 times a day and 20 mgs nocte (at night) as a regular prescription to start on 21 May 1999, **Admitted and found proved**

iv. doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient in 21 and 22 May 1999, **Amended to read:** doses of Oramorphine, Diamorphine and Midazolam were subsequently administered to the patient **on** 21 and 22 May 1999, **Admitted as amended and found proved**

b. In relation to your prescription for drugs described in paragraph 13.a.ii. and/or iii.,

i. there was insufficient clinical justification for such prescriptions, **Found proved in relation to heads 13a ii and 13a iii.**

ii. the dose range of Diamorphine and Midazolam was too wide, **Admitted and found proved**

iii. the prescriptions created a situation whereby drugs could be administered which were excessive to the patient's needs, **Admitted and found proved**

iv. your actions in prescribing the drugs described in paragraph 13.a. ii. and or iii. were,

a. Inappropriate, **Found proved in relation to heads 13a ii and 13a iii.**

b. Potentially hazardous, **Admitted only in relation to head 13a ii b and found proved.**
Found proved in relation to the remaining elements of head 13a ii.
Found proved in relation to head 13a iii.

c. Not in the best interests of patient L, **Found proved in relation to heads 13a ii and 13a iii.**

c. You did not obtain the advice of a colleague when Patient L's condition deteriorated; **Admitted and found proved**

'14. a. You did not keep clear, accurate and contemporaneous notes in relation to Patients A, B, C, D, E, F, G, H, I, J K and/or L 's care and in particular you did not sufficiently record,

i. the findings upon each examination, **Admitted and found proved**

ii. an assessment of the patient's condition, **Admitted and found proved**

iii. the decisions made as a result of examination, **Admitted and found proved**

iv. the drug regime, **Found proved.**

v. the reason for the drug regime prescribed by you, **Admitted and found proved**

vi. the reason for the changes in the drug regime prescribed and/or directed by you, **Admitted and found proved**

b. Your actions and omissions in relation to keeping notes for Patients A, B, C, D, E, F, G, H, I, J, K and/or L were,

i. inappropriate, **Admitted and found proved**

ii. not in the best interests of your patients; **Admitted and found proved**

'15. a. In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K, L, **Amended to read:** In respect of the following patients you failed to assess their condition appropriately before prescribing opiates: Patients A, B, C, D, E, F, G, H, I, J, K **and/or** L, **Found not proved in relation to patients A,B, C, E, F, G, H, I, J, K and L.**
Found proved in relation to patient D.

b. Your failure to assess the patients in paragraph a. appropriately before prescribing opiates was not in their best interests."
Found not proved in relation to patients A,B, C, E, F, G, H, I, J, K and L.
Found proved in relation to patient D.

"And that in relation to the facts alleged you have been guilty of serious professional misconduct."

Determination on facts given on 20 August 2009

Dr Barton

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

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

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

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

which take account of each and every amendment made since this session commenced on 8 June of this year.

PART ONE

1. Inappropriate transfers onto Dryad and Daedalus wards

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

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

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

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

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

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

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

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

3. Your dealings with patients' relatives

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

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

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

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

4. 'Happy for nurses to confirm death.'

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

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

5. The role of note-taking in clinical care

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

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

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

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

6. The absence of notes of specific events

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

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

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

i. Mr Kark advanced the view that any failure to reduce into writing instructions governing the circumstances and required procedures in relation to the administration of anticipatory prescriptions was serious. He argued that such failure

in respect of a prescription which gave nurses the authority to initiate syringe drivers at an unspecified date, and loaded with a variable dose of Diamorphine / Midazolam mix was especially serious as it reduced the ability of the prescriber to safeguard patients' interests against inappropriate action by nursing staff.

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

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

8. Euphemisms relating to end of life status

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

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

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

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

9. Guidelines and the Analgesic Ladder

The Panel heard that the British National Formulary (BNF) is the definitive evidence-

based guide for doctors on the prescribing of drugs. It gives clear advice on prescribing in specific situations such as *Prescribing in Palliative Care* and in *Prescribing for the Elderly* where extra care needs to be exercised.

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

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

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

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

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

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

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

11. Side effects / adverse consequences of opiates

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

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

- Drowsiness, potentially leading to unconsciousness
- Respiratory depression, potentially leading to unconsciousness and ultimately death
- Confusion

- Agitation
- Restlessness
- Hallucination
- Nausea

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

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

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

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

12. The Diamorphine / Midazolam mix

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

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

13. Prescribing opiates outside the guidelines

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

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

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

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

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

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

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

14. Anticipatory prescribing and the delegation of powers

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

ii. The value of such a practice in the swift treatment of pain is obvious. The Panel heard evidence from both Professors M and N, as well as from the consultants who gave evidence, that they had all engaged in anticipatory prescribing.
iii. It was acknowledged that one risk attendant on anticipatory prescribing is that

nursing staff might decide to administer the prescription at a time when it was not clinically justified.

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

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

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

vii. The Panel also heard that it was not unusual for anticipatory prescribing to allow for a range of doses. The reason for this was to enable the trained nurses administering the drug(s) to exercise their discretion as to the dose currently required by the patient before them. The Panel heard that it was usual for nurses to begin administration of a prescription by starting at the lowest dose prescribed, though it was accepted that they were able to administer at a higher rate if they determined that it was appropriate to do so; and the Panel received evidence of occasions when they did so.

