GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (SERIOUS PROFESSIONAL MISCONDUCT)

Tuesday 14 July 2009

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

Chairman: Mr Andrew Reid, LLB JP

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

Legal Assessor: Mr Francis Chamberlain

CASE OF:

BARTON, Jane Ann

(DAY TWENTY-FOUR)

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

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

(Transcript of the shorthand notes of T A Reed & Co Ltd.
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THE CHAIRMAN: Good morning, everybody. Welcome back, Professor Ford. I think you are on the final run now. Mr Kark.

GARY ASHLEY FORD, Continued
Re-examined by MR KARK

Q Professor Ford, I am going to follow the same pattern, as it were, that Mr Langdale chose, which is to deal with general questions first and then very briefly, I think, to each individual patient. I want to start, please, if you could turn up the file 1 and turn to tab 6. This document, we understand, was written by a doctor, we were told, called Dr Logan, I think it was. It is page 27 of tab 6. I just want to re-examine with you where you agree, as it were, with the sentiments expressed and where you depart from them. If you look four lines down in the second paragraph, you can see the words:

> "I felt when there was any question that the patients had pain then they should be given the benefit of analgesia. Unfortunately there were no really very useful middle range drugs between Codeine and Dihydro-codeine and Diamorphine. I also explained that, besides their pain relieving properties Diamorphine and Morphine had very useful psychological effects producing some psychological detachment and euphoria which can do much for a patient's tranquillity."

Now, just pausing there for a moment, the beginning words were "I felt when there was any question that the patients had pain then they should be given the benefit of analgesia", and the words that I noted down from your evidence were "significant concern".
A Yes. I think the problem with saying "any question" is any question by whom, and after what assessment? In my view, some of the patients, there was an interpretation that their agitation was likely to be due to pain, when, from the information that was found in the notes, to me I thought that was not likely, because they had dementia, previous history of behavioural disturbance. So I, for example, would not consider that "any question" of them being in pain: I think one would have to have a reasonable possibility that they were in pain; that is you identify a cause of pain, or you cannot identify another cause for their behaviour after observation. So I think the problem with "any question" is it potentially leaves it open almost to anybody, a nurse or any doctor who sees the patient, after any assessment to think, "Well, they might be in pain. Let us try strong analgesia", and I would depart from that view. The reason for that is there are, as we have seen in some of these patients, adverse effects of opiates, so one has to take a balanced approach, weighing up the potential benefits of treatment and the risks of treatment. So I get back to, which is the general practice of good medicine, which is emphasising good medical practice, which is one requires an assessment of the patient to make a judgement. So he is right, Dr Logan, to emphasise that you should be looking to see if patients are in pain and seeking to relieve it, but I think it is a question of what one interprets as pain, and I think there was in my view over-interpretation of symptoms as being likely due to pain when there were other causes.

Q It is a question of setting the hurdle---
A Yes.

Q ---and you say this is setting the hurdle rather too low?
A I think one would have to ask Dr Logan himself what he meant by that phrase. I do not think he would have meant it as liberally perhaps as it might be interpreted by some, I think is my point.

Q You also, I think, dealt with the words:

"Having established that and being content that the patient was distressed and probably in pain, then one should not hesitate to use opiate analgesia if necessary."

I think your comment was that the challenge is identifying if the patient is in pain. So if you have an agitated and distressed patient, that may be for a number of reasons.

A Yes. I mean, I think my view was that a trial of analgesia is a reasonable approach, so the point is it does not end with the decision to give the prescription. What one has got to do is see does the patient's behaviour that one is interpreting is pain improve, and is the treatment that is started tolerated without adverse effects. So part of good management is not so much the decision to try to treat pain with opiates, it is how that is monitored and the response that is taken to the treatment. I think we have had a lot of discussion about was it appropriate for this patient to be started on opiates at that particular point in time, and I said good practice is to go through the ladder, but in a way the key issue is the response that is taken when that decision is made, and I think the problems were that the dose was excessive and then there was not proper monitoring and consideration given, rather than just focusing on the decision to start opiates themselves.

Q On a similar and perhaps related issue, we have heard a lot in this case about how experienced Dr Barton was and how experienced her nurses were, and you said this on Day 22/43:

"One does not necessarily gain expertise alone from having exposure to a patient group. It has to be accompanied by specific training or working with peers and developing one's skills interactively in that context."

I just want to examine that with you for a moment. "Working with peers and developing one's skills"; in Dr Barton's case, in her particular position of Clinical Assistant, who were her peers?

A Well, by peers I mean not necessarily the parallel group of other clinical assistants. I mean in this context consultants in geriatric medicine, it could be consultants in palliative care if that is a key area of what one is looking at, and also, I think, registrars are often highly competent. I do not know to what extent Dr Barton might have had exposure to registrars.

Q We heard from one. We heard about Dr Ravindrane. There may have been others.

A I think, however experienced one is, it is important to have, I mean we now give it a proper name, continuing professional development, and one goes to meetings, one has audit meetings where one discusses cases, one keeps up to date, and these are absolutely critical, however good you are. I mean, they are critical in my case to maintaining the expertise in where I practice, and I do not know to what extent Dr Barton had that framework. I get a sense that maybe there was not a very strong framework of training and support in terms of interaction with her peers and continuing professional development in elderly care.

Q There is no question that Dr Barton certainly had very long term exposure to a particular patient group.

A I agree.

Q From what you have just said, that does not necessarily lead to gaining in skill?

A No. I think the other thing is practice changes over time. I mean, what was considered good medical practice when I qualified in 1982 would in many instances, I think, now not be considered good medical practice, and so practice evolves and changes and the standards and expectations change, which is why continuing professional development is so important.

Q I want to ask you about another area of your evidence dealing with inadequate staffing, and this question is put to you by Mr Langdale:

> "Would you agree with this? Where good nursing care – and I stress this – with adequate staffing ratios and regular patient supervision is lacking, the use of drugs earlier and at a higher dosage to control symptoms can help to ease the distress of patients and indeed their relatives."

You gave a long answer to that, starting with "I do have trouble agreeing with that". This was Day 22/48. You said during the course of your answer:

> "The problem with that is of course the problem of inducing unnecessary adverse effects ..... if you have an environment with a low level of nursing time, you will not get equally the monitoring for that and so you are ending up with a situation where you are having to use potent drugs in a very undesirable, one can say more risky way."

Now, let us take that scenario, that you are perhaps under-staffed and perhaps under-managed, as it were, from above: first of all, can you continue to practise in that way over a lengthy period, or should you?

A Well, I think there is an obligation, a professional obligation, to highlight, if that is one's response, and I think many doctors' response would be more conservative and might say, "Actually, if there is inadequate nursing environment you have to be more cautious with dangerous potent drugs", because the risks are too high, even accepting that you may not be able to fully relieve patient's pain, what I am saying is there are different approaches to this, but the key issue is if one genuinely believes there is inadequate staffing, one has to raise that with whoever is responsible for managing the unit, both at a clinical level and a managerial level, and point out what one is having to do which one considers is suboptimal practice. I mean, if we take thrombolitis, for example, generally very powerful treatment, if the appropriate monitoring is not in place we simply do not provide it to patients and patients are denied an effective treatment, but we will do that because we put doing no harm to patients as a first priority.

Q You spoke about the importance of adequately being able to titrate the drugs you are using to the best response. Does that mean continuing assessment of the patient once you have started the patient on analgesia?

A Yes, and we talked about the sort of standard of care laid out now by the Liverpool care pathway, but I do not think it was very different in the 90s of, for example, four-hourly observations of a patient's behaviour and whether they appeared to be in pain and whether they are restless or agitated. I think that would not be an unreasonable expectation of nursing staff. I mean, I am not a nurse so I have to be a little bit wary about what I comment on, but as a doctor that is the sort of level of observation I would expect for patients who are deteriorating and dying as a minimum.

Q Just to finish that topic, how do you regard the suggestion, if this is what was being put to you, that because there is inadequate staffing levels, or inadequate time, it is legitimate either to use more drugs or to use the drugs earlier?
A I may not have directly said "No", but in my last answer, which I still hold to, I said I could not agree with that as a justification for undertaking prescribing what is acknowledging a suboptimum.

B Q I want to turn to another broad topic, about which you were questioned on a number of occasions in different ways, and that is the concept of using opiates for agitation, or for some other symptom other than pain. I am afraid I have not got the reference for this, but my brief note of what you said at one stage was a reasonable body of medical opinion would use opiates for purposes other than pain, and I just want to re-explore with you what limits, if any, there are to that answer.
A Yes. We did not go through all the indications for opiates. They are used for reasons C other than pain relief. I mean, one which we have not talked about, I do not think it was a problem for any of the patients being discussed here, was terminal breathlessness, and that is a well recognised indication, using opiates to relieve breathlessness. In a completely different setting, one uses potent opioids to induce anaesthesia, and also for long-term sedation in an intensive care unit setting, but again that is not relevant to this setting. It is also used, and we talked a little bit about this, for the treatment of left ventricular failure in acute pulmonary oedema, and again I think that was only a potential indication in one or two D patients, but usually one is giving it intravenously or intramuscularly, not orally, in that setting.

