IN THE GENERAL MEDICAL COUNCIL
FITNESS TO PRACTISE PANEL

CASE OF:-

JANE ANN BARTON

ADVICE

A. Introduction

1. I am asked to advise the Council for Healthcare Regulatory Excellence ("the Council") on the merits of referring to the High Court a decision of the General Medical Council's Fitness to Practise Panel ("the Panel") made on 29 January 2010 in respect of Dr Jane Ann Barton. Having made a finding of serious professional misconduct, the Panel imposed conditions on Dr Barton's registration, deciding not to suspend or erase her from the register.

2. In preparing my advice, I have read the transcripts of the fifty-seven day Panel hearing and reviewed the exhibits produced at that hearing. I have also considered the submissions that have been sent to the Council from various interested parties.

Background

3. Dr Barton is a general practitioner who started working part time at Gosport War Memorial Hospital ("GWMH") in 1988. Her job description stated that the post was for *"five sessions a week, worked flexibly to provide 24 hour medical cover to long stay patients"* [C1, Tab 2, p.1]. She split the post with other members of her general practice partnership. From around 1996, she worked three and a half sessions per week and the other partners covered one and a half sessions [Day 25, p.10E]. Dr Barton split the three and a half sessions, attending the wards every week-day morning for about an hour and a half and returning at lunchtime if any new patients had been admitted or if there were any other patients whose conditions gave rise to concern [Day 25, p.13G-F].

4. During the relevant period, Dr Barton worked on two wards at GWMH - Dryad and Daedalus, both of which were described as "continuing care" wards (although Daedalus ward had 8 "slow-stream" stroke beds). Her job description stated that the patients would be *"slow stream or slow stream rehabilitation"*. However, the patient mix changed over time, with more unstable patients being admitted to the wards. Both wards were consultant led, but the level of consultant cover was limited. I will consider the evidence as to Dr Barton's working conditions in more detail below.

Heads of Charge

5. The GMC case against Dr Barton relates to her treatment of twelve patients on Dryad and Daedalus wards between 1996 and 1999. All twelve patients died whilst under her care. There was a police investigation and an inquest into a number of these deaths. However, it is very important to note that the GMC did not allege before the Panel that Dr Barton intended to hasten the death of any of her patients or that Dr Barton's actions necessarily caused any of their deaths.

6. The heads of charge against Dr Barton relate to her use of opiate analgesia. The GMC alleged that:
   a. the lowest doses of opiates prescribed by Dr Barton for certain patients were too high; [1]
   b. certain prescriptions were not clinically justified;[2]
   c. the doses actually administered or authorised, in some cases, were excessive or inappropriate to the patients' needs;[3]
   d. the range of doses provided for in prescriptions was too wide, creating a situation whereby drugs could be administered which were excessive to patients' needs;[4]
   e. and these actions were inappropriate, potentially hazardous and not in the patients' best interests.

7. It was further alleged that Dr Barton failed to carry out adequate assessment of the patients before prescribing opiates;[5] that she did not seek the advice of colleagues;[6] and that her note-

[1] Heads of Charge: 2(b)(i) (patient A); 3(b)(i) (patient B); 11(b)(i) (patient J); 12(c)(i) (patient K)
[2] Head of charge: 12(b) (patient K); 13(b)(i) (patient L)
[3] Heads of Charge: 2(c), (d) (patient A); 9(b)(i) (patient H); 10(e) (patient I)
[4] Heads of charge: 2(b)(ii) (patient A); 3(b)(ii) (patient B); 4(b)(i) (patient C); 5(b)(i) (patient D); 6(b)(i) (patient E); 7(b)(i) (patient F); 8(b)(i) (patient G); 9(c)(i) (patient H); 10(c)(i) (patient I); 11(b)(ii) (patient J); 12(c)(ii) (patient K); 13(b)(ii) (patient L)
[5] Head of Charges: 3(d)(i),(ii) (patient B); 10(b) (patient I); 15 (all patients)
[6] Heads of Charge: 9(e) (patient H); 11(d) (patient J); 12(e) (patient K)

taking was inadequate.[7]

8. At the outset of proceedings, Dr Barton admitted that the range of doses that she had prescribed in most of the cases was excessive and potentially hazardous.[8] She also admitted that her note taking was inadequate. The inadequacy of Dr Barton's clinical notes created a difficulty for the Panel in reaching any firm conclusions as to the appropriateness or otherwise of her clinical assessments and decision-making, more than ten years after the event.

9. The heads of charge are set out in full at [Day 1, p.7-17]. In my analysis I have sought to address the most serious allegations and the general themes arising in this case. I have not referred specifically to every allegation.

B. The Panel's Determination

10. In all twelve cases, Dr Barton wrote anticipatory prescriptions for Diamorphine and Midazolam to be administered subcutaneously by syringe driver. In most of the cases, the prescription was for 20mg to 200mg of Diamorphine and for 20mg to 80mg of Midazolam. The syringe driver administered a regular dose over a 24 hour period generally to patients who were unable to swallow. In Dryad and Daedalus wards there were no facilities for intra-venous hydration. Patients who were put on syringe drivers would not receive hydration and medical and nursing staff gave evidence that starting a patient on a syringe driver was acknowledgement of the fact that the patient was on the "terminal pathway" and not expected to live more than a few days [Day 49, p.17D].

11. The anticipatory prescriptions allowed nurses to administer pain killing drugs as and when they were needed, without having to wait for a doctor to be called. There was some contradictory evidence as to when and how syringe drivers were first administered, in particular as to whether nurses would always consult a doctor before starting a patient on a syringe driver. Whilst Dr Barton stated that she expected the nurses to consult her or another doctor, she conceded that it was "their prerogative" to start the driver [Day 25, p.66].

[7] Head of charge: 14 (all patients)

[8] Admitted: 3(b)(ii) (patient B); 4(b)(i) (patient C); 5(b)(i) (patient D); 6(b)(i) (patient E); 7(b)(i) patient F); 8(b)(i) (patient G); 9(c)(i) (patient H); 10(c)(i) (patient I); 11(b)(ii) (patient J); 13(b)(ii) (patient L)

General Observations

12. The Panel set out various general observations before making specific findings on the individual heads of charge:

a. The panel noted that opiates are extremely powerful drugs, especially in the treatment of the elderly who tend to be particularly sensitive to their effects. The side effects can include drowsiness and respiratory depression (potentially leading to unconsciousness and ultimately death), confusion, agitation, restlessness, hallucination and nausea. The Panel referred to the opinion of Professor Ford (the GMC's expert) that it is incumbent on prescribers to exercise extreme caution in determining dosage to protect patients from over-sedation [Day 49, p.10].

b. The Panel further noted that Midazolam, which was prescribed by Dr Barton alongside the opiates, has a powerful sedating effect and that one has to be doubly cautious when using Midazolam in combination with Morphine [Day 49, p.11].

c. The Panel referred to the British National Formulary ("BNF"), the Palliative Care Handbook and the World Health Organization Analgesic Ladder which emphasise the importance of using analgesics appropriate to a patient's level of pain, and of moving from weaker to stronger analgesics in a stepwise manner [Day 49, p.8].

d. The Panel noted that departure from these guidelines could be justified in certain circumstances. They held that it was a matter for a clinician on the ground to assess whether the analgesic needs of a given patient required such departure, but they also found that departure from guidelines was exceptional and noted that *"when placing patients on syringe drivers [Dr Barton] routinely prescribed outside those guidelines in order to ensure that the patient would not experience pain"* [Day 49, p.12].

