council for healthcare regulatory excellence



**Registrant:** BARTON, Jane

**Email received:** 26/03/2010 16:46:02
**Sent From:** Code A
**Subject:** 100326 Notes and files regarding 1st case meeting

From: Ludlam, Joanna [mailto: Code A
Sent: 24 March 2010 20:34
To: Harry Cayton; Michael Andrews; Tim Bailey
Cc: Briony Mills
Subject: LEGALLY PRIVILEGED AND STRICTLY CONFIDENTIAL

Dear Harry, Mike and Tim

I attach the draft note of yesterday's meeting, with which Peter agrees.

You will see that the note does not follow the precise order in which you debated the issues, as I have tried to link your comments to the various questions you needed to address. In some cases, you may not have expressly articulated those questions yourselves, but you clearly articulated the answers, and I hope I have remained true to the debate you had about each issue.

You will see that there are one or two areas where there is arguable inconsistency between your comments and your conclusions. This may be because Peter and I have misunderstood you, so correct me if that is the case. If not, there will be an opportunity to iron these issues out when the meeting reconvenes.

Please do let me have any changes you would like to make.

In the meantime, I have spoken to Robert's clerk and he believes this will require 3-4 hours of Robert's time at his usual CHRE rate of £250 per hour. Please can you confirm that what you would like from Robert is not a lengthy note of advice, but rather a short note stating that he has read Peter's advice and the draft meeting note and considered the issue of referral, and setting out his views on prospects of success and recommendations? If that is sufficient, it is likely that we will have his views before the end of this week.

I look forward to hearing from you.

Kind regards.

Jo

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# COUNCIL FOR HEALTHCARE REGULATORY EXCELLENCE
# NOTE OF SECTION 29 CASE MEETING ON 23 MARCH 2010

## JANE ANN BARTON

**PRESENT:** Harry Cayton (in the Chair)
Michael Andrews
Tim Bailey

**IN ATTENDANCE:** Briony Mills (Senior Scrutiny Officer, CHRE)
Bethan Bagshaw (s29 Legal Secondee, CHRE)
Joanna Ludlam (Baker & McKenzie LLP, Legal Advisor)
Peter Mant (Counsel, 39 Essex Street, Legal Advisor)

## 1. DEFINITIONS

In this note the following abbreviations will apply:

| | |
|---|---|
| "CHRE" | The Council for Healthcare Regulatory Excellence |
| the "Members" | CHRE as constituted for this Section 29 case meeting |
| "*Ruscillo*" | The decision of the Court of Appeal in CHRE v Ruscillo [2004] WECA Civ 1356 |
| the "2002 Act" | The National Health Service Reform and Health Care Professions Act 2002 |
| the "Panel" | The Fitness to Practice Panel of the General Medical Council |
| the "GMC" | The General Medical Council |

## 2. THE RELEVANT DECISION

The relevant decision is the Panel's determination on 29 January 2010 that Dr Barton was guilty of multiple incidences of serious professional misconduct, and imposing conditions on Dr Barton's registration for a period of three years.

## 3. DOCUMENTS BEFORE THE MEETING

The following documents were available to the Members:

3.1 Transcripts of the hearing dated between 8 June 2009 and 20 August 2009 and 20 - 29 January 2010;

3.2 Exhibits put before the Panel;

3.3 Determination of the Panel dated 29 January 2010;

3.4 Correspondence received from the public, including a letter from Blake Lapthorn dated 23 March 2010, received at the start of the meeting;

3.5 GMC's Good Medical Practice;

3.6 Section 29 Process and Guidelines;

3.7 GMC's Indicative Sanctions Guidance;

3.8 Order of the Interim Orders Panel dated 12 November 2009;

3.9 Lawyers' report prepared by Baker & McKenzie LLP dated 9 March 2010;

3.10 Note of Advice prepared by Counsel dated 28 February 2010; and

3.11 Supplementary Note to Advice prepared by Counsel dated 9 March 2010.

## 4. CONFLICTS OF INTEREST

The Chair asked whether the Members had any apparent conflict of interest. No conflicts were declared. The Chair confirmed that the Members convened had no conflicts of interest and none were registered.

## 5. JURISDICTION

The Members confirmed that they were satisfied that CHRE had jurisdiction to consider this case under Section 29 of the 2002 Act, and noted that this section 29 case meeting was taking place within the statutory time for an appeal, which would expire on 5 April 2010. As 5 April 2010 falls on Easter Monday, the last day to lodge an appeal will be 1 April 2010.