Q I wanted to pause on that for a moment, because you were fairly specific about how morphine could be used in those circumstances. Would a long term infusion by syringe driver be an appropriate response to MI or something like---
A It is not an approach I have ever used with myocardial infarction or heart failure, and E it is not an approach I am aware that cardiologists use. I mean, there are many other approaches to manage end stage heart failure. I think opiates may be used in the final stages of intractable heart failure to treat breathlessness, but again I think that would be the limit.

Q The limits on using morphine for agitation: agitation is one of the constant themes in this case – agitation, restlessness, bad behaviour, if you like to call it that.
A Well, it is covered, I think, by the Wessex protocols, which talk about the F management of agitation, and they do not list opiates as a treatment, and this was apparently the basis for practice that the Gosport War Memorial Hospital staff referred to. So it is helpful in patients who are in severe pain in reducing their agitation and giving a sense of euphoria, that is well recognised, a sense of detachment, but opiates, I stand by my statement, are not a treatment for agitation per se, and all the palliative care guidelines then and now use other approaches, predominantly antipsychotics, and other non-drug measures, and sedatives as an alternative if antipsychotics do not work.

G Q During the course of your cross-examination you were asked about a particular report from 1987, Wilson J A et al on palliative care.
A Yes.

Q Certain figures were put to you. Did you have an opportunity of checking that report at any stage?

H

A I was only able to get the abstract. I could not get the full article. So I have read the abstract, which indeed looked at practice in 150 or so – I have it printed off somewhere – patients who died, elderly patients in a continuing care setting, and, as Mr Langdale indicated, showed opiates were used in just over 50 per cent, and usually in single repeated doses at that point in the 1980s.

Q Because at that time they were not using syringe drivers to that---
A Well, there were syringe drivers, but it mirrored what appeared to be the practice – obviously I did not look at the drug charts – and I went round and looked at the practice in our own unit over the last year, where most patients were clearly getting low doses, as I indicated, and the highest dose received over 24 hours of diamorphine was 20mg, and most were receiving 2.5, 5 or 10 mg, and the doses were likely to be single doses.

Q Were those end of life patients?
A These were all patients who had died, and this was prescribing in the last few days of life, but it did agree, which was my estimate, that I thought about a quarter to a third of patients, and we found a third of patients had some need for opiates and were given opiates towards the end of life.

Q I am sorry to come back to file 1, but could you turn back to file 1, tab 4, please, the *Palliative Care Handbook.* You were being asked about version rates and particularly paragraph 7 under the heading "Use of Morphine".

"When oral administration is not possible because of dysphagia..."

A I am sorry. What page is that?

Q Page 6.
A I have it.

Q Paragraph 7:

"When oral administration is not possible because of dysphagia, vomiting or weakness, consider changing to diamorphine by subcutaneous infusion using a syringe driver. The conversion from oral morphine to subcutaneous diamorphine (total daily dose) varies between 1/3 – 1/2 allowing some flexibility depending on the requirement for increased or decreased opioid effect."

We have been, I think, taking it as something of an assumption that the one half conversion rate is an equivalent?
A Yes. I was trying to be generous, if that is the right way of describing it, in interpretation, but the implication there is that would be an increase in dose, yes.

Q So that the flexibility between one third and a half, the half appearing on the face of that to be allowing for an increase if pain is not controlled?
A If one accepts that it is a third conversion, that is what other sources point to in terms of equivalence of subcutaneous infused diamorphine to oral morphine. Doing a half conversion is equivalent, 33 per cent to 50 per cent is equivalent, to doing the 50 per cent increase which is the recommended increase step to make if you want to increase the dose of opiates if you do not have symptom control, so the half is not a standard conversion, then there is implied here to be incorporating an increase in dose. Yes, I would agree with that.

MR KARK: I was going to deal with this when we deal with specific patients, but since we have this file open and this page, it may be appropriate now to put in another page of the BNF. This comes from – and I should have written it on the top – the 1999 BNF. I have given one copy to Mr Langdale already. I am going to suggest that we just slip it into the back of our tab 3 and this is dealing specifically with co-dydramol which I think is one of the very few pages of the BNF we have managed not to copy already in the file. I think this should go in.

THE CHAIRMAN: Do you want us to give it a page number?

MR KARK: Yes, it could do.

THE CHAIRMAN: It goes in at the end of three. It would be 51.

MR KARK: Yes. It might be worth keeping it out just for the moment, though, while we look at the page in the *Palliative Care Handbook*. (To the witness) This, in fact, if we look at the top of the page, comes under the heading "Non-opioid analgesics". Co-dydramol: if we look to the right hand side, the first entry there is co-dydramol. Before that we can see "co-codamol" in the third column along.

A Yes.

Q There are three types of co-codamol in differing packs, I think, with differing strengths of drug, but can we just look at co-dydramol first of all at the right hand side. They contain dihydrocodeine tartrate 10mg and paracetamol 500 mg. Would you put these into an opioid category?

A They are mild opioids. Mr Langdale asked me yesterday about how they compare, and they are very mild. I am not sure. I think it is wrong to call the combination non-opioid analgesics. I think the paracetamol is a non-opioid and what they have done is, they have put the combination in. This is the sort of change of heading under which they have put the drug in, but I think you would find dihydrocodeine and codeine, when they are listed separately in this BNF, being described as opioid analgesics, I suspect. I was asked the question yesterday, "Do you take account of it?" I said "No", and the reason is I had a look through, before starting again this morning, what level of doses of co-dydramol and co-codamol the patients had received. I think the most patients had received was eight tablets a day, which will be the standard. In the case – maybe you are going to ask me this – of dihydrocodeine it would amount to 80 mg of dihydrocodeine and it is about a one to ten conversion. Mr Langdale was pressing me on this.

Q A one to ten conversion of what?

A Equivalent to morphine over 24 hours. I said we did not usually take account of that. The reason is, it is so mild that a patient who had eight tablets a day of co-dydramol would have had an 8 mg morphine equivalent over 24 hours, which would be equivalent to about 3 mg of diamorphine over 24 hours. That is why in practice we do not take account of it, because it is such a small amount of strong opioid equivalent. It does not alter the dose that she has got to infuse with. The only exception, I think, would be if the patient had an adverse effect to mild opioids at that level one would be very cautious about moving to stronger opioids. I think that would be the only way it would work.

Q You can put that away. Finally, while we have this file open, page 2 of tab 3, which is the beginning of the BNF, *Prescribing in Palliative Care*", this phrase was put to you. This is, in fact, where it came from. Look at the left hand side of the page under the heading "Pain":

> "Analgesics are always more effective in preventing the development of pain than in the relief of established pain."

Again I just want to explore with you the limits on that. Is that an opening, as it were, to prescribing opiates to patients without pain?
A It is a surprising statement in a way in a palliative care section because to my knowledge palliative care specialists do not pre-emptively prescribe strong analgesia. The principle is very important if you are going to undertake a painful procedure on a patient such as surgery or a joint manipulation. You would always give analgesia before that rather than wait for the pain and then give it. But there is animal work that suggests that is true in terms of animal models and also experimental human models. I am not a pain expert, and it is also a well established principle that if you treat pain early you can get on top of it and prevent some of the secondary problems that patients may get. But I do not think it acts as a justification to give opioids to patients who do not have pain because you think they might develop pain.

Q I am going to take a very quick canter, as it were, through some of the patients. I think I have possibly one or two questions to ask you first of all about Patient A. Again, I am going to stay entirely with the chronologies. Can we turn to page 13, please. You agreed with Mr Langdale, if you look at pages 13 and 14, that there came a time when this patient was on 30 mg of Oramorph. I just want to explore with you when in fact this came about chronologically. Will you just find it in your report?
A Yes. I make a statement in my report that he was receiving 30 mg of oral morphine over a 24-hour period on 14 January. That was the information I had extracted.

Q If we go back to page 12 and 13, we can see the date is 10 January 1996 and then, if we go to page 13 in the middle, we can see that Arthrotec is discontinued?
A Yes.

Q And the suggestion is that because you are taking Arthrotec away, you need to replace it with some sort of analgesic. If the result of taking Arthrotec away is to leave the patient in pain, no doubt you agree with that?
A It is slightly more complicated, if I can answer that. He was started on Arthrotec just two days beforehand, I think, and the question would be whether he had had any benefit from that. I actually suspect, since it was discontinued, there was no obvious benefit, in which case it is no different from if he did not have it. Again, the notes do not record, I believe, whether he had an improvement or not with the Arthrotec, but he had not been taking this long-term, so the relevance would be had he had any symptom improvement for the two or three days he had been taking the drug.

Q On 10 January, therefore, the patient is started on Oramorph. The prescription is to be given five times daily, but on 10 January he receives 5 mg in fact.
A That night.

Q At night. The last dose given to him at night?

A Yes.

Q On the same day he is prescribed diamorphine starting at 40-80 mg and over the page we can see then on the following day, 11 January, Dr Barton changes the prescription to increase the prescription at night of Oramorph and it remains as it was during the day, four times 5 mg daily?
A Yes.

Q That is, in fact, administered on that day and that is where we get our 30 mg starting. Yes?
A Yes, although I note here it only records... Yes. If it includes the six o'clock dose the following morning – yes, that is the 30. That is where I obtained the 30 mg a day from, yes.