e. The panel accepted that anticipatory prescribing of drugs was not uncommon, especially in the management of pain. The risk of such prescriptions was that nursing staff might decide to administer the prescription when it was not clinically justified. The risk was particularly significant on Dryad and Daedalus wards where the prescriptions included a variable mix of Diamorphine and Midazolam to be delivered by syringe driver (where the starting of a syringe driver loaded with such a mix was an indication that the patient was on the "terminal pathway" and expected to die in a matter of days) [Day 49, p.13].

f. The Panel held that one of the ways generally of minimising the risk was to have a written protocol for administering such prescriptions and that, in the absence of such a protocol, *"patients were entitled to expect that clear written instructions would be available to all those who might be expected to administer the prescription"*. The Panel *"noted with concern that [in the present case] nurses [had] used their own discretion to start higher doses than the minimum prescribed dose and that a nurse had doubled the dose of Midazolam at a time when the corresponding dose of Diamorphine had been halved on instruction of a consultant because of over-sedation"*. Dr Barton had not provide detailed written instructions for administering her prescriptions and the Panel did not accept that verbal instructions at handover sessions were a safe or prudent way of ensuring that they were administered properly [Day 49, p.14].

g. The Panel heard that it was not unusual for anticipatory prescribing to allow for a range of doses, but accepted Professor Ford's view that a dose range that allowed for an increase of more than 100% from the lowest to the highest was too wide. Counsel for Dr Barton pointed out that the doses actually administered to patients in the present cases never reached the highest dose, but the Panel took the view that *"while this was fortunate, the fact remained that this method of prescribing gave rise to risk that the highest doses could be administered"* [Day 49, p.15-16].

h. They noted with particular concern Dr Barton's apparent assumption that, when prescribing on an anticipatory basis, the required dose would necessarily increase, so that the lowest dose in the anticipatory range was set at a higher level than whatever was the dose at the time of the prescription. The Panel held that this gave rise to a danger that excessive analgesia would be administered. If the patient did not require a higher dose, it left the nurse with two undesirable options, either to wait for a doctor (with the patient in pain) or to administer at an inappropriate level [Day 46, p.15].

i. The Panel further noted that, where subcutaneous analgesia was not controlling the patients' pain or other symptoms, Dr Barton followed a practice of "doubling-up". The Panel held that this would be almost certain to prevent the manifestation of breakthrough pain. However, it also greatly increased the risk of over-sedation. The Panel considered that *"this practice demonstrated [Dr Barton's] approach to protecting patients from pain even at the cost of protecting them from over-sedation and adverse side-effects"* [Day 49,

p.16].[9]

j. The Panel further noted that syringe drivers were not an effective means of providing immediate relief from pain because the continuous rate of infusion meant that it would take some hours before the amount of analgesia in the patient's body reached the optimal level. Dr Barton, in her evidence, expressed surprise about this fact [Day 49, p.17].

k. The Panel recited the opinion of Professor Sikora (Dr Barton's expert) that, in an ideal situation, a titration approach would be used over two or three days, using oral morphine or four-hour injections, to work out the appropriate dose, before giving subcutaneous morphine by syringe driver; and that, unless this was done, there was a serious risk that the driver would be started either too high or too low. The Panel noted Dr Barton's evidence that she did not adopt this approach as it was "not practical" and she had not been trained in it.

l. The Panel also referred to Professor Sikora's view that it would be reasonable to start on a higher dose of analgesia where staffing levels, and therefore levels of observation, were lower. However, the Panel were skeptical of this opinion, noting that such a strategy might create the need for higher levels of observation if patients were to be adequately protected from any adverse consequences of the higher doses.

m. Finally, the Panel considered the principle of double effect. They recited Professor Ford's evidence that it was widely and generally accepted that drugs administered to palliate pain could have the effect of shortening a patient's life. The Panel considered that, in addition to the right to be provided with appropriate analgesia, the patient had a balancing right to be kept conscious. In response to a question as to why she did not reduce the level of medication for patient B to keep her more alert, Dr Barton responded: *"More alert to feel more pain"*. The Panel considered that this response *"gave clear insight into how [Dr Barton] viewed the desirability of balancing pain relief with the desirability of keeping the patient as free as practicable from the side effects of the opiates"*.

[9] This approach was contrary to the guidance in the BNF and the Palliative Care Handbook (which recommended increasing the does by up to 50%) but it was an approach approved by Dr Barton's superiors, notably Dr Reid, the clinical director (see para 52 below).

The Heads of Charge

13. As to the individual heads of charge:

a. The Panel found in eleven of the twelve cases that Dr Barton had prescribed doses of Diamorphine and/or Midazolam that were too wide and that the prescriptions gave rise to a situation whereby drugs could be administered which were excessive to the patients' needs. The prescriptions were inappropriate, potentially hazardous and not in the patients' best interests.[10]

b. In the case of four of the patients (patients A, B, J and K) the Panel found that the lowest doses of Diamorphine and/or Midazolam prescribed by Dr Barton were too high.[11] In the cases of patients A, C and K, the Panel noted that the prescribed level of Midazolam, taken in isolation, was in accordance with the level recommended in the Palliative Care Handbook. However, given its overall sedative effect when taken in combination with Diamorphine, the Panel held that the prescribed minimum dose for each patient was too high. In the case of patient A, the Panel further held that a prescription for 50mg of Nozinan was inappropriate in combination with the other drugs already prescribed. [Day 49, p.26F; p.31E; p.47C; p.50B].

c. Particular concern was expressed by the Panel in relation to the care of patient K who had been prescribed Fentanyl before she was started on the syringe driver. The Fentanyl would have been at its peak when the syringe driver was started and, as a consequence, the Panel held that *"this prescription put the patient at severe risk of respiratory depression, coma and premature death".* The Panel noted that the patient lapsed into unconsciousness shortly after the syringe driver commenced and that she remained unconscious until her death two days later [Day 49, p.50B].

d. In the case of Patient D, the Panel held that Dr Barton had failed to conduct an adequate assessment before prescribing opiates.[12] [Day 49, p.37]

e. As to the case of patient H, the Panel found that a prescription for an initial dose of 10mg of Oramorph was inappropriate, potentially hazardous and not in the patient's best

[10] Only in relation to patient A was it found that the dose range was not too wide.

[11] Head of charge 2(b)(i) (patient A); 3(b)(i) (patient B); 11(b)(i) (patient J); 12(c)(i) (patient K) proved

[12] Proved: 15(a), (b) in relation to patient D

interests, given his history of alcoholism and liver disease. The Panel held that, if opiate analgesics were needed, it would have been appropriate to start on a lower dose.[13] However, the Panel could not be sure that the prescription was likely to lead to serious and harmful consequences.[14] [Day 49, p.42-43]

f. In relation to Patient J, the Panel found that Dr Barton failed to obtain any advice from colleagues and held that she should have sought such advice before deciding to start the syringe driver. The Panel held that Dr Barton's failure to do so was inappropriate and not in the patient's best interests.[15] [Day 49, p.48]

g. In the case of patient L, the Panel held that there was insufficient clinical justification for the prescription that was given.[16] [Day 49, p.53]

h. Various other allegations were found not proved. In particular, the Panel held that they could not be sure that the doses of Diamorphine administered to patient A on 15 and 17 January 1996 were excessive[17] [Day 49, p.27F] and could not be sure that Dr Barton failed to carry out appropriate assessment and examination of patient B[18] [Day 49, p.33F]. More generally, the Panel held, in view of the paucity of the evidence (contributed to by her poor record keeping) they could not be sure, either way, as to the appropriateness of Dr Barton's assessment of any of the patients except patient D[19] [Day 49, p.55A].