The purpose of this section 29 case meeting was to consider this case in full under Section 29 of the 2002 Act.

## 6. FACTS OF THE CASE

Dr Barton is a general practitioner who started working part time at the Gosport War Memorial Hospital in 1988. Her job description stated that the post was for "5 sessions a week, worked flexibly to provide 24 hour medical cover to long stay patients". 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. 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.

During the relevant period, Dr Barton worked on two wards, Dryad and Daedalus, both of which were described as "continuing care wards" (although Daedalus ward had eight "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.

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, 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.

The heads of charge against Dr Barton related 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;

(b) certain prescriptions were not clinically justified;

(c) the doses actually administered or authorised, in some cases, were excessive or inappropriate for the patients' needs;

(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;

(e) and these actions were inappropriate, potentially hazardous and not in the patients' best interests.

It was further alleged that Dr Barton failed to carry out adequate assessments of the patients before prescribing opiates; that she did not seek the advice of colleagues; and that her note taking was inadequate.

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. 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 in firm conclusions as to the appropriateness or otherwise of her clinical assessments and decision making, more than ten years after the event.

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 - 200mg of Diamorphine and for 20mg - 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 intravenous 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.

The anticipatory prescriptions allowed nurses to administer painkilling drugs as and when they were needed, without having to wait for a doctor to be called. There were 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. While 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.

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.

(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.

(c) The Panel referred to the British National Formulary, the Palliative Care Handbook and the World Health Organisation Analgesic Ladder which emphasised the importance of using analgesics appropriate to a patient's level of pain, and of moving from weaker to stronger analgesics in a step-wise manner.

(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".

(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).

(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 nurses [had] used their own discretion to start the 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 provided 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.

(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 a 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 put the view that "while this is fortunate, the fact remained that this method of prescribing gave rise to risk that the highest doses could be administered".

(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 a 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.

(i) The Panel further noted that, where subcutaneous analgesia was not controlling the patient's 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".

(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 will take some hours before the amount of analgesia in a patient's body reached the optimal level. Dr Barton, in her evidence, expressed surprised about this fact.

(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 was this 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 had not adopted 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 was sceptical 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".

As to the individual heads of charge:

(n) 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.

(o) 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. 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.

(p) Particular concern was expressed by the Panel in relation to the care of Patient K who had been prescribed Fentanyl before she started on a 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.

(q) In the case of Patient D, the Panel held that Dr Barton had failed to conduct an adequate assessment before prescribing opiates.

(r) 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 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. However, the Panel could not be sure that the prescription was likely to lead to serious and harmful consequences.

(s) 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 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.

(t) In the case of Patient L, the Panel held that there was insufficient clinical justification for the prescription that was given.

(u) 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 and could not be sure that Dr Barton failed to carry out appropriate assessment and examination of Patient B. 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.

The Panel held that Dr Barton fell short of the standards set out in "Good Medical Practice" in relation to a number of areas of her practice. These areas are listed in Appendix A to this meeting note.

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

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

The main aggravating factor identified by the Panel was Dr Barton's lack of insight. Dr Barton insisted in the circumstances that her actions had been correct. She told the Panel that, were the situation and circumstances to repeat themselves today, she would do nothing differently. 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". The Panel also referred to Dr Barton's "denigration of senior colleagues and guidelines". 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".

The Panel noted five points in mitigation of the offence. First, 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. The Panel noted that inappropriate referrals from acute wards put Dr Barton under "unreasonable pressure". 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". The Panel 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.

Further, by way of personal mitigation, the Panel noted that Dr Barton had been in safe practice as a GP for over ten years since the events in question. 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).

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

Taking all of these factors into account, the Panel determined that it had "no hesitation" in concluding that a reprimand would not be appropriate for 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 find herself in a situation like that which she faced at Gosport. They took into account the fact that 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.

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.

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.

The Panel therefore decided to impose restrictions on Dr Barton's' registration for a period of three years, with provision that these restrictions be reviewed before the end of the period of conditional registration. A full list of the conditions is at Appendix B to this meeting note.

## 7. APPLYING SECTION 29 OF THE 2002 ACT

**Undue Leniency**

The Members noted that the test they had 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. The question is whether the decision of the Panel was "manifestly inappropriate" having regard to Dr Barton's conduct and the interests of the public (*Ruscillo*). The Members noted that it was not enough that they themselves might have come to a different view.