Q In terms of prescribing I do not want to go through the whole list of them again, of converting from Oramorph to diamorphine and all the rest of it. Is there any legitimacy to the approach to prescribe a patient 30 mg of Oramorph and, at the same time, to prescribe a conversion dose of diamorphine – ignore the rates for the moment?
A I answered this, I think, around some of the patients. I would view it as reasonable, if the prescription clearly specifies it, to prescribe subcutaneous morphine or diamorphine as an alternative to the oral morphine where the patient was not able to swallow. But no, it is not appropriate to be putting a prescription for subcutaneous infusion of diamorphine as well as oral morphine. Of course, all the evidence I have heard was that everybody understood on the unit ---

Q There would not be a ---
A --- it was to replace. But as I indicated, I think I consider the prescription of a 24-hour subcutaneous infusion is not the right approach in this setting. If one is concerned that the patient may be unable to continue receive oral doses of morphine, an appropriate response is to have an alternative route which the prescription could specify "for administration if patient unable to swallow," for example, and to give a PRN dose of subcutaneous diamorphine equivalent to the oral dose that is being administered at that time point. That could be given then at a nurse's discretion, under clear instructions, when a doctor was not available. If it was felt that this was very uncomfortable, to have repeated injections, in my view there was on-call medical cover that could reasonably be expected, except under exceptional circumstances, to attend within four hours to write up that infusion. The idea that one has to write up, even if it is the correct conversion, a 24-hour infusion of diamorphine because there is not a resident doctor there, I do not accept. I do not think it is best practice.

Q I am not going to delve yet again into the amounts that were prescribed, and I will move on. You can put that one away, please. Patient B: can we go to page 7, please, Elsie Lavender. This was the lady "? [query] fall, ? [query] stroke".
A Yes.

Q Can we remind ourselves of pages 7 and 8 of the chronology. I think your comments that I have noted in relation to 22 February was that it is too early here to say that her chances of recovery are small; she has a reasonable chance.
A Yes. I think the situation was certainly not hopeless.

Q At page 8, we see the entry on 24 February by Nurse Joines.

"Pain not controlled properly by D.F. 118"

Is that dihydrocodeine?
A If I remember correctly, yes; that is the trade name for dihydrocodeine.

Q Your comment was, "The pain should not be getting worse at this point". I just wanted again to explore this very briefly with you. Is that on the premise that she was being treated for a stroke?
A No. This was on the premise, because stroke rarely present with pain. If it does, if you get post-stroke pain, it is certainly not a problem one would treat with mild or strong opioids or standard analgesics. It is usually neuropathic pain, so one uses carbamazepine, amitriptyline or other agents to treat neuropathic pain. Initially my reading of the notes was, it was thought the pain was due to her having fallen down the stairs and sustained considerable musculo-skeletal injuries, to the extent that she had an X-ray to check whether there was a fracture, or a number of X-rays to check whether there were any fractures. My point was that if the pain was thought to be due to that, by this point it should be getting better if it is simple bruising in the absence of a fracture. I think with the benefit of hindsight, and looking at this, that is why myself and, I believe, a previous expert thought it was much more likely the pain was related to cervical cord injury. That was the point. The pain should be improving by now if the working diagnosis was that it was musculo-skeletal injury.

Q If it were a stroke, there should not be the sort of ---
A There should not be this sort of pain, and if it is post-stroke pain it is the wrong approach to use opioids to it.

Q And if there is continuing pain and one's assessment was, therefore this cannot be a stroke, or it is unlikely to be a stroke, it must be a cord injury, what is the plan for treatment, if any?
A I think the pain should have ideally prompted a re-examination of the patient and documentation. It was not just pain; she had weakness as well in her hands, which I think had been attributed to the stroke, but I think that was incorrect. Then if one had thought there was a cord lesion, one would have had a discussion about imaging and one would have had to have done an MRI scan.

Q All of which would be ---
A There would have had to have been a discussion about it and one would have looked very hard to check she did not have a neck fracture and of course we have not seen the cervical spine x-ray or the result of it. We do not know if that was a fully adequate view of the cervical spine, assuming it was obtained – there is some question about that; we think she had it. So there are a number of issues and a different approach one would have taken and one would almost certainly have tried immobilising the neck with a collar. These may have helped.

Q This comes back to the issue we have discussed frequently. When faced with a patient in pain, it is important to identify what is causing that pain if you can.
A Yes. I think this lady was a difficult case. If there was a weekly consultant review happening, I would have expected that was the opportunity to look at what was happening and for the consultant to think, "Why is she still having pain?"

Q We can put that chronology away. Miss Alice Wilkie, Patient D. I only have one question to ask you about this. You can turn it up by all means if you wish; it is page 8 of the chronology, but it is quite a short point. This patient was started on 20 August on 30 mg of diamorphine and 20 mg of midazolam. The basis of that appears to have been – this was suggested to you – that her daughter had said to one of the nursing staff that her mother was in pain. If a relative comes to a nurse – I think it was Phillip Beed in this case – and says, "My mum is in pain. Can you do something for her?" obviously that should not be ignored, but what is the proper approach? What should happen then?

A If this is a new symptom, it should be reported to a member of the medical staff and evaluated. Obviously if it is known what the pain is due to, appropriate analgesia should be provided, but I think the response has to go beyond providing PRN analgesia that has been written up, particularly when it is very potent analgesia.

Q This patient had been on no painkillers at all during this course of her visit to hospital. If she was in pain and the relative said she was in pain and believed she was in pain, would it in your view in any circumstances be appropriate to start at this sort of rate for those two drugs?

A No. Older people are the same as the rest of us. They deserve the same level of medical care and attention. If you went to your GP, saying, "I have pain", you would not expect to come out without a history and examination with a prescription for an opiate; you would think that was not appropriate care, and the same principles apply to the care of older, frail patients, as I have indicated. The medicine and medical practice of looking after these patients is more difficult and more challenging, but the same principles apply.

Q We can put that chronology away. Can we turn to Patient F, please, Ruby Lake? In relation to this patient, your comment was this, as we noted it from yesterday: in retrospect it is easy to say she should not have been transferred. Again, I just want to explore that with you. Why are you saying in retrospect it is easy to say she should not have been transferred? If we go to page 12 – and obviously if you want to start earlier, please do ----

MR LANGDALE: Sir, I hesitate to interrupt, but there is an issue as to whether this arises out of cross-examination. My friend will recall that in chief the witness said that he concluded that she was not really fit for transfer on reflection. I do not see how this question arises out of cross-examination.

THE CHAIRMAN: Mr Kark, perhaps you can answer that question.

MR KARK: I am not seeking to undermine the evidence in any way, but it is right that it was raised in chief. It is right also that it was raised in cross-examination and I simply want to explore with the Professor what his basis for saying that has been. I am not suggesting there is not a good basis for it, but it may assist the Panel to know what it was about this patient that made her on reflection less stable than she otherwise would have been.

MR LANGDALE: I still think my point is right, but I do not want to be over-technical. If my friend wants to go over the same ground, please do so.

MR KARK: I do not think the Professor has covered this ground, in the sense that he has not given the specific reasons. (To the witness) I am not going to ask you to spend very long on it.

A Just to elaborate on my response to Mr Langdale yesterday, my view – it was put to me that she was an unstable patient and I think the medical notes from the Royal Hospital Haslar indicate that. Then she appeared to be stable for a period of days. As I indicated, you really want to try and avoid transferring patients who are medically unstable and then having to manage a deterioration in a suboptimal environment. The point I was trying to make was that it is easy to recognise in retrospect who should not have been transferred. It is very difficult when you are placed with patients to judge when they are ready to transfer. If you are too conservative, you never transfer anybody, because you are worried something might happen. The reason I said "in retrospect" was because after she was transferred to Dryad, she then I think developed chest pain on the 19th. So what I was saying was that she was transferred on the 18th and then within 24 hours she developed chest pain. One does not like to see this happening, but the point I was trying to make was that this is part of what one sees in geriatric medical practice. You cannot get it right perfectly all the time.

Q On 17 August – and really this is what I was seeking to clarify with you – at the top of page 13 we can see, "Well, no chest pain". But then we see at the bottom of the page there is what you referred to as a "spike" in her temperature.
A Yes.

Q Then over the page, we see, "Well, comfortable and happy. Last pm spike temp, now [normal]." Then she is transferred, but despite the fact that it might appear that her issues have resolved, it is possible they are going to recur.
A No. I think for example if someone had discussed this sort of lady with me immediately prior to transfer and said, "In the last 24 hours she has had a spike of temperature and she has been more breathless", I would have said, "Well, let's just wait a couple of days and see how she is." I do not think there is any suggestion that that information was fed through to a senior consultant on either the medical team or the geriatrician. So I am not critical of the transfer in any way. These things happen.

Q Can I move on to Arthur Cunningham? Again, I am going to be very brief, I hope. Could you go to page 7? It is the issue of this patient's anti-psychotics. I have added in to my page 7, I do not if anybody else has, that on 14 September 1998 the patient was on something called risperidone.
A Yes. That is an anti-psychotic which has less Parkinsonian adverse effects.