Serious Professional Misconduct and Sanction

14. The Panel held that Dr Barton fell short of the standards set out in 'Good Medical Practice' in relation to the following aspects of her practice [Day 57, p.3]:

    - Undertaking an adequate assessment of the patient's condition based on the history and clinical signs, including where necessary, an appropriate examination;

[13] Proved: 9(b)(i),(ii), (iv)
[14] Not proved: 9(b)(iii)
[15] Proved: 11(d)
[16] Proved: 13(b)(i)
[17] Not proved: 2(b),(c)
[18] Not proved: 3(d)(i)-(iii)
[19] Not proved: 15 (except in relation to patient D)

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

15. In light of these failings, the Panel concluded that Dr Barton was guilty of multiple instances of serious professional misconduct.

16. Having reached this conclusion, the Panel went on to consider what sanction (if any) was appropriate, listing the relevant aggravating and mitigating factors.

17. The main aggravating factor, identified by the Panel, was Dr Barton's lack of insight [Day 57, p.6]:

    a. Dr Barton insisted that, in the circumstances of the time, her actions had been correct.

    b. She told the Panel that, were the situation and circumstances to repeat themselves today, she would do nothing differently.

c. The Panel concluded that Dr Barton showed *"a worrying lack of insight"*. They were *"particularly concerned by Dr Barton's intransigence over matters such as balancing the joint objectives of keeping a patient pain-free and alert"*.

d. The Panel also referred to Dr Barton's *"denigration of senior colleagues and guidelines"*.

e. Overall, the Panel considered that Dr Barton's evidence produced *"an image of a doctor who was convinced that her way had been the right way"*

18. The Panel noted five points in mitigation of the offence [Day 57, p.6-7]:

a. The nature and volume of Dr Barton's work and responsibilities increased greatly between the date of her appointment and the period with which the Panel was concerned.

b. The Panel noted that inappropriate referrals from acute wards put Dr Barton under *"unreasonable pressure"*.

c. They also held that Dr Barton was denied appropriate levels of *"supervision and safeguard, guidance, support, resources and training necessary to ensure that she worked within safe limits"*.

d. They accepted that Dr Barton believed she was acting with the approval and sanction of her superiors and they noted that Dr Barton's practice of anticipatory prescribing of variable doses by syringe driver was validated by a hospital protocol.

19. Further, by way of personal mitigation, the Panel noted that [Day 57, p.7]:

a. Dr Barton had been in safe practice as a GP for over ten years since the events in question.

b. She had voluntarily agreed not to prescribe opiates for the past eight years (and for the past two years had been subject to formal conditions imposed on her registration by the Interim Orders Panel)

c. The Panel also referred to a bundle of testimonials from Dr Barton's patients and colleagues.

20. Taking all these factors into account, the Panel had "no hesitation" in concluding that a reprimand would not be appropriate to the seriousness of the charge. In deciding to impose conditions on Dr Barton's registration, the Panel accepted that it was unrealistic to consider that Dr Barton could ever again find herself in a situation like that which she faced at GWMH. They took into account the fact the she had been in safe practice for ten years since the events in question. Given the seriousness of the multiple findings, and Dr Barton's lack of insight, the Panel was unable to conclude that she posed no risk, but they accepted that it might be possible to formulate conditions which would be sufficient to protect patients [Day 57, p.9-10].

21. In relation to public confidence in the profession, the Panel made clear that Dr Barton had not deliberately caused the death of her patients, but her acts and omissions had put patients at increased risk of premature death. This was a very serious case and, even ten years after the event, it was justified to take action against her registration to maintain public confidence in the profession. The Panel considered that, by imposing restrictions on her registration, it would send a message to the public that it would not tolerate serious professional misconduct. The same applied in relation to the declaring and upholding of standards [Day 57, p.10-11].

22. The Panel stated that it was *"greatly impressed"* by the many compelling testimonials from colleagues and patients, all of whom had been made aware of the findings of fact. The Panel was satisfied that there was an informed body of public opinion that supported the contention that preserving Dr Barton's services as a GP was in the public interest [Day 57, p.11].

23. The Panel therefore decided to impose the following restrictions on Dr Barton's registration for a period of three years, with provision that these restrictions be reviewed shortly before the end of the period of conditional registration (I have highlighted the most significant conditions in bold):

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

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

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

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

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

f. –

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

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

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

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

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

j. She must not undertake Palliative Care.

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

i. Any organisation or person employing or contracting with her to undertake medical work;

ii. Any locum agency or out-of-hours service she is registered with or apply to be registered with (at the time of application);

iii. Any prospective employer or contracting body (at the time of application);

iv. The PCT in whose Medical Performers List she is included, or seeking inclusion (at the time of application);
v. Her Regional Director of Public Health.

C. Analysis

24. The decision of the Panel to impose restrictions on Dr Barton's registration was a "relevant decision" within the meaning of section 29(3) of the Healthcare Professional Act 2002 ("the 2002 Act"). The Council may, therefore, refer this decision to the High Court, pursuant to section 29(4), if it considers that it was:

    a. "unduly lenient" as to the penalty imposed; and

    b. it would be desirable for the protection of members of the public for the Council to refer the case.

25. The test for the Council to apply when considering "undue leniency" is whether the decision was one which the Panel, having regard to the relevant facts and to the objective of the disciplinary proceedings, could reasonably have imposed. It is not enough that members of the Council might themselves have come to a different view. The question is whether the decision of the Panel was "manifestly inappropriate" having regard to the practitioner's conduct and the interests of the public (*Ruscillo v Council for the Regulation of Healthcare Professionals* [2004] EWCA Civ 1356 at para. 77).

26. In order to assist the Council in answering this question, I have split my advice into three sections:

    a. First, setting out the legal principles governing sanctions;

    b. then summarising the relevant evidence (with reference to transcripts and exhibits); and

    c. finally, considering whether, in my opinion, the Panel's approach to the law and the evidence was manifestly inappropriate.

The Legal Principles

27. The purpose of sanctions is not to punish the registrant for misconduct, but to protect the public interest (see *Raschid v General Medical Council* [2007] EWCA Civ 46). The public interest includes:

    a. Protection of patients;

    b. maintenance of public confidence in the profession; and

    c. declaring and upholding proper standards of conduct and behavior.

28. When assessing the public interest, the Panel must also have regard to the *Indicative Sanctions Guidance.*

29. The Guidance addresses various general considerations before setting out the circumstances in which different sanctions should normally be applied. It states that, in deciding what, if any, sanction to impose, the Panel should have regard to the principle of proportionality, weighing the interests of the public with those of the practitioner. The Panel should consider the sanctions available starting with the least restrictive. Any sanction which is imposed must be necessary to protect the public interest (see paras. 21 -22).