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

ix. It follows that the danger was if at the time of administration the prescribed minimum dose was too high that excessive dose was likely to be administered anyway. Indeed, if the nurses were to form the view that the lowest dose in the variable range was too high, in the anticipated event that they were unable to obtain

assistance from a doctor, their choice of action was limited to not administering the medication at all or administering it at what they judged to be too high a dose. In the Panel's view, the appropriate safeguard would have been for you, whenever you were anticipatorily prescribing a variable range of diamorphine, to match the lowest dose in the range to the equivalent of the dose the patient was on at the time of prescription. In the case of an opiate naïve patient, the Panel accepted Professor M's view that a prescription in line with the Analgesic Ladder referred to at paragraph 9 above would be appropriate.

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

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

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

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

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

15. Syringe Drivers

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

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

but discontinuous course of injections.

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

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

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

16. Syringe drivers and the immediate relief of pain

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

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

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

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

Your response: 'I did.'

17. Titration and the use of syringe drivers

i. Professor M told the Panel that to ensure a patient did not suffer during the syringe driver's build-up period it was necessary to provide additional alternative analgesia first.
ii. The Panel heard that, depending on the circumstances, opiates could be delivered

by a variety of routes:

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

iii. In Professor M's view:

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

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

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

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

When pressed by Mr Kark you said that your patients did not suffer from a lack of nurses but that "they would have if two trained staff had been tied up titrating and

drawing up and giving injections of Diamorphine, even every four hours, let alone every hour."

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

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

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

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

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

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

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

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

19. The role of consultants

The Panel heard that, at the time in question, the presence of consultants on Dryad and Daedalus wards was extremely limited. Although the consultants who gave evidence before the Panel were supportive of you, their evidence tended to suggest

that they had not critically examined your prescribing practice, and in many instances had not appreciated your admitted prescribing failures. Had they done so, this should have resulted in appropriate changes being made to your prescribing practice.

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

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

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

21. The principle of double effect

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

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

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

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

control patients' symptoms."

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

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

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

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

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

You replied: "At that point I was not concerned about any potential adverse effect. I wanted Mr xxx (Patient A) comfortable and free of all these wretched symptoms."

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

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

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

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

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

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

PART TWO

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

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

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

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

Head 1 has been admitted and found proved.

xxxxx (Patient A)

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

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

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

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

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

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

The Panel first reviewed the Midazolam dose in the light of the guidance contained in the Wessex Protocol. Taken in isolation, the Panel could not conclude that the

lowest dose of Midazolam was too high. However, the Panel also had regard to paragraphs
12 and 14 above regarding the overall sedative effect that the Midazolam might have when combined with the Diamorphine which was also prescribed. On this basis, the Panel was sure that the lowest dose of Midazolam prescribed was too high.

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

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

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

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

Head 2b iii has been admitted and found proved.

Head 2c has been found not proved.

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

Head 2d has been found proved.

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

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

In the light of the Panel's findings that the lowest prescribed dose of Diamorphine was too high and that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs, the Panel concluded that

this prescription was inappropriate, potentially hazardous and not in the best interests of the patient.

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

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

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

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

Xxxxx (Patient B)

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

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

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

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

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

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

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

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

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

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

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

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

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

On 26 February 1996 you increased the prescription for MST from 10 mg to 20 mg twice a day and prescribed a variable dose combination of Diamorphine and Midazolam on syringe driver. The Panel considers that the increased dose of MST was in itself high. The Panel has noted that at the outset of the hearing you admitted that this prescription was too wide, potentially hazardous and created a situation whereby drugs could be administered which were excessive to the patient's needs. Further, and having regard to paragraphs 11 – 14 above, in relation to the prescription of opiates, their side-effects and effect in combination with Midazolam, the Panel is satisfied that your actions in issuing this prescription were inappropriate and not in the best interests of Patient B.

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

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

Head 3d i has been found not proved.

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

Head 3d ii has been found proved.

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

Head 3d iii has been found not proved.

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

Head 3d iv has been admitted and found proved.

Heads 3e i and ii have been found proved.

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient C)

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

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

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

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

Head 14a iv has been found proved.

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

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient D)

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found proved.

The Panel has received no documentary evidence to indicate that you assessed this opiate naïve patient prior to prescribing opiates. You told the Panel that you could not be sure that you had formally assessed the patient as you might have been away around that time. You told the Panel that on your return to the ward on about 17 August 1998 that "we had mayhem occurring", and that though you might have seen the patient, you would have relied on the verbal reporting of assessments made by nursing staff. It follows that this prescription to an opiate naïve patient was not based on an appropriate assessment by you, and that your failure was not in the patient's best interests.

xxxxx (Patient E)

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

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

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient F)

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

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

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

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

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

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient G)

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

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

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

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

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

The Panel had regard to paragraphs 12 – 14 above as to combining Diamorphine and Midazolam, prescribing opiates outside the guidelines, and anticipatory prescribing, and noted your admissions that the dose range was too wide, that the prescription created a situation whereby drugs could be administered which were excessive to the patient's needs and that your actions in prescribing the drugs were potentially hazardous. In all the circumstances, the Panel concluded that your

actions in prescribing these drugs were inappropriate and not in the best interests of the patient.

Head 8d has been admitted and found proved.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient H)

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

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

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

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

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

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

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

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

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

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

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

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

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

Head 9e has been admitted and found proved.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient I)

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

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

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

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

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient J)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient K)

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

Head 12b has been found proved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Head 12e has been admitted and found proved.

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

xxxxx (Patient L)

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

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

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

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

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

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

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

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

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

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

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

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

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

Head 14a iv has been found proved.

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

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

Heads 15a and b have been found not proved.

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

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

PART THREE

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

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

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

Determination in relation to Serious Professional Misconduct and Sanction given on 29 January 2010

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 unadmitted 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 Mrs R, 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 two hundred 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).

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.

There were no further submissions. The Chairman therefore announced that the interim order would be varied as indicated and that concluded the hearing.

Confirmed

29 January 2010 Chairman