Q And carbamazepine?
A That is a mood stabiliser, I suspect it was being used for. Or it can be an analgesic in neuropathic pain or an anti-epileptic drug, but I do not think he had epilepsy, so I think it was probably being given as a mood stabiliser.

Q If, when he gets to the Gosport War Memorial Hospital, he is no longer receiving those anti-psychotics, I just want to explore with you again what is the proper approach. First of all, if those who are treating him at the Gosport War Memorial Hospital know of that background and the patient does become agitated, does that affect the proper approach to take with this patient?
A I think you have to re-introduce the anti-psychotics, because any other approach is unlikely to be effective. Sedatives, for example, are not an appropriate approach for behavioural disturbance in dementia. They are not the preferred approach, anti-psychotics are not, because of the adverse effects and because they are not as effective. Opiates are not

an appropriate approach. Both sedatives and opiates in particular may make the problem worse, may make people more confused and agitated.

Q That is what I wanted to ask you about. You said this is a man who has had agitation, therefore diamorphine could make it worse. Do you say that because the man had previously been on anti-psychotics? If he has dementia of some form or another, is the effect of diamorphine any worse or is it the same?

A Any drug that produces confusion as an adverse effect is more likely to do so in the elderly and is much more likely to do so in older people with impaired cognitive function and most likely to do so in people with dementia. So they are an at risk group. It is common to see systemic illness such as infection and drugs produce acute confusional states in people with dementia.

Q At page 14 of the chronology, Mr Langdale reminded you of this entry:

"Became a little agitated at 23.00, syringe driver boosted with effect."

Again, I just want to explore with you very briefly how quickly one would expect to see the effect of a boost of the syringe driver in these circumstances.

A Not very quickly. Again, in someone with dementia the initial approach to agitation would be better with an anti-psychotic drug, but if you are increasing the rate of midazolam, it will not work immediately within half an hour, because it takes longer to get a significant amount of drug in. I am very critical of the very large increase in midazolam in this man.

Q I want to explore this with you. It may be important. On the side of the syringe driver – I have not looked at it for a while, but the Panel have it – there is a button which I believe says "Start boost". So you start it with a button and you boost it with a button. You may not be able to answer this. Do you know what happens when you press the boost button?

A I do not and I did not think it was used actually, because I am not sure how one controls the boost button to give an extra loading dose. There is no suggestion from any of the nursing administration charts or of course the prescribing charts that, if you like, what we call a bolus dose was given, but having looked at that pump, but not having read the instructions or personally used a syringe driver to give opiates, I would not know how to use boost function. Clearly in patient-controlled analgesia, patients give incremental boost doses in that setting, but I did not gain the impression that these patients were being given at any point booster doses.

Q That is why I have raised it in this context. If we look at the following page, the top of page 15, we can see that the diamorphine in relation to this particular syringe driver was – the original syringe driver at 9.25 was discarded and the same amount of diamorphine was put into the syringe driver and that was restarted at 2000 hours. Midazolam was in fact increased from 20 mg up to 60 mg. I am not going to ask you again about that; you have given lots of evidence as to what you think about that. That is also done at eight o'clock. We can see also that the hyoscine remained the same. Coming back to our note on page 14, if this reflects what actually happened:

"Became a little agitated at 23.00, syringe driver boosted with effect."

That does not seem to indicate that that is a fresh syringe driver. Can you comment on that?

A I had not looked at that specifically, but I take the point you are making that the syringe driver appears to have been boosted before the report of agitation.

Q You cannot take that any further.
A Well, the syringe driver it appears was boosted before the reports of agitation, but maybe the recording of the agitation is incorrect by the relevant nurse. It is difficult to tell.

Q Or the boost may, I suppose, refer to something else.
A I do not believe using these drugs that there would have been an increased dose given without that being recorded in the prescribing chart for a drug like midazolam.

Q We can put that chronology away. Enid Spurgin. I do not think we need to turn up the chronology for Patient I, but the issue arose in relation to infection. My note of your evidence was – and I just want to confirm this with you – in relation to septicaemia, was there any evidence of septicaemia for this patient and what is septicaemia?
A Infection in the joint would be confined to the joint and would produce pain and swelling and inflammation and a temperature. Septicaemia is when you get infection and bacteria actually replicating in the blood stream. It is a very serious condition. That is usually manifest by circulatory collapse, low blood pressure, patients look very unwell and often, but not always, have a high temperature, occasionally a low temperature. So it is a much more marked clinical picture. I think in my response to Mr Langdale, I said there was no evidence recorded in the notes that she was septicaemic and the chronic infection which we are postulating may well have been there would have been there for some days and weeks.

Q Can I just ask you this? Can a chronic local infection kill you without it turning into septicaemia?
A I think it certainly can. Chronic infections can cause a patient to waste away; they do not eat, but it is not an acute, sudden death. But it can lead to secondary problems. If you have a chronic infection in your hip and you are immobile, you are at very high risk of developing a pulmonary embolus, which can kill you quickly. So there are consequences of a chronic infection, depending on the nature of it, which can lead to death without septicaemia, but related to immobility and other problems.

Q Thank you for that. Finally, can we turn to Patient L, please. I am aware that I have doubled up on my timing, but I am almost there.
A I have doubled up on my response, I suspect.

Q Jean Stevens: you have told the Panel that there was, I think you said, a 15 per cent transfer back rate of stroke patients. Have I got that right?
A There was a paper that looked at this in the 1980s or 90s, it was in Orpington Hospital, and they had an off-site stroke rehabilitation unit, and we have had that in Newcastle for many years, and it reported the extent to which patients who were transferred for stroke rehabilitation developed problems which required management back on the acute District General Hospital site in about 15 per cent of patients, and I think that would accord with our own experience, they develop problems that you cannot manage effectively in an off-site hospital.

Q Mr Langdale was examining the issue of aspiration pneumonitis with you, and if we go to page 15 – well, no, sorry, we should start earlier than that: we have looked at the note which indicated that her nasogastric tube appeared to have gone wrong.
A Yes.

Q If we look at page 12, and we can go earlier certainly if anybody wants to, she is being reviewed on 11 May, she is then being fed through a nasogastric tube; on 12 May the same. Then page 14, we can see at the bottom:

"Tolerating feeds without any problems."

I am afraid foolishly I have not recorded where we saw that note of what the date was that the nasogastric tube had gone wrong.
A On the first or the second occasion? There was one entry, which Mr Langdale took me through---

Q Sorry, I have got it, it is page 6, I think, top of page 6, when we have looked at the X-ray, and the nasogastric tube did not appear on the chest X-ray but it was in, which indicated that it had been pulled out to some extent. So that is back on 30 April---
A I mean, just to comment on that, usually nurses do not start feeding through a nasogastric tube until they have had the X-ray back and it is confirmed it is in place, so slightly surprising that there was feeding, and it is possible the house officer had assumed there was feed going down it when it had not, but his record certainly suggests that there was feed going down the tube, and then the end of it was found to be in the nasopharynx, and you would certainly expect the patient then to have an aspiration pneumonia if feed had been placed---

Q Which she did, and if we go to page 12 we can see complaints of chest pain, and that is on 11 May and 12 May; are those indications possibly of pneumonia?
A Well, nitrates were given, so the assumption here was the chest pain was angina, but it could be what we call pleuritic pain due to infection. You can get chest pain related to the infection. You do not commonly do so. She could have had other causes for chest pain, which I think we discussed.

Q We did. Come back to page 14. This is where I had started. Feeds continuing on 16 May. 17 May "[Patient] no real change", and then it is:

"[No] further pyrexia since 14/5. Creps L base".

Is that crepitations?
A Crepitations left base, which is where she had infection on the X-ray.

Q Does that mean that there is still some infection?
A Well, when a patient improves from pneumonia, the temperature goes down and their breathing improves, you can still hear signs at the left base for quite some time, and the X-ray takes often quite a period to clear. It does not mean there is anything not consistent with her improving from her aspiration pneumonia at this point.

Q Page 15, on 18 May, we can see:

"Liaised with GWMH. Happy to take Mrs Stevens with above results. Tolerating NG feeding well. Seems to have recovered from aspiration pneumonitis."

If we go over the page, because we should not stop there, on 19 May she is:

"Referred by physiotherapist.
Referred for collection of sputum sample, but no added sounds and has poor cough."

Now, is that an indication that that is a continuing problem of pneumonitis?
A No, I do not think the poor cough is evidence of continuing infection, but the physiotherapist must have been asked, and it says here that she was asked, to see if she could obtain a sputum sample to send for culture, and one would assume at this point, I cannot recollect, that she was off antibiotics – one would not normally send sputum cultures until the patient had finished antibiotics, or they were not responding – and this reports that there were no secretions to suck out to send for culture, which again would be consistent with that things are improving.

Q Then on page 17 we can see that she is transferred to Daedalus Ward. We can see the nursing referral note in the middle of the page:

"Has had aspiration pneumonia, now resolved."

A Yes. This is now almost three weeks since the initial aspiration pneumonia, so that seems entirely reasonable.

Q Then we have the entry, if we go to page 19, and there are two entries here which may be relevant, and these are on the day of transfer, on 20 May:

"[complaining of] abdo pain due to history of bowel problems. Oramorph given".