30. The Guidance states that, in deciding what sanctions to impose, the Panel should consider all aggravating and mitigating factors:

    25. ...Mitigation might be considered in two categories:

    Evidence of the doctor's understanding of the problem, and his/her attempts to address it. This could include admission of the facts relating to the case, any apologies by the doctor to the complainant/person in question (see also paragraphs 32 - 37 below), his/her efforts to prevent such behaviour recurring or efforts made to correct any deficiencies in performance;

    and Evidence of the doctor's overall adherence to important principles of good practice (i.e. keeping up to date, working within his/her area of competence etc. - see also paragraph 28 below). Mitigation could also relate to the circumstances leading up to the incidents as well as the character and previous history of the doctor. This could also include evidence that the doctor has not previously had a finding made against him or her by a previous Panel or by any of the Council's previous committees.

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

31. In relation to testimonials, the Guidance states:

30. The doctor may present references and testimonials as to his/her standing in the community or profession. Panels should consider, where these have been provided in advance of the hearing, whether the authors are aware of the events leading to the hearing and what weight, if any, to give to these documents.
31. As with other mitigating or aggravating factors any references and testimonials will need to be weighed appropriately against the nature of the facts found proved. The quantity, quality and spread of references and testimonials will vary from case to case and this will not necessarily depend on the standing of a practitioner.

32. The Guidance refers to statements in *Good Medical Practice* that a doctor should act immediately to put matters right and offer an apology when a patient has suffered harm or distress. It states that there is an expectation that patients should be protected from similar events recurring and that doctors should take positive steps to learn from their mistakes. It refers to the need for insight, but states that insight may be reflected in different ways:

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

33. The Guidance states that conditions may be imposed on a doctor's registration for up to a maximum of three years in the first instance, renewable in periods of up to 36 months thereafter. It states that conditions are likely to be appropriate where the concerns about a doctor's practice are such that a period of retraining and/or supervision is likely to be the most appropriate way of addressing the failings:

57. ...Panels will need to be satisfied that the doctor has displayed insight into his/her problems, and that there is potential for the doctor to respond positively to remediation/retraining and to supervision of his/her work.

34. The Guidance then sets out a series of bullet points most or all of which should be present for conditions to be imposed. The points (insofar as relevant) are:

- *No evidence of harmful deep-seated personality or attitudinal problems.*
- *Identifiable areas of the doctor's practice in need of assessment or retraining.*
- *Potential and willingness to respond positively to retraining, in particular evidence of the doctor's commitment to keeping his/her knowledge and skills up to date throughout his/her working life, improving the quality of his/her work and promoting patient safety (Good Medical Practice, paragraphs 12-14 regarding Maintaining good medical practice).*
- *Willingness to be open and honest with patients if things go wrong (Good Medical Practice, paragraphs 30 – 31).*
- *Patients will not be put in danger either directly or indirectly as a result of conditional registration itself.*
- *It is possible to formulate appropriate and practical conditions to impose on registration.*

35. In relation to suspension, the Guidance states:

Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner... Suspension will be an appropriate response to misconduct which is sufficiently serious that action is required in order to protect patients and maintain public confidence in the profession. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that the Panel considers that the doctor should not practise again either for public safety reasons or in order to protect the reputation of the profession). This may be the case, for example, where there may have been acknowledgement of fault and where the

Panel is satisfied that the behaviour or incident is unlikely to be repeated. The Panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions.

36. Again, a list of bullet points is provided. The Guidance states that suspension may be appropriate when some or all of the following factors are apparent:

- *A serious breach of Good Medical Practice where the misconduct is not fundamentally incompatible with continued registration and where therefore complete removal from the register would not be in the public interest, but which is so serious that any sanction lower than a suspension would not be sufficient to serve the need to protect the public interest.*

- *In cases involving deficient performance where there is a risk to patient safety if the doctor's registration were not suspended* ***and*** *where the doctor demonstrates potential for remediation or retraining.*

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

- *No evidence of repetition of similar behaviour since incident.*

- *Panel is satisfied doctor has insight and does not pose a significant risk of repeating behaviour.*

37. Finally, as to erasure, the Guidance refers to caselaw which emphasises the fundamental importance of maintaining public confidence in the profession. A series of bullet points are set out, **any** of which "may well" make erasure the appropriate sanction:

- Particularly serious departure from the principles set out in *Good Medical Practice* i.e. behaviour fundamentally incompatible with being a doctor.

- A reckless disregard for the principles set out in *Good Medical Practice* and/or patient safety.

- Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients.

- Abuse of position/trust (see *Good Medical Practice* paragraph 57 "you must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession").

- Violation of a patient's rights/exploiting vulnerable persons (see for example *Good Medical Practice* paragraphs 24 to 28 regarding children and young people, paragraph 33 regarding expressing personal beliefs, and paragraphs 61 to 62 regarding information about services).

- Offences of a sexual nature, including involvement in child pornography (see further guidance below at paragraphs 92 - 104).

- Offences involving violence.

- Dishonesty, especially where persistent and/or covered up (see further guidance at paragraphs 105 - 111 below).

- Putting own interests before those of patients (see *Good Medical Practice* – "Make the care of your patient your first concern", and paragraphs 75 to 77 regarding conflicts of interest).

- Persistent lack of insight into seriousness of actions or consequences.

The Evidence

38. I set out below the evidence relevant to sanction. I have sought to pick out the most probative examples; my list of references is not exhaustive.

Dr Barton's practice and testimonials

39. Dr Barton submitted to the Panel 184 testimonials from colleagues, patients and members of the public. Her counsel stated that all of the people who provided testimonials had seen the heads of charge and the Panel's findings of fact [Day 50, p.24G].

40. The testimonials included two letters from colleagues who had carried out peer appraisals:

a. A letter from Dr Alan McFarlane, dated 13 August 2008, stated that Dr Barton maintained good clinical care and achieved good QOF [Quality Outcomes Framework] results [Exhibit D8, p.145]

b. A letter from Dr Evelyn Beale, dated 12 January 2010, stated that Dr Barton's performance was more than competent; she had shown evidence of good clinical care; she performed well in the practice questionnaire, with patients preferring to wait and see her rather than consulting another doctor; she had no significant complaints in the past year; she had abided by the conditions imposed on her by the GMC; and overall she was a good, caring and competent doctor [Exhibit D8, p.266]

c. Counsel for Dr Barton offered to provide further appraisals to the Panel, if required [Day 50, p.25A]

41. Dr Barton's colleagues who gave oral evidence expressed the view that she was a good, competent, hard-working doctor: Dr Lord [Day 26, p.3]; Dr Reid [Day 16, p.67]; Dr Tandy [Day 18, p.47-8]; Sister Joines [Day 33, p.9]; Senior Nurse Beed [Day 9, p.60]; Nurse Couchman [Day 7, p.38]; Nurse Barratt [Day 10, p.81]; Dr X [Day 11, p.60]; Nurse Douglas [Day 12, p.25]; Nurse Robinson [Day 32, p.63-4].

42. An exception to the generally positive evidence from colleagues was the evidence of Nurse Hallman. Nurse Hallman brought a grievance against Dr Barton and Sister Hamblin in 1999. This grievance was investigated and not upheld (see [Day 13, p.68] and documents in relation to the grievance at [Exhibits D1-D3]).

Dr Barton's Working Conditions

43. As stated above, Dr Barton was contracted to work on Dryad and Daedalus wards at GWMH for three and a half sessions per week, with her GP colleagues covering a further one and a half sessions. Dr Barton attended the wards every weekday morning, returning at lunchtime to clerk new arrivals or to deal with any other matters of concern. During the same period, she worked full time (eight sessions per week) as a GP. The time available to her for clerking patients was very limited [Day 25, p.16D]. There were around 48 beds on Dryad and Daedalus wards [Day 25, p.10B].