*Sanctions*

The Members considered the legal principles governing sanctions. They noted that the purpose is not to punish the practitioner for misconduct, but to protect the public interest (which included protection of patients, maintenance of public confidence in the profession and declaring and upholding proper standards of conduct and behaviour).

The Members noted that, when assessing the public interest, the Panel must have regard to the Indicative Sanctions Guidance, although it was accepted that the Indicative Sanctions Guidance is not a rigid tariff. They also noted that the Panel should consider all aggravating and mitigating factors. Mitigation might consist of evidence of the doctor's understanding of the problem and attempts to address it (such as admission of the facts, making an apology), as well as evidence of the practitioner's overall adherence to important principles of good practice. Mitigation could also relate to the circumstances leading up to the incidents, testimonials, lack of training or supervision at work. The Members noted in particular that the Guidance refers to the need for insight.

The Members then considered the series of points set out in the Guidance, most or all of which should be present for conditions to be imposed. The points are as follows:

- No evidence of harmful deep-seated personality or attitudinal problems.
- Identifiable areas of the doctor's practice in need of retraining.
- Potential and willingness to respond to retraining.
- Willingness to be open and honest with patients if things go wrong.

- 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.

The Members went on to consider the evidence relevant to sanction, noting that the Panel had the benefit of hearing the evidence first-hand, and that the Members should accord due respect to this fact.

The Members observed that Dr Barton had stated, in evidence, that she would not do anything differently if she was presented with the same circumstances today. They noted the Panel's finding that she displayed a "worrying lack of insight" and its concern at her intransigence. Although the Members noted that Dr Barton had admitted certain allegations (such as the range of doses being too wide), they considered that the admissions were in fact limited, and that there was no admission in relation to key findings,. In particular, she did not admit that any of her actions had not been in the best interests of her patients..

The Members further noted Dr Barton's persistent disregard for guidelines, and considered that it was arguable that Dr Barton had an attitudinal problem. The Members questioned whether, if she considered she had done nothing wrong, it was possible for Dr Barton to be retrained.

The Members noted Dr Barton's working conditions, the lack of regular consultant cover and Dr Barton's evidence that her prescribing practices were necessitated by circumstances. Further, the Members noted the finding that Dr Barton reasonably felt she was acting with the approval of her superiors.

The Members noted that failing to keep accurate patient records is a serious allegation. They noted the Panel's comment that poor record keeping by Dr Barton had contributed to the difficulties in deciding the case. The Members observed that this failing might well apply to all aspects of Dr Barton's practice, not just in the context of palliative care. The Members further observed that the conditions, as drafted by the Panel, were arguably not wide enough to embrace the concerns as to record keeping in Dr Barton's general practice. Practising in a group of at least four doctors did not guarantee appropriate record keeping by Dr Barton. On the other hand the Members noted the testimonials from Dr Barton's peers, observing that the appraisers had not raised any concerns as to Dr Barton's note-taking.

The Members made similar observations in relation to the Panel's finding that Dr Barton had fallen short of maintaining trust by respecting the views of patients.[1] They noted that not listening to patients was an extremely serious concern. Again, this failing might conceivably apply to Dr Barton's general practice, not just her conduct in the context of palliative care, and it was not certain that the conditions, as formulated by the Panel, are sufficiently broad and specific to protect individual patients and the public. The Members noted, however, the positive testimonials of Dr Barton's peers.

The Members considered that it was practically possible to draft appropriate conditions to address the failings of Dr Barton, with the possible exception of the lack of insight concern, which is addressed in more detail below. The Members noted, however, the numerous findings of serious professional misconduct, and expressed their concern that the conditions, as drafted, fail to address all the matters where Dr Barton's conduct fell short of acceptable, especially in relation to her failure to keep proper

[1] [NOT TO BE INCLUDED IN FINAL DRAFT] We will ask Robert to advise on this point. As Peter pointed out in the meeting, some of the findings of serious professional misconduct in terms of the breaches of the requirements set out in Good Medical Practice do not relate obviously to the heads of charge. The Registrant could reasonably argue, therefore, that she was not given a proper opportunity to respond to these allegations and that these matters should not properly be taken into account when considering sanction. On the other hand, if appropriate heads of charge were not brought to reflect that findings of fact, there may have been under-charging on the part of the GMC which, in itself, might be a reason to refer.

medical records, to respect patients' views and to assess properly a patient's condition before prescribing. These were all areas which applied to Dr Barton's general practice as well as palliative care[2].