Then below that:

"Oramorph ..... given. [Complaining of] pain in stomach and arm."

I just want to explore with you, first of all, is there any relevance between abdomen pain in this case and pneumonitis?
A No. I certainly did not think there was. She had a history of chronic abdominal pain, and so the assumption I would work on seeing this lady was this was her chronic abdominal pain recurring that she had had for some years.

Q If the patient was suffering from chronic abdominal pain, are opiates an appropriate response?
A I believe Mr Langdale asked me that question yesterday and I said since she had been assessed by a consultant gastroenterologist or surgeon, and it was thought to be irritable bowel syndrome or adhesions, no, opiates had not been considered then, so the situation has not changed because she has had a stroke.

MR KARK: Professor Ford, that is all that I ask you. Thank you very much.

THE CHAIRMAN: Thank you, Professor. We are at the time now when you would ordinarily be invited to take a break, and I am going to do just that, but we are also at the time when, following that break, it would be time for the Panel to ask questions, if they have any, of you, and we normally take some time, as you are probably aware, with a major witness to consider what questions we may have. I think that on this occasion the areas of questioning have crystallised dramatically, and we probably will not need as much time in camera as we normally have. So I am going to say we will break now and parties will be informed as soon after the break as we have finished our discussions and we will ask you to come back. Thank you very much indeed.

(The Panel adjourned for a short time)

THE CHAIRMAN: Welcome back, everyone. Professor, as I indicated a while ago, we have now reached the point where Panel members have the opportunity to ask questions of you. I am going to ask first of all for Panel members who have general questions rather than patient specific questions to put those, and I am going to go first of all to Dr Roger Smith, whom you will recall is a medical member of the Panel.

Questioned by THE PANEL

DR SMITH: Professor Ford, on the subject of syringe drivers and their prescriptions, we have discussed diamorphine and midazolam at some great length, and touched upon hyoscine. Can you just remind us what hyoscine does, what its indications are?
A It is an anticholinergic drug which is prescribed to reduce secretions, and in the context it is being prescribed here it is being prescribed to reduce the unpleasant rattle and retention of secretions patients can have in the upper airways. So it is a commonly used treatment in patients at the end of life who are on opiates and other sedative treatment, and also in people, who are not on opiates and sedatives, if they have got problems swallowing secretions or producing a lot of respiratory secretions.

Q In ten of the twelve patients that are the subject of the inquiry, either the anticipatory or the first prescription for the syringe driver drugs has included hyoscine. So there have been three drugs – diamorphine, midazolam and hyoscine – at the very first prescription. Can you help us as to what might be the purpose of that?
A The assumption I made in looking at those prescriptions, and I have not commented on them very much in my report, was that this was anticipatory prescribing for end of life care, anticipating that these patients may develop problems with swallowing secretions, and that the nursing staff could then commence hyoscine if that problem developed. That was how I interpreted the prescription of the hyoscine in these patients.

DR SMITH: Thank you very much.

THE CHAIRMAN: Thank you. Mr William Payne is a lay member of the Panel.

MR PAYNE: Good afternoon. I only have two or three small general questions. Staying with the syringe driver, and I am not going to take you specifically to any specific patients, but I think in your evidence that you have given you said that the best way to formulate the level of analgesic required would be to start by giving it either orally, or injection every four hours, till you get to a base, and then go on to a syringe driver to maintain a level. Am I right?

A Yes, that is the standard approach which is recommended in most guidelines.

Q Well, can I just direct you to this: I mean, it is only a small thing and---

THE CHAIRMAN: Let us make sure that the Professor has a copy of it. This came with the syringe driver, which is our exhibit C16, and the Panel were all given copies of the document, which is headed "Me and My Syringe Driver".

A I do not believe I have looked over this document before.

Q I think there is a copy coming to you now. (Same handed)

A Thank you very much.

MR KARK: Are there copies for counsel as well?

THE CHAIRMAN: It is a very small point. Perhaps I can assist and just ask if counsel can look at, on the central pages – I think Mr Payne's question is in relation to point number 2.

MR KARK: It is could be copied in the meantime, I am sure Mr Langdale and I can – (Inaudible as microphone not switched on).

A Do you wish me to carry on?

Q Certainly. I did not mean to delay the questions. It is just so we can look at the document in due course.

MR PAYNE: This is a very simple document. The lay members on the Panel can understand this, so can everyone else, but in the middle, and it says "Am I getting worse?", it says:

> "[There] are three reasons why the syringe driver is used. Not all of these reasons will apply to you."

Number 1 is:

> "cannot take pills ..... and difficulty swallowing",

which we have heard a lot about. The second part is:

> "It may be used if the Doctor is having difficulty finding the right dose of drug to control pain, sickness or another symptoms".

Now, that seems to be the opposite to the evidence that you have given us.

A It is. You can adjust the pump, the dose of drug being given. I have indicated that the effects of that, the final adjustment, will not be apparent for what we call five half-lives of the drug. It is not a strategy most doctors would use in finding the right dose of drug. The intermittent dosing and varying the dose to begin with is a better way of doing it generally.

Q Okay.

A I mean, I do not know who wrote this document, what advice they sought, and obviously there are no references, but you can certainly adjust the dose that is infused of any drug in it, but it is not in the guidelines listed as an indication for using a syringe driver. That is the only comment I think I can make about this.

Q Thank you very much. Another question I have; can you place me somewhere in the hospital hierarchy where the title of Clinical Assistant comes? I am not quite sure where I can pitch it, if you understand me.
A Well, it is a sub-consultant grade. I mean, clinical assistants can be key posts in delivering high quality services. The key point is they are non-training posts, so they are often occupied, like consultants, by people for many years. So they are an experienced clinician who is trained, generally as a general practitioner, who would not necessarily have had specialist training in the areas they work, under consultant supervision. In terms of what sort of level of expertise would the average clinical assistant have, you would expect them to be at registrar level, but they bring a whole experience of primary care, which a registrar in hospital would not have, so they have a different experience, which can be very valuable.

Q Thank you. That is helpful. So it is around registrar level, is that what you have just said?
A Yes, but they are not directly comparable. The registrar would have usually had more specific specialist structured training in the specialty they are working in than the GP, although not necessarily, but the clinical assistant would usually have had a broader medical experience, and, if they are general practitioners, working obviously in a primary care setting, which a registrar would not have, but they both are below consultant level.

Q Yes, I understood that. My other question for you and, once again it is not a specific patient but I have pulled this in, it is in regard to the drug charts. The front page of the drug chart – if you want to look this is K, page 279A.
A Yes.

Q That is the start of it. It is a prescription sheet. I have asked this question to someone else before, but as you are the medical expert I will ask you it again. At 9 it says:

> "Put date prescription needs to be reviewed in 'review' box of Regular Prescription Section."

If you turn to "Regular Prescription Section", which is page 281, it shows a review date, but there is no date filled in. I am wondering how critical that is, how critical the review date is, and whether it should be filled in and whether it is good practice to fill it in, and whether it is done regularly?
A I think it is true to say not all drug charts used in other hospitals would have a review date entered, so that is my first comment. I am trying to recollect if our own does. I think there are additional comments you can make, but I do not think all drug charts have a review date. You certainly in my view would not expect that to be routinely filled in. It really acts as an opportunity to act as a reminder, for example, with antibiotics, after a certain time period to review. Is the antibiotic still needed? I understand where your question is coming from – should it have been used before giving analgesia. I do not think it should necessarily have been used. I think it acts there as an opportunity to prompt the clinical team to look at an individual prescription at a specific time, but it does not override the general need to do so in individual circumstances for that drug, depending on the patient.

Q It is not a mandatory thing?
A I certainly would not view it as such. Let me put it another way: I do not think it is a failure of good medical practice to not complete it.

MR PAYNE: That answers my question. Thank you very much.

THE CHAIRMAN: Thank you, Mr Payne. We now go to Ms Joy Julien, who is a lay member of the Panel.

MS JULIEN: My question relates to my colleague's previous question relating to the role of the clinical assistant. Could you tell me – in Dr Barton's case – where her responsibility, you think, would have started and ended, firstly generally in terms of the structure and the general quality of care?

A I think I would go back to the job description because that does define the individual clinical assistant's role. I think that does, for example, have a phrase – and we could refer to it if necessary – saying "responsible for the day to day care of patients on certain areas." In fact, I believe the job description is not correct in reflecting the wards that Dr Barton was actually working on.

THE CHAIRMAN: Could I interrupt you just for a second? Mr Kark, I am not sure that this is a document that the Panel have been directed to.

MR KARK: It is tab 2 and it starts at page 1. It is not a document we spent any time on. Strangely, the last statement that was going to be read to you was going to be producing this document.

THE WITNESS: I think that should be the starting point in discussing it, because of the clinical director's job. I do not know if it is necessary for me to read through this: to visit the units, to be available on call.

MR JULIEN: No, that is fine. Really I was thinking in terms of their shortcomings or any sort of inadequacies, where would her role start and end?