44. The only other regular medical input on these wards came from the consultants:

a. At the relevant time, Dr Althea Lord was responsible for Daedalus ward. Dr Lord attended Daedalus ward every other Monday for continuing care ward rounds and on Thursday afternoons for slow-stream stroke ward rounds [Day 25, p.11E].

b. Initially, Dr Tandy was responsible for Dryad ward. She, at first, carried out weekly ward rounds every Wednesday, but this changed to every Monday, so Dr Barton could only be with one or other of the consultants during their rounds [Day 25, p.12B].

c. Dr Tandy went on annual leave from April 1998, followed immediately by a period of maternity leave. She did not return to work until February 1999. A decision was taken by the hospital management not to fill Dr Tandy's position with a full-time locum, so there was no regular consultant cover on Dryad ward during this period (although Dr Barton did state that "occasionally senior registrars or locums were sent down") [Day 25, p.13D].

d. In February 1999 Dr Reid took over from Dr Tandy as the consultant responsible for Dryad ward. Dr Reid was the clinical director. Dr Barton was able to accompany Dr Reid on his ward rounds approximately every other week (see Dr Barton [Day 25, p.13A]; Dr Reid [Day 16, p.29D]). Dr Reid stated in evidence that Dr Barton and Sister Hamblin, the senior nurse on Dryad ward, were "much more experienced" than he at prescribing analgesics [Day 16, p.35E].

45. Medical and nursing witnesses gave evidence that the type of patients admitted to Dryad and Daedalus wards changed significantly over time, with more unstable and dependant patients, with multiple co-morbidities, being admitted to the wards. See Dr Barton [Day 25, p.25D]; Dr Reid [Day 16, p.31B; p.69E]; Dr Brigg [Day 2, p.39]; Nurse Couchman [Day 7, p.38F]; Nurse Barratt [Day 10, p.75]; Nurse Shaw [Day 12, p.78G-79B]; Nurse Robinson [Day 32, p.65].

46. These changes added significantly to the pressures on Dr Barton and on the nursing staff. There were not the appropriate facilities on Dryad and Daedalus wards to care for patients with serious unstable conditions, in particular there were no facilities for intra-venous hydration and there was no full-time medical cover. There were limited facilities for rehabilitation and relatives of patients often had unrealistic expectations of what could be achieved. See Dr Barton [Day 25, p.25E, p.28E-H]; Dr Lord [Day 26, p.3-4]; Dr Tandy [Day 18, p.51-52]; Professor Ford [Day 22, p.45,

p.48]; Dr Brigg [Day 2, p.40]; Sister Joines [Day 33, p.31-33]; Senior Nurse Beed [Day 9, p.47]; Nurse Shaw [Day 12, p.53]; Nurse Robinson [Day 32, p.31-32].

47. Dr Barton stated in evidence that she had complained orally to colleagues about the pressures on her wards, but she did not raise the issue formally until 28 January 2000 when she wrote to Dr Reid complaining of "intolerable" pressure [Exhibit D6]. She resigned her post in April 2000. Her resignation letter stated that *"the existing staffing levels do not provide safe and adequate medical cover or appropriate nursing expertise"* [Exhibit D6]. It should be noted that the complaint letter and resignation came after the start of the police investigations into Dr Barton's conduct. Nonetheless, after Dr Barton resigned, she was replaced on the same wards by a full-time staff grade doctor [Day 25, p.45F].

48. Dr Barton claimed in evidence that her prescribing practices were necessitated by circumstance. When asked why it was necessary to prescribe subcutaneous analgesia in advance, she said that: *"with all the best will in the world and for all that I was available to the ward, either in person or on the end of a telephone, I was not always there and, despite what the professor of pharmacology and palliative care [Professor Ford] felt, there was sometimes quite a considerable gap in time before a patient who patently needed subcutaneous analgesia was going to be given it"* [Day 25, p.63]. She also stated that there was no *"practical alternative"* [Day 25, p.63].

49. However, Dr Barton expressly denied the suggestion that, because of staffing shortages, she prescribed opiates earlier or started patients on opiates earlier, or at a higher dose, than she otherwise would have [Day 28, p.83A] and she insisted that patients did not suffer as a result of staffing shortages [Day 28, p.83A]. Similar evidence was provided by the nursing staff, for example: Sister Joines [Day 33, p.26]; Nurse Beed [Day 9, p.49]; Nurse Barratt [Day 10, p.81]. At one stage in her evidence, Dr Barton went so far as to say that, even if she had more time, she would not have made any different decisions in relation to any of the 12 patients in this case [Day 28, p.64-5].

Dr Barton's Superiors

50. As set out above, the Panel accepted that Dr Barton reasonably felt she was acting with the approval of her superiors. The letter referencing an "agreed protocol" for prescribing opiates, to which the Panel referred in their decision, is at [Exhibit D4]. It states that:

> *"It is an agreed protocol that Jane Barton, clinical assistant, writes up diamorphine for a syringe driver with doses ranging between 20 and 200 mgs a day. The nurses are trained*

to gradually increase the dose until the optimum level has been reached for the patient's pain relief. If the prescription is not written up in this way the patient may have to wait in pain while a doctor is called out who may not even know the patient".

51. Dr Barton stated in evidence that the consultants were aware of her prescribing practices [Day 25, p.68D]:

    a. Dr Lord accepted that this was the case (although she claimed "not quite to have registered" the dose range) [Day 26, p.5C-6C].

    b. Dr Tandy agreed that she generally was aware of Dr Barton's prescriptions and she did not recall having any concerns [Day 18, p.48-49].

    c. Dr Reid stated that he discussed anticipatory prescribing of variable doses with Dr Barton and that he accepted her reasons for adopting this approach (initially he claimed that he did not see prescriptions for 20-200mg of Diamorphine but, under cross examination, he conceded that he must have done) [Day 16, p.32G-33D; p.76G; p.82A].

    d. See also: Professor Ford [Day 24, p.22E], regarding broader institutional responsibility.

52. As to the policy of "doubling up" levels of analgesia (which the Panel criticised in their decision), this was done in accordance with a protocol drawn up by Dr Reid in December 1999 [Exhibit D5; Day 16, p.89-90]. Although this protocol was drawn up after the incidents in question, it can reasonably be assumed that if Dr Reid wrote this protocol in December 1999, he approved of the same practices in the months running up to that date.

The 1991 Complaints

53. It was suggested by the GMC that complaints raised by some nurses about the use of opiate analgesia in 1991 should have been a clear warning to Dr Barton that her practice needed to be reviewed. It is important to note that the complaints were not raised directly with Dr Barton, but were taken up with the hospital management. The documents in relation to these complaints are at Exhibit C1, Tab 6.

54. The issues raised in 1991 bear obvious similarity to the issues in the present proceedings. A note of the first meeting held on 11 July 1991, between nursing staff and the patient care manager, Isobel Evans, records concerns that: Diamorphine was being prescribed to patients who were not

in pain; that no other forms of analgesia were considered; that the drug regime was used indiscriminately; that the use of syringe drivers prevented trained staff from adjusting the dose to suit individual patients' needs; that patients' deaths were sometimes hastened unnecessarily; and that other similar units did not use morphine so extensively [C1, Tab 6, p.2-4].