The Members were concerned by the findings of the Panel in relation to Dr Barton's lack of insight and her failure to acknowledge her mistakes and apologise for them. The Members noted the seriousness of the case, affecting as many as twelve aged and vulnerable patients. The Members considered that the Panel failed to have due regard for the Indicative Sanctions Guidance, which emphasised the importance of insight. They noted the Guidance applicable to erasure which set out a series of bullet points, any of which "may well" make erasure the appropriate sanction, in particular "particularly serious departure from the principles set out in Good Medical Practice, i.e. behaviour fundamentally incompatible with being a doctor" and "persistent lack of insight into seriousness of actions or consequences". The Members considered that these bullet points could be said to apply to Dr Barton, and that this part of the Guidance strongly suggested that conditions were not the appropriate sanction in Dr Barton's case.

**Public Protection**

The Members then considered the question of whether the imposition of conditional registration was appropriate to protect individual patients. They concluded that, although it was open to the Panel to decide that the risks to individuals could adequately be controlled by way of conditions, their view was that the conditions as drafted were not always wide enough to address the findings of professional misconduct, in particular with regards to the failings concerning record keeping and maintaining trust[3].

The Members further considered whether conditional registration in this case was appropriate to protect the wider public interest (including upholding the reputation of the profession and declaring and upholding standards). The Members determined that the Panel's decision was unduly lenient in this regard. The Members expressed their grave concern at the number of patients involved, the breadth and seriousness of the findings of serious professional misconduct and Dr Barton's cavalier attitude to the guidelines. There remains the real possibility that Dr Barton's attitude, views and practice could give rise to different dangers in another context. The Members observed that a doctor who does not follow evidence-based guidelines clearly puts her patients at risk. Further, bearing in mind the deterrent objective of sanctions, the Panel's decision failed to address the need to promote public confidence in the profession and in the system of regulation.

The Members considered that conditions were not sufficient to maintain public confidence in the profession or to act as a deterrent. The Members noted that there are clear distinctions between the present case and that of *Southall*. Although Dr Southall lacked insight, he was an eminent expert in his field and the public interest in his continued practise was substantial. The public interest in Dr Barton's continued practise was not so great.

In conclusion, the Members considered that the Panel reached an unsustainable decision in relation to the maintenance of public confidence [and that they therefore intended to refer the case to the appropriate court under s 29 of the 2002 Act][4].

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[2] Note that CHRE also said that although the conditions were not as prescriptive as they would have liked to see, they could not say they were inadequate to meet their objective, so not manifestly inappropriate. CHRE's observations regarding conditions are therefore somewhat contradictory. I have drafted the note in a way which would support a referral, if that is what the Members decide to do following advice, but suggest that the Members revisit this issue and clarify their decision when the meeting is reconvened.

[3] Note the slight inconsistency in CHRE's observations. The Members said that the decision of Panel that conditions would protect was OK, but then focused on the lack of insight which would suggest conditions were not enough. To resolve once Robert has advised.

[4] This decision was not in fact made but is a logical sequitur to the reasoning of the Members.

The Panel adjourned in order to take further legal advice and will reconvene as soon as that legal advice is available and in any event in order to take a decision before 1 April 2010.

**[Under Prosecution in terms of Undercharging**

The Members considered whether the case against Dr Barton had been under prosecuted due to undercharging. The Members noted a letter of complaint in which it was alleged that there had been a mis-prescribing of anti-psychotic drugs. The Members noted that there are very clear guidelines in relation to the use of such drugs in older people. If allegations regarding Dr Barton's prescribing of anti-psychotic drugs had been tested, there was a possibility that conditions may have been inappropriate, or that the drafting of those conditions may have been unduly lenient.

The Members determined that, although there was a possibility that a misuse of drugs was wider than that tested by the Panel, leading to sanctions which may not have been wide enough to address the problems with Dr Barton's clinical practice, there was not enough evidence of such a mis-prescription of anti-psychotic drugs for the Members to determine that a charge in relation to this ought to have been brought.][5]

[5] I am minded to leave this part out of the note as although it was debated, the Members were persuaded it was not in fact an issue.