A Consultants are responsible for what happens to the patients under their care. I think you cannot hold consultants responsible for every single action that happens. If you employ a locum doctor, you do not know them or the hospital does not, and they work for you and they do a single incompetent incident, it is difficult. You are not directly responsible as the consultant. But if there is a pattern of practice that goes on over a period of time, I think you have a responsibility for that practice. There is an issue about how aware you are of practices, which is a broader issue. Around prescriptions, I think it is more complex. The law is clear. Prescribing is a key privilege given to doctors and the prescriber takes primary responsibility for their action, and we are looking at a lot of issues around prescribing here. I do not think the consultant takes all the responsibility for a prescription.

Q I am sorry. When you are saying the "consultant", are you talking about Dr Barton specifically, or are you talking about ---

A No, sorry. Dr Barton is not a consultant. I am talking about the consultant staff that she worked for, if you like, or with on the elderly care service and unit. For example, particularly with trainees, consultants are expected to exercise considerable oversight to ensure that trainees are acting responsibly. You would expect less oversight for a non-training post, clinical assistant post, but for example if the consultants were aware of Dr Barton's prescribing practices my personal view is they do take some responsibility even though the legal responsibility for that prescription lies with the person ho wrote it. That is my view and it is the nature of consultant responsibility. I did indicate in an earlier comment

in my evidence, that when things go wrong with patient care, and if that is the final judgment that is taken here, it is rarely the fault in hospital settings, certainly, of a single individual. There is usually a system of things that have happened that have allowed that to happen, if it has happened over a repeated period. That is one aspect. The pharmacist was reviewing prescriptions. I think – I believe – many pharmacists might have questioned the nature of the prescriptions. It is difficult to be certain. Obviously the pharmacist at Gosport War Memorial Hospital did not. Nursing staff could have questioned. They might have said, "We are not clear what this prescription means." They might have said, "Where is the protocol by which we operate these prescriptions?" The framework that doctors work in is that the person who writes the prescription, because it is a privilege one acquires being a registered doctor, you do take a heavy responsibility for that prescription.

Q So when you were giving your evidence, on quite a few occasions you would say, "I am critical of that prescription" or "that sort of prescribing," when you are saying that, are you laying most of the blame at Dr Barton or would we need to always bear in mind the context which you have just described?
A I would like to use the word "responsibility". I would lay responsibility with the prescriber, yes, but for example – I am not saying this happened – but if consultants had said, "We think we need a policy of writing up prescriptions of diamorphine 20-200," or whatever, and then Dr Barton and other doctors on the unit did that, if a clinical assistant is implementing an approach, a policy, that has been put forward by the unit, I think it would be hard to hold that individual responsible if there was a policy or protocol there.

Q If there were situations, as we have heard, of a clinical assistant working in an environment that is a very difficult environment with staffing levels and other issues, how far in your view should that clinical assistant go in terms of trying to redress the situation?
A I think any senior qualified doctor in a non-training post who is in a role, if they have concerns about the environment they are working in, they have a duty and obligation for the benefit of their patients to raise those concerns with the senior doctor or consultant they would report to. That could be the individual consultant or it could be the consultant in administrative charge of the unit or, indeed, it could be a senior member of management.

Q To raise it in a formal way or to.... I am just trying to think how far.
A I think it should be. If one is concerned about patient care and the actions one is taking, I think one is obligated to raise that in a formal way. I think having a corridor conversation saying, "I'm a bit worried that we haven't got enough staff and patients are suffering," is not in my view an adequate response because of the sort of problem you get when people say, "What did you do?" You need to lay these things down in a clear way.

MS JULIEN: I think that is all, thank you.

THE CHAIRMAN: Thank you. Mrs Pamela Mansell is a lay member of the Panel.

MRS MANSELL: I think it is just going to two aspects of your evidence, really, and I want to understand why on the surface they look somewhat different. If I have a look at Day 21, we were talking about end of life care. I think we were talking about the best interests of the patient and sedation therapy. You were saying that the quality end of life experience for many people might be to be alert and to be able to hold a loved one's hand, et cetera. I could understand where you were coming from. You were talking about the potential problems with sedation therapy. When I actually then looked at some answers that you gave under

cross-examination, you were actually saying, this was talking about drug dependency in terminal care. You were saying you do not have to worry about the adverse consequences of necessary opiates, in people who are dying, to control symptoms. Part of what we have been looking at is that part of that package of opiates and prescribing may have actually contributed to that sedation, et cetera. I was trying to say, "Okay. How do I actually interpret these?" What are you actually saying?

A Yes. I am sorry. I do not think my responses are contradictory. What I was trying to outline was what you are trying to achieve at end of life – a patient whose symptoms are palliated, who is not in pain, who is not agitated, who is not distressed and is alert and able to communicate with their family and friends. Of course, that is not always possible to achieve. Sometimes patients do have pain and they need control, and they may have agitation which would usually require anti-psychotic drugs, or are very restless and would need sedation therapy. What I was acknowledging, and I think this is generally well acknowledged, is you do not withhold treatments that are needed to treat pain and terminal restlessness because you want to keep the patient awake. You have to accept that you may not be able to achieve that. I think I also mentioned that the key issue is, you have to use these drugs judiciously. It is not like giving a very high dose of antibiotic to make sure we kill the infection where the antibiotic is quite safe. You do not have to adjust the dose. We give a standard dose which we know will be effective if the organism is sensitive. There are clear adverse effects here and it is incumbent, particularly because sedatives, the literature shows, can be abused to result in a shortening of life. So it is incumbent that you have to have good reason to give them; you have to document, as in good medical practice, contemporaneous notes as to why you are giving them and there should be evidence of adjusting and optimising the sedative treatment. We spent a lot of time talking about the use of diamorphine but in many ways I would actually be more critical of the midazolam where there was often not a clear indication that the patients, at least in the notes, from my reviewing it, had terminal restlessness or other severe distress that merited it.

Q Thank you. That is very helpful. Just from my perspective, when we are talking about terminal restlessness – and I am looking at the patients and I am looking to see around terminal restlessness – what are the characteristics I am looking for?

A You have a patient who is moving around in the bed, may be flinging their limbs, may be actually alert and obviously distressed – it covers a range of descriptions. The key point is that those symptoms are present when you have given analgesia and you think you are controlling pain. It is another symptom. The Liverpool Care Pathway in Palliative Medicine, and you see it in the Wessex Protocols, separates out pain from agitation and they actually talk about restlessness separately.

Q What you would be looking for, then, is a very clear description of what is generating the agitation. So if you have the pain control but you still have agitation?

A No. I think the terminal restlessness can occur in the absence of pain. It can be a distressing symptom at the end of life that may be unrelated to pain.

MRS MANSELL: Thank you very much.

THE CHAIRMAN: Professor, finally it is myself, and I, as you know, am also a lay member of the Panel. I would like, if I may, to go back to the area of questions that we had from Ms Julien which I suppose is the wider picture, if you like. You have, to use your own words, been critical of a pattern of practice in the prescribing of Dr Barton over a number of years, and you have indicated that one might expect a variety of different persons to have

views on that pattern of prescribing. You have mentioned nurses, for example, and I know you are aware of the series of meetings that were held in the early nineties as a result of nurses indicating concern. You have indicated also that there is a pharmacist who is regularly involved. I think you just told us that many might have questioned the nature of the prescriptions. We have heard absolutely no evidence one way or another on that. We have heard that there was a pharmacist looking at these, but we have not heard from any pharmacist and we do not have anything to assist, but from you today we heard that pharmacists, or many pharmacists, might have questioned that. Then, of course, there is the whole issue of the consultants and over this number of years, and over two wards, there were a number of consultants. Would you have expected those consultants to have been aware of the pattern of prescribing practice of which you yourself are critical?

A I am trying to think how I would view this if it had gone on in the hospital wards I had responsibility for. I would have expected to be aware of it, either through myself seeing patients and picking up a drug chart, and my own practice – any doctor's – is that when you see a patient to always look at their drug chart to see what they are taking, to consider whether drugs may be a cause of their symptoms and to understand what their current therapy is, and it is what you think it is. So if one was saying, "Well, how could the consultants not have been aware of it?" that would require that nurses had never, ever mentioned the way that opiate drugs or midazolam were used on the unit to them, that the patients – and these patients did generally die fairly quickly, so that this all happened in between their weekly ward rounds and they were unaware of it. You can postulate a scenario where the consultants were possibly unaware of it, although I think at least in one case Dr Reid saw that prescription and reduced it. I have only looked at 12 cases, but there was at least one case where one of the consultants was aware of the prescribing practice. I think that is clear. I also believe, if I recollect correctly, Dr Reid said that Dr Barton had more experience in prescribing at the end of life, but I would consider that they are his patients, under his care and he would still carry prime responsibility as the consultant.

I have not been asked to do a review, as Mr Langdale pointed out, an inquiry into what happened, but in my opinion there is a broader institutional responsibility for what was happening and where you place that is a judgment. I think in my opinion – and I am trying to be very balanced about this – to say Dr Barton wrote the prescription and therefore that is the end of the matter in terms of responsibility is somewhat of a narrow perspective on the care of patients over a number of years. There were clearly other people that were aware of this prescribing practice. Senior nurses were and a consultant was in at least one case. Pharmacists would have been reviewing the use of diamorphine and midazolam. I think it is worth pointing out that this prescribing – I have never come across such wide and high prescribing of opiates and from talking to other people, I am not aware of it happening anywhere else. So it is not at all a usual practice and you could argue from that that it should have triggered someone to question it.