55. A second meeting was held on 17 December 1991 at which Dr Logan (who was the consultant at the time) gave a presentation to staff. Dr Logan stated that the decision to prescribe was a question of professional judgment and that any staff who had concerns should first approach Dr Barton and Sister Hamblin [C1, Tab 6, p.25].

56. Evidence was heard from various witnesses in relation to these issues. It was suggested that the complaints may have been motivated by a personality clash between Sister Hamblin and Sister Giffin, but whatever the motivation for the complaints, and whatever their underlying validity, the important point, for present purposes, is that Dr Barton was aware of the issues and, on her own account, did not change any aspect of her practice [Day 29, p.5]. It could be said that this demonstrated unwillingness on Dr Barton's part to look self-critically at her performance.

57. However, the complaint was not made directly against Dr Barton. She was aware of the issues, but the matter was considered by hospital management and by her consultant; and they made no criticism of her performance. In these circumstances, the extent to which Dr Barton can be criticised for not reviewing her practice may be limited.

Insight

58. A degree of insight arguably was demonstrated by Dr Barton in that she admitted a significant proportion of the factual allegations against her (specifically in relation to the range of doses being too wide and potentially hazardous).

59. She also, apparently, accepted that, in different circumstances, it might have been appropriate to adopt a different approach:

> *"I think that in an ideal situation it would be easier to use lower doses and use methods of titrating doses, with small boluses given every four hours, assessments of the patient every hour. We could not in all consciousness ever do that on wards, in nursing homes I worked for or in general practice, life just was not like that". [Day 28, p.82C].*

"I have felt throughout that Professor Ford's criticism has been perfectly appropriate with the benefit of hindsight and looked at by a secondary care specialist with tertiary specialisation in palliative care - not a community hospital run by a part-time jobbing general practitioner: a completely different world of nursing, medical and everything treatment. I could not have provided the sort of care that he had at his fingertips in my cottage hospital" [Day 31, p.2]

60. However, she demonstrated absolutely no insight into that fact that what she did in the circumstances was wrong:

    a. When repeatedly asked by the Panel whether, with retrospect, she would have done anything differently, her answer, categorically, was "no" [Day 31, 2]

        Q. ... is there anything now you have been going over these cases where you think 'oh, well, maybe I should not quite have done that like that'? Is there anything?

        A. Nothing at all

    b. When specifically questioned about her treatment of individual patients, in light of the criticisms made by Professor Ford, she stood by her actions and said she would not have done anything differently: patient A [Day 25, p.85]; patient E [Day 27, p.14]; patient F [Day 27, p.24]; patient G [Day 28, p.13]; patient J [Day 28, p.48].

    c. She further stated, as set out above, that even given more time she would done the same things.

61. She also demonstrated, at times, a worrying disregard for established guidelines:

    a. When asked whether she thought the BNF had been produced by people who had never stood by a bedside, she replied: *"I sometimes wondered"*. [Day 29, p.13F].

    b. She stated that she kept the palliative care handbook in her pocket because it was useful for doses of drugs that she was not familiar with, rather than for those she used most regularly [Day 29, p.14E].

c. She said that *"in general practice and in palliative care we go outside the guidelines, outside product licenses often, and we accept that it could be recognised as unreasonable"* [Day 28, p.69C].

62. However, it should be noted that she denied ignoring the guidelines, stating that she made clinical decisions, where appropriate, not to apply them (see, for example, [Day 28, p.79]).

Opinion

63. As set out above, the question for the Council to decide is whether, in light of the evidence and applying the relevant legal principles, the Panel came to a decision as to sanction that was "manifestly inappropriate". In applying this test, the Council must bear in mind the specialist expertise that the Fitness to Practise Panel brings to bear on issues of medical conduct.

64. In *Ruscillo*, the Court of Appeal held that:

> *"Where all material evidence has been placed before a disciplinary tribunal and it has given due consideration to relevant factors, the Council and the Court should place weight on the expertise brought to bear in evaluating how best the needs of the public and the profession should be protected. Where, however, there has been a failure of process, or evidence is taken into account on appeal that was not placed before the disciplinary tribunal, the decision reached by the tribunal will inevitably need to be re-assessed"* (para. 78)

65. The weight to be placed on such expertise will depend on the circumstances of the case. In *CRHP v Southall* [2005] EWHC 579, at para 11, Collins J held that, where there is misconduct constituted by a failure to reach proper standards in treating patients, the expertise of the tribunal in deciding what is needed in the interests of the public is likely to carry greater weight than where the cases involves, for example, dishonesty or sexual misconduct. The present case falls squarely into the former category - the allegations relate to medical practices in a complex and difficult field where there always will be controversy as to the proper balance to be stuck between alleviating pain and sustaining life. The Council must accord due respect to the Panel's findings, whilst not, of course, deferring any more than is warranted in the circumstances.

66. With this in mind, the first issue to address is whether the Panel considered all of the relevant evidence and applied the correct legal tests. If they did not, the Panel's decision will have to be reassessed irrespective of any deference. Three issues arise in this regard.

67. First, the Panel did not refer expressly in their determination to the issues that arose in 1991, but they did, in general terms, state that the submissions of the parties had been considered; submissions which included reference to the 1991 complaints. The Panel found that Dr Barton lacked insight and was convinced "her way was the right way". The significance of the 1991 incident, as submitted by the GMC, was that Dr Barton lacked insight despite having a "clear warning that her practice needed to be reviewed" [Day 50, p.6C]. Therefore, although the Panel did not refer to the complaints expressly, they did make a finding on the main matter to which these complaints were relevant and, given the Panel's general reference to having considered all the submissions, it could not, in my opinion, be said that they failed to take into account this matter as a relevant factor when deciding sanction.

68. Second, a semantic point could be taken in relation to the Panel's finding that "it might be possible to formulate conditions which would be sufficient for the protection of patients" [Day 57, p.10E]. Clearly, that is not enough to meet the legal requirement to protect patients and the wider public. Conditional registration is appropriate only where, affirmatively, it is possible to formulate sufficient conditions. However, taking the Panel's decision as a whole, and reading the above passage alongside the later statement that the Panel was *"satisfied, looking forward, that the conditions it has directed provide further safeguards for the protection of patients, and... it is appropriate and proportionate to impose conditions for the maximum period"* [Day 57, p.13G] - it is clear that the Panel did believe that the conditions would (not could) protect individual patients.

69. The third issue is more substantial; that is whether the Panel had due regard to the Indicative Sanctions Guidance. The Guidance emphasises the importance of insight and Dr Barton's lack of insight, including her apparent disregard for guidelines (at least in relation to the prescribing of analgesics), was a major aggravating factor. As set out at paragraph 32 above, the Guidance clearly states that the Panel should be satisfied a doctor has displayed insight if they are to impose conditions on registration. It also states (see paragraph 37 above) that erasure "may well" be appropriate if one of a number of factors, listed in bullet points, are present, one of which is *"persistent lack of insight into seriousness of actions or consequences"*. These parts of the Guidance suggest strongly that conditions were not the appropriate sanction in Dr Barton's case.

70. However, the bullet points in relation to conditional registration - most of which, according to the Guidance, should be apparent for sanction to be imposed – are less clear cut. It is arguable that at least three did not apply to Dr Barton. The three being - no evidence of harmful or deep-seated personality or attitudinal problems; potential or willingness to respond positively to retraining; and willingness to be open and honest with patients. However, in my opinion, it would not have been

manifestly inappropriate for the Panel to conclude that most of the bullet points did, in fact, apply in this case.

71. Taking the debatable three first:

    a. Dr Barton's intransigence certainly could have been viewed as a deep seated attitudinal problem. However, in light of her otherwise safe practice and the fact that she (however misguided) always acted in what she thought was the patients' best interests, it was not, in my opinion, unreasonable for the Panel to conclude the lack of insight did not reach such a level.

    b. As to her willingness to respond positively to training, again, a lack of insight could have been taken to indicate that re-training was not appropriate and the Panel could, without criticism, have reached such a conclusion. However, Dr Barton's lack of insight related to a unique set of circumstances in the past. The fact that she stubbornly stood by what she did then does not necessarily mean that she would not respond positively to training going forward. She specifically said that she had not been trained in titration and expressed surprise at parts of Professor Ford's evidence. Her most recent peer appraisal states that she has read up on palliative care and that she is "keen to learn more" [Testimonials Bundle, p.266]. In my opinion, it was open to the Panel, having heard all the evidence and assessed Dr Barton's attitude in the round, to conclude that she might respond positively to training.

    c. As to Dr Barton's willingness to be open and honest with patients when things go wrong, this criterion is concerned with doctors who seek to conceal mistakes or to mislead their patients. Dr Barton never sought to cover anything up. She has not admitted that things went wrong (because she stands by what she did), but neither has she failed to be open or honest, as such.

72. A number of the other bullet points (which indicate that sanctions are appropriate) apply, in my opinion, very clearly to Dr Barton's case:

    a. It could not be disputed that there is an identifiable area of Dr Barton's practice - namely, the use of opiate analgesics - that is in need of assessment or re-training.

b. For reasons set out below, I am also of the view that patients would not be put at risk as a result of Dr Barton's conditional registration (so long as those conditions were sufficiently rigorous).

c. It is possible to formulate appropriate and practical conditions given that Dr Barton has been operating safely under such conditions (at first self-imposed and then imposed by the Interim Orders Panel) for the past eight years.

73. Overall, it would seem that the Guidance does not point all in one direction or the other and, in any event, the Guidance does not set out a strict tariff or rigid rules. The fact that Dr Barton may have displayed behaviour that fits with one of the bullet points that "may well" make erasure suitable, does not mean that erasure is obligatory. The Guidance is something to which the Panel must have regard, but each case will turn on its own facts (see *CRHP v Leeper* [2004] EWHC 1850). In their determination, the Panel did not refer to any specific passages in the Guidance, but they did state, in general terms, that they had taken it into account.

74. In my opinion the Panel considered all relevant factors in this case, including the Guidance, and they were directed to, and applied, the correct legal tests; considering the need to protect patients; to maintain confidence in the profession; and to declare and uphold standards. In these circumstances, the Council must look at the weight that the Panel accorded to those factors, assessing not whether they would have weighed the factors differently, but whether the decision to impose conditions was one to which a reasonable decision maker could have come (with due deference paid to the specialist expertise of the Panel). It is only in fairly exceptional circumstances that a court will interfere with the balancing exercise of an expert tribunal that has applied the correct law and considered the relevant evidence.

75. Ultimately, there are just two questions to consider in assessing this balancing exercise:

a. Was the imposition of conditional registration appropriate to protect individual patients?; and

b. was the conditional registration appropriate to protect the wider public interest (including upholding the reputation of the profession and declaring and upholding standards)?

76. In relation to the first question, it was, in my opinion, open to the Panel to conclude, in general terms, that the risk to individuals could adequately be controlled by way of conditions imposed on Dr Barton's registration (the exact nature of the appropriate restrictions I will consider below).

77. The misconduct with which Dr Barton was charged was extremely serious. Her acts and omissions were potentially hazardous and gave rise to serious risk that patients' lives could be prematurely shortened. However, these acts and omissions took place in a unique set of circumstances, over ten years ago, when Dr Barton was working under obvious pressure with very little support or supervision. It was accepted by the Panel that Dr Barton would not be placed in that position again. Hospital governance and controls have moved on.

78. However, that is not a complete answer to the question of risk as there remains the possibility that Dr Barton's attitude, views and practice could give rise to different dangers in another context (even with greater support and supervision). Her apparent disregard for guidelines is a concern in relation to her practice more generally. A doctor who does not follow evidence based guidelines clearly puts her patients at risk.

79. Nonetheless, there is no evidence that Dr Barton had, in any other context, failed to follow appropriate guidance. Her actions, prescribing sometimes high variable doses of opiates, administered by way of a syringe driver, arose because of her particular view, in particular circumstances, which placed emphasis on pain relief over keeping a dying patient alert. It was reasonable for the Panel to conclude that sanctions restricting Dr Barton's use of opiates, and her involvement in palliative care, could effectively control the risks associated with that view; and the compulsory training, with review after three years, allowed sensibly for the possibility of future insight (whilst maintaining the option of extending restrictions). The fact that some form of restrictions are workable is evidenced by the existence of past restrictions (at first self-imposed and then imposed by the Interim Orders Panel), operating effectively for the past eight years.

80. As to any broader risk that Dr Barton might pose to patients in her general practice, in my opinion, the Panel was entitled to place significant weight on the fact that Dr Barton has been practicing safely as a GP for over ten years since the incidents that gave rise to these proceedings. The fact that she practiced safely was not just inferred from the absence of any known complaints; it was also backed up by testimonials from colleagues and patients. These included the evidence of two peer reviewers, both of whom reported that Dr Barton was safe and competent.

81. However, the evidence appears to indicate that, for most of those ten years of safe practice, Dr Barton was not prescribing or administering any opiates at all. The conditions of registration, as drafted by the Panel, leave open the possibility to Dr Barton of prescribing oral opiates and, for this reason, it is, in my view, arguable that they are unduly lenient. Whilst most of heads of charge in this case relate to the prescription of Diamorphine, administered by way of syringe driver, the

adverse findings in the case of patient H concerned a prescription for an orally administered opiate, namely Oramorph (to a man with liver disease and alcohol problems). Dr Barton did not admit that she was wrong in this regard, so there is an arguable danger, under the Panel's conditions, that she could write a similar prescription again. The Council may wish to consider referring the case to the High Court on the basis of this discrete point.

82. The merits of this point will depend, to some extent, on the wording of the interim order. I have not seen that order and my Instructing Solicitors should seek to obtain a copy prior to the Council meeting. Counsel for Dr Barton referred to a restriction on prescribing Diamorphine – which usually is administered by injection - rather than a ban on prescribing all opiates [Day 50, p.23]. If the interim order did only restrict the use of Diamorphine, the argument that the Panel's order does not go far enough is weaker, since Dr Barton has been practicing safely under the interim restrictions for a period of years. However, in her oral evidence, Dr Barton said simply that she voluntarily agreed not to prescribe "opiates" and that the interim orders panel had imposed the same restriction [Day 25, p.76]. If the restrictions imposed by the Panel are looser than the previous restrictions, that begs the question, why, particularly in the absence of insight or re-training.

83. Subject to this discrete point it was, in my opinion, reasonable for the Panel to conclude that any risk to individual patients could be controlled by way of conditions restricting the prescription and administration of opiates. That being so, it remains necessary to consider whether conditions (whatever their precise terms) were sufficient to maintain public confidence in the profession and to uphold and declare proper standards of conduct, in the broader public interest.