Q I should make it very clear that I am not for a moment seeking to expand on the ambit of this inquiry, but I am sure you will appreciate we have to look at the allegations against the doctor in the context in which they are alleged to have occurred and it is extremely important therefore for us to understand what the situation would have been on those wards at all levels and you have been very helpful in dealing with the issue of the nurses and the pharmacist. I am going to press you, if I may ---

A Can I just make a comment? I think when I was writing my report, it was quite difficult to give a highly informed opinion on the context, because one does not have all the information about the context. One has the notes which record the patient care. So I think

counsel may have thought my approach was narrow and I think that is the nature of being asked to review a series of notes. I am just explaining my position.

Q That is understood. In terms of where we are now, the Panel have heard a great deal of live evidence and I know you have had the opportunity to follow the transcripts. My question so far as the senior medics, the consultants, are concerned, widening it from just the unfortunate Dr Reid, the consultants in general who would have been responsible on those wards over the years, is it conceivable that consultants operating in the way we are told they were, going on doing ward rounds with Dr Barton once a fortnight, but conducting individual ward rounds once a week, would not have known what the prescribing practices of Dr Barton were?

A I think it surprises me they did not. I can just about see in some instances it might have been conceivable they did not. I mentioned Dr Reid, but also I would have expected any complaint – and I am sorry, I cannot remember when any patient complaints came about the use of diamorphine or midazolam, syringe drivers – that should have prompted an immediate look at what was happening by the responsible consultant. That is one comment I make. I can just about see it is possible, if it was only every two weeks, that one might not have seen that prescribing and if it was never discussed by the nursing staff – I find it difficult, because of the discussions that had been had in the early 1990s. You would think then, as a consultant and you were aware of that, you would ask the nurses, "Are you comfortable with how we are using opiate drugs?" because there was then, unless some of the consultants were unaware of that, that discussion in the early 1990s should have meant the unit as a whole and the consultants were sensitive to the issue. So I find it slightly surprising that there was no discussion of this. All I can say is, I suspect the consultants were very busy doing work on the main site, but in the context of what we now call clinical governance, which was not such a strong concept then, you would expect the consultants and the senior nursing management to be aware of it, mainly because it was clearly a very contentious issue in the early 1990s.

Q That was the one other category you had mentioned of parties who might be expected to have had an interest. You referred earlier to senior members of management. Given what we know about the events in the early 1990s, would it be a fair reading of those documents that senior management were also aware of the situation at that time?

A They must have been, would be my view. There is also – I forget at what point, was there not an independent review that I believe took place? I do not believe I have looked at the details of that, but at some point – I thought in the late 1990s – one of the cases after a complaint was reviewed by an external person and I do not know whether they looked specifically at the prescribing practice. That again should have prompted – if the prescribing went on after that, after that case was reviewed, and I cannot remember, but if the conclusion of that was that Dr Barton's prescribing was not a problem – but again, I have not seen that – management have to hold some responsibility for that if it is now accepted that that prescribing was not appropriate, which is certainly my view.

Q On that subject, I do not know whether you have seen exhibit D4, but it was certainly referred to during earlier evidence. Exhibit D4 is a Portsmouth Healthcare NHS Trust memorandum dated 27 October 1999. Do you have that in front of you, Professor?

A I do.

Q If I could direct you to paragraph 3(d), near the bottom, "Good practice in writing up medication".

A I am surprised, because there is a statement that it is an agreed protocol, but I do not believe we have seen the protocol. A statement that Dr Barton can write up doses of between 20 to 200 mg of diamorphine – I note there is no mention of midazolam – is not a protocol in my view. I am not sure if this was the protocol that Dr Reid talked about that he developed and was then changed.

Q No, it is not. This specific one Dr Reid says he was not aware of. When he was shown it, he said he had never seen this before and had known nothing about it.
A The question is, who has agreed it? I would be fairly dissatisfied, let us say, as a consultant that a protocol was agreed and I was unaware of it about prescribing. You would expect any consultant to be aware of important prescribing protocols on a ward.

Q That is very helpful. We are getting some picture through all the evidence we have heard what the practice and procedures were and to an extent what the knowledge was at that time. We have heard finally that in your view a doctor in the position of Dr Barton who might be feeling that they are in a situation where they are under-resourced, under-staffed, expected to do far more than is reasonably possible for them to do, should take the matter up formally and make formal representations. I understand that.
A Maybe that is – I think certainly you would expect that now. I would expect there to be a clear conversation with the responsible consultant. That would be the starting point. Should that be written at that point? No. But I think if there were then repeated conversations and there was no improvement in the situation one was concerned about, I think one is obligated to then raise it formally. I do not think one would immediately write a formal letter to the Chief Executive, for example. One would first of all explore the issue with consultants and other managerial staff responsible for the unit.

Q Would you expect managers, consultants, other senior staff, to be aware of that sort of situation where a unit was in effect under-resourced?
A Absolutely. The consultants would know what the staffing levels were. They should have a clear idea in their own minds of what staffing was required and they should be reviewing that all the time. As the nature of practice changed on the unit, as was described, which I have indicated was common across the NHS, the continuing care beds were being changed into rehabilitation beds. Those patients were not brought by Dr Barton to those wards for rehabilitation; they were brought by the consultants to those ward for rehabilitation. The consultants have responsibility for ensuring adequate resources were in place to provide effective and safe care.

Q You may already have answered this next question in that. Just as you have indicated that in these circumstances you would expect Dr Barton to have done something, would you also have expected consultants and senior management to have done something if they were seized of that knowledge ----
A Yes.

Q ---- and, if so, what?
A I think Dr Barton is a senior experienced clinician. If a senior experienced clinician on your unit tells you there are problems, that is something you cannot and should not ignore. You take serious note of it. It depends who makes the complaint. If it was a very junior doctor who had little understanding, you might not take it seriously if actually you did not think there was a problem, but that is not the situation I think where you have an experienced

clinical assistant working for you. If they have raised a concern with care, you have to look into that seriously.

THE CHAIRMAN: Professor, thank you very much. You have certainly clarified a lot of the issues in my mind. We are almost there. We are at the point now where the barristers have an opportunity to ask any questions that may have arisen out of the questions that have been asked by members of the Panel. I am going to ask Mr Langdale if he has any questions.

MR LANGDALE: I do not have any questions arising out of the matters raised by the Panel, thank you.

THE CHAIRMAN: Thank you, Mr Langdale. Mr Kark?

Further re-examined by MR KARK

Q I only have one matter. It is really to ask for your assistance about the phrase "terminal restlessness", which we have heard before, but you have just come back to. You have described it as "Moving around and a flinging of limbs. The symptoms are present even when under the effect of sedation."
A Maybe I meant opiates if I said sedation. They can be present in an alert patient who is very agitated and restless and they can be present in somebody who has a depressed consciousness level. That may or may not be in the context of receiving sedation therapy, because people who are at the end of life become less alert, even without sedation therapy necessarily. They can be twitching or moving.

Q I just want to ask what I am sure is a very basic question. When you use the phrase "terminal restlessness", the restlessness arises from the patient's illness at a time when they are at a terminal point in their life, or is there actually an illness of terminal restlessness?
A I am using the phrase that the palliative care guidelines use. They are talking about this occurring in a patient where it has been agreed they are at the end of – it has been recognised they are at the end of life. You are not approaching it in the same way as somebody who might be very agitated and restless who is not at the end of life, where you would need to investigate and assess the patient. So it is in a very specific context. The phrase "terminal restlessness" should not be used to describe, for example, somebody with severe dementia who may be unwell, but is not actually at the end of life or on the end of life care pathway.

MR KARK: I am very grateful. That is all that I ask.

THE CHAIRMAN: Mr Langdale?

Further cross-examined by MR LANGDALE

Q This will not take more than a moment, Professor Ford. I wonder if you would take a look at this document. I do not want you to say anything about its contents; it is simply to identify it. (Same handed) You made reference to seeing material relating to a complaint. Is that the document you have had the opportunity of seeing?
A No. I have never seen it. I was aware that there had been an assessment. I have not seen this document before. I was aware that there had been an independent assessment of practice in a patient, but I have not seen the outcome of that.

Q Would you just take a look at the document? I am not asking you what it says, but simply, does that accord with what your understanding was as to the nature of the matter that you were informed about?
A Yes, it does. I understood that a review of the case – it disagrees with my own opinion of course – but that is not what you are asking me.

Q I appreciate you have already said that. That appears to be the matter about which you had heard?
A I believe that is, yes.

MR LANGDALE: That really is it. Thank you very much.

THE CHAIRMAN: Thank you. You have heard it from all three of us now. You have come to the end of your testimony, Professor Ford. Thank you very much indeed for being here to assist us so clearly and ably. We can now release you to get back to that holiday! Thank you very much indeed for coming.

(The witness withdrew)

THE CHAIRMAN: We will break now, ladies and gentlemen, resuming at two o'clock, please.

(Luncheon adjournment)

THE CHAIRMAN: Welcome back, everyone. Mr Kark.

MR KARK: Sir, the very last piece of evidence that the GMC are going to bring before you is a statement to be read from a Mr Richard Oliver Samuel, and I ought to mention that he in fact came in during the opening and then left, but I do not think that will affect his evidence given that it is in written form. This is, I think, agreed evidence as it is going to be put to you.

THE CHAIRMAN: Can I just clarify, agreed that we should hear it or agreed that it is evidence of fact?

MR KARK: I believe agreed evidence of fact.

MR LANGDALE: The latter.

THE CHAIRMAN: Thank you.

MR KARK: I am grateful.

Statement of RICHARD OLIVER SAMUEL, read

"I am the Director of Corporate Affairs for Hampshire Primary Care Trust. I have been employed in this position from October 2006 to the present day. This role encompasses responsibility for PCT-wide performance, legal issues and matters regarding the public interest, clinical quality, patient safety and assurance .....

My first knowledge of the investigation into events at Gosport War Memorial Hospital was whilst I was employed at the Strategic Health Authority in 2001. I was responsible for liaising with the Police and the Commission for Healthcare Inspection around their respective investigations into the care and treatment of patients at Gosport War Memorial Hospital .....

I believe that the first complainant went to the Police at the same time as making a complaint to the Trust, in 1998/9."

I have been asked to make it clear that that was in relation to Mrs Gladys Richards.

"However I am unaware of the outcome of this first Police investigation. I understand that around 2000 a second Police investigation was commenced but similarly, I am unaware of [that] outcome".

He says:

"I will now provide some background information regarding Gosport War Memorial Hospital, the role of the Clinical Assistant and of Dr Jane Barton. This background is provided on behalf of Hampshire Primary Care Trust. I do not, however, have direct personal experience of working at Gosport War Memorial Hospital or with Dr Barton in her clinical capacity .....

Gosport War Memorial Hospital situated on the Gosport peninsula was opened on 19th April 1923 with 26 beds. In May 1932 an extension including the provision of an Out Patient Department was opened. GWMH was handed over to the newly formed NHS in 1948.

In 1963 Out Patient and Accident and Emergency Departments were opened followed in 1966 by new departments for Physical Medicine and X-ray. During the 1960's Redclyffe Annexe was donated to the hospital.

1991 saw the commencement of a two-phase development, including new wards and Day Hospitals for the elderly and the transfer of Maternity Services to a new Maternity ward. More recently GWMH had 113 beds. The hospital does not admit patients who are acutely ill and has neither an A&E department nor intensive care facilities.

A full range of outpatient services was provided, although the bulk of these relate to Portsmouth Hospitals NHS Trust. Occupational Therapy, Podiatry, Speech and Language Therapy and Community Dental services were also to be found at the site.

In 1998, three wards (Dryad, Daedalus and Sultan) at Gosport War Memorial Hospital admitted older patients for general medical care. This was still the case in 2002.

Gosport War Memorial Hospital is currently undergoing extensive remodelling of the interior lay-out of the hospital and adjoining health centre in order to accommodate services currently located at royal Hospital Haslar including the accident treatment centre (minor injuries) .....

GWMH was originally under the management of the Portsmouth District Health Authority prior to the formal establishment of Portsmouth HealthCare NHS Trust in 1994. Between 1994 and 2002 Portsmouth HealthCare NHS Trust provided a range of community and hospital bases services for the people of Portsmouth and the surrounding areas of south east Hampshire."

Then the heading is:

"Dr Jane Barton – employment history

Dr Jane Barton is a GP working at the Forton Medical Centre."

He then refers to a document dated 1 December 1980. If you go to tab 2 of bundle 1, I am afraid we do not actually have the particular document that he first refers to, but can I just take you through the documents that we do have, because I do not think we have spent any time in any sense looking at these. Page 1, as you will see, was the job description for the post of Clinical Assistant to the Geriatric Division in Gosport, and you will see that at that time (this is back in the 80s) there is reference to the Gosport War Memorial Hospital, the Northcott Annexe and also the Redclyffe Annexe. You can see the job summary is set out and the duties are also set out, which were referred to this morning by Professor Ford. I am not going to take time to read through those now. If we go to page 5 in fact, this is a document, which I think is dated 17 March 1988 if we look at page 6, and this is the application for the post of Clinical Assistant in Geriatric Medicine. She sets out her qualifications. Her present employer is said to be Hampshire FPC, "General Practitioner (minimum full time 20 hrs) From: 1980 To: Now". If we go over the page, she describes her experience and training.

"In general practice locally since 1980. We have an average number of geriatric patients viewed nationwide, but the" – I am afraid I cannot read that.

MR JENKINS: "general feeling locally".

MR KARK: I am grateful:

"general feeling locally is that they are well served and well looked after both within the community, in sheltered care and when they need inpatient care.

It will be a pleasure to extend the care that we as a practice give to our elderly with the support we get from our district nurses and community health nurse/health visitors.

As a minimum full timer only working 20 hours weekly on practice commitments I am ideally placed to offer continuity of care and my partners have agreed to share the on call cover."

That is dated 17 March 1988. Over the page, page 7, we see the Personnel Officer is writing to Dr Grunstein, who is the Consultant Physician in Elderly Services at St Mary's:

"Dear Dr Grunstein

I enclose a copy of the sole application for the post of Clinical Assistant in Geriatrics at Gosport which was advertised recently.

Please let me know if you would like me to arrange an interview."

Then if we go to page 9, I am just going to read the first paragraph, and this is dated 28 April 1988:

"Dear Dr Barton

I am instructed by the Portsmouth and South East Hampshire Health Authority to confirm the offer of appointment as Clinical Assistant in Geriatric Medicine for a period of one year commencing on 1 May 1988 and terminating on 30 April 1989. The post required attendance at Gosport War Memorial Hospital for five sessions per week."

It deals with remuneration---

MR LANGDALE: Can we have that? Can you read the remuneration paragraph.

MR KARK: Certainly.

"The remuneration for this post will be £9275 per annum as laid down in the Terms and Conditions of Service of Hospital Medical and Dental Staff ..... It is subject to amendment from time to time".

That was all that I was going to read from that letter, unless my learned friends would like anything else from it.

Now, in fact the statement reads, and my learned friends may be able to correct this, but the statement reads that he produces a "copy of a letter from Hampshire Health Authority ..... to Dr Jane Barton dated 1 December 1980". I think these must be wrong---

MR JENKINS: It is 88.

MR KARK: It is meant to be 88, I am grateful, "confirming Dr Barton's appointment to the general practitioner medical staff", and I am not going to read the rest of that. He produces the application form and the job description. I am going to read on from paragraph 17, unless my learned friends want anything else:

"From 1st October 2002" – so this is post these events – "onwards Dr Barton voluntarily undertook not to prescribe benzodiazepines or opiate analgesics. Patients requiring ongoing therapy with such drugs were transferred to other partners within the practice with their agreement so that their care was not compromised. Dr Barton elected not to accept any house visits if there was a possible need for such drugs to be prescribed. Medicines Review Management has reviewed this on a regular basis since 2002 providing the PCT with ongoing auditable assurance. No breaches or problems have been evident throughout this time and the review process continues."

That deals with his statement, again unless my learned friends want anything else out of it, and that concludes the GMC's case.

THE CHAIRMAN: Thank you very much indeed, Mr Kark. Yes, Mr Langdale.

MR LANGDALE: Sir, it may be, and this need not hold up proceedings in any way at all, we will be seeking to agree an admission with my learned friend Mr Kark, and I am not going to trouble the Panel with it now, but it is something which, if it is to be agreed, can be dealt with at any stage, whether it technically forms part of his case or not.

Sir, I appreciate that we are hardly into the afternoon session, but I am going to ask, bearing in mind the stage that we have now reached, that the Panel allow us and sees to it that there is an adjournment until tomorrow morning first thing. I need to consider as to whether it is appropriate to make any submissions to the Panel, and I need a little time just to consider that. I can indicate now that if there are to be any submissions, they will not be lengthy ones, and I have to decide whether it is appropriate to make them at all at this stage if they are not likely to completely remove a head of charge from the Panel's consideration. That is a matter for me to decide, and I would like a little time to consider that. I can indicate to the Panel that if there are not any submissions, the evidence the Panel will next be hearing will be the evidence of Dr Barton, and I would like a little time with her before she gives her evidence, for obvious reasons. So for those reasons if none other I wonder if the Panel would consider adjourning until tomorrow morning.

Perhaps I can indicate in terms of overall timing, subject to the problems we have with video link and so on and so forth, we anticipate that the evidence called on behalf of Dr Barton will occupy not only the remainder of this week but all of next week. Quite how long thereafter I am not able to say, but it is going to be more than just a day or two, and there will be an amount of evidence, apart from the evidence of Dr Barton, about which the Panel will be hearing.

THE CHAIRMAN: Very well. So far as the request is concerned, I think general approbation from the Panel. Mr Kark, do you have any observations?

MR KARK: No.

THE CHAIRMAN: No. Very well. Then we will with pleasure accede to that request and look forward to starting bright and fresh tomorrow at 9.30.

MR LANGDALE: Thank you very much.

THE CHAIRMAN: Thank you very much indeed. Thank you, everybody.

(The Panel adjourned until 9.30 a.m. on Wednesday, 15 July 2009)