84. In *Bolton v Law Society* [1994] All ER 486 (which was cited with approval by the Privy Council in *Gupta v General Medical Council* [2001] PC 61), the Court of Appeal held that, since a professional regulatory body is not primarily concerned with matters of punishment, considerations which would normally weigh in mitigation of punishment have less effect on the exercise of this kind of jurisdiction:

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

85. However, upholding the reputation of the profession does not mean bowing to media pressure, where that pressure is not informed. In *Giele v General Medical Council* [2005] 2143 (Admin), Collins J stated that:

"Although the maintenance of public confidence in the profession had to outweigh the interests of the individual doctor, confidence would be maintained by imposing such action as was in all the circumstances appropriate. Thus in considering the maintenance of confidence, the existence of a public interest in not ending the career of a competent doctor would play a part. The fact that patients and colleagues had, in the knowledge of the misconduct found, clearly indicated their views that erasure was not needed was a matter which could carry some weight in deciding how confidence could properly be maintained. However, misconduct which was so serious that nothing less than erasure would be considered appropriate could not attract a lesser sanction simply because the practitioner was particularly skilful."

86. Applying Collins J's approach to the present case, the Panel were entitled to consider the testimonials from colleagues and patients of Dr Barton and to accord them due weight, but there remains a question as to whether Dr Barton's actions were so serious and her lack of insight or regret so egregious as to make anything less than suspension or erasure inappropriate. Many members of the public, no doubt, would be offended by Dr Barton's lack of remorse. However, regulatory proceedings are not concerned with punishment. Lack of insight, even in very serious cases, is not alone justification for erasure (and does not necessarily make restrictions inappropriate).

87. In *CRHP v Southall* [2005] EWHC 579 (Admin) the registrant, a pediatrician, who inappropriately alleged that a man killed his child based solely on a television interview, stood by his views, expressed no remorse and demonstrated "a complete lack of insight". A GMC panel imposed sanctions on his registration to prevent him for conducting any child protection work, but stopped short of imposing suspension or erasure. Upholding the decision of the Panel, Collins J held that:

"Absence of remorse and contrition is likely to be indicative of a lack of insight or of maintenance of unreasonable views. In either event, it may show that a risk of repetition exists. This is clearly relevant in deciding on the appropriate sanction. But lack of remorse should not result in a higher sanction as punishment. Punishment may be an inevitable effect of whatever sanction is imposed but it must not be an element in deciding what is the appropriate sanction. The PCC must decide whether the risk of repetition does really exist. Provided that they have properly considered all the relevant circumstances and have had regard to the correct principles and have reached a conclusion which is itself reasonable, this court will not interfere. Furthermore, the Guidance is just that and it does not automatically follow that erasure must follow if any of the bullet points set out apply. The overarching principles must be taken into account and

they include a recognition that the public interest may, despite a finding that he has been guilty of serious professional misconduct, indicate that a doctor should be able to return to safe work. And the conduct must, if erasure is to be justified, be fundamentally incompatible with being a doctor. In that respect, I agree with what is said in the Guidance."

88. On the facts of the case, Collins J held that the panel had been entitled to conclude that, with restrictions imposed, there was no risk of repetition. The same (subject to the points raised above) is true here.

89. Moreover, for the alternative sanction of erasure to be appropriate, as Collins J stated, Dr Barton's conduct would have had to have been "fundamentally incompatible with being a doctor". Her acts and omissions were undoubtedly serious, but they were motivated by a particular view of her patients' best interests. Dr Barton was never malicious or deceitful. She was working hard under undoubtedly difficult conditions, attempting to do her best. In these circumstances, it could not, in my opinion, be said that the Panel's decision to impose conditional registration, rather than erasure or suspension, was "manifestly wrong".

Interested Parties' Submissions

90. I have read all of the submission made to the Council by interested parties. None of these submissions affect the substance of my advice as set out above. Blake Lapthorne Solicitors wrote to the Council on 3 February 2010 and on 24 February 2010, on behalf of a number of the families of patients who died. In their letters they raise various issues which I address below:

    a. *The Panel failed to have regard to the seriousness of the events*
    This allegation is not borne out by the Panel's decision which clearly states that that they considered Dr Barton's acts and omissions to be very serious [Day 57, p.11B]

    b. *The Panel reached an unsustainable decision in relation to maintenance of public confidence*
    For the reasons set out above, in my opinion, the Panel's decision on public confidence was one reasonably open to them.

    c. *Conditions are inappropriate, inadequate and unworkable*
    For the reasons set out above, in my opinion, there may be an arguable case that the conditions imposed by the Panel are inadequate. However, I do not consider that

conditions, in principle, are inappropriate or unworkable. The fact that conditions, generally, are workable is borne out by the fact that Dr Barton has been practicing safely under conditions (self-imposed and later imposed by the Interim Orders Panel) for over eight years.

d. *The testimonials were not objective*
In any case, testimonials will come from colleagues and patients known to the registrant. This does not mean that they should be disregarded. The mere fact that the author is a colleague or patient does not in itself mean that a testimonial necessarily lacks objectivity.

e. *The authors of the testimonials could not have been aware of the findings against Dr Barton when they wrote their submissions*
Counsel for Dr Barton stated that all those who provided testimonials had been contacted and informed of the factual findings and confirmed that they wished their letters to be used [Day 50, p.24G].

f. *The testimonials were unreliable and irrelevant*
There is no reason to suppose that the testimonials were unreliable and their relevance to the question of whether Dr Barton was safe to practice and whether it would be in the public interest for her to continue to practice is self evident.

g. *The families of patients who died were not given the opportunity to put forward their own testimonials*
The Panel was not asked to admit any such evidence and some relatives did give oral testimony. Bad character testimonials are not generally appropriate in regulatory hearings since the facts alleged and proved are themselves the evidence of unfitness to practise.

h. *Delay should have made no difference to sanction - had proceedings been brought earlier Dr Barton would have been struck off*
This submission is wrong in law. The Panel must consider what sanction is necessary to protect individual patients and the broader public interest, looking forward. The public interest may change over time. A continuous period of safe practice is relevant to this consideration.

i. *The Panel cannot say with certainty that the ten years practice since the allegations demonstrates that Dr Barton has been acting safely*

It was reasonable to infer safe practice from the absence of any contrary submissions or evidence. No doubt Dr Barton's practice has been under considerable scrutiny. Testimonials and peer reviews also supported the contention that Dr Barton has been practicing safely.

j. *The Panel failed to have regard to Dr Barton's lack of insight and lack of regret*
Dr Barton's lack of insight is the point of greatest concern in this case. However, it is wrong to say that the Panel did not have regard to this matter - see [Day 57, p.6-7].

91. The other written submissions either repeat points addressed above or express general disagreement with the decision without raising any specific legal points.

D. Conclusion

92. For the reasons set out above, the decision of the Panel to impose conditions on Dr Barton's registration, rather than suspending or erasing her from the register, was not, in my opinion, unduly lenient. However, there may be an arguable case that the specific conditions drafted by the Panel, allowing Dr Barton to prescribe orally administered opiates, are not sufficiently robust. The strength of this case will depend, in part, on the wording of the interim order. My instructing solicitors should seek to obtain a copy of this order in advance of the Council's meeting so that I may advise further on this discrete point.

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2 March 2010