

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Monday, 14 November 2011

Held at:
St James's Buildings
79 Oxford Street
Manchester M1 6FQ

Case of:

GORDON ROBERT BRUCE SKINNER
MB ChB 1965 University of Glasgow
Reference No: 0726922
(Day One)

Panel Members:
Dr N Hester (Chairman)
Dr M Jeffries
Mrs S Pond
Mr R Ince (Legal Assessor)

MR C FOSTER, Counsel, instructed by RadcliffesLeBrasseur, Solicitors, represented the doctor, who was present.

MR P ATHERTON, Counsel, instructed by GMC Legal, appeared on behalf of the General Medical Council.

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A THE CHAIRMAN: Good morning, everybody. My name is Dr Hester, I am the Chair of the Panel. The lay Panellist on my right is Mrs Pond, and the other medical Panellist is Dr Jeffries. This is a Fitness to Practise Review Panel operating under the General Medical Council (Fitness to Practise) Rules of 2004.

B Today we are considering the review case of Dr Skinner. Dr Skinner is present and represented by Mr Charles Foster, counsel, instructed by RadcliffesLeBrasseur, Solicitors. Mr Peter Atherton, counsel, instructed by GMC Legal, represents the Council. The Legal Assessor on my right is Mr Robin Ince and on my left Miss Jackie Kramer is the Panel Secretary.

Are there any preliminary proceedings which you wish to offer?

C MR ATHERTON: Sir, we have identified a preliminary issue for the Panel, which concerns a matter of admissibility of evidence.

Before I make submissions relating to that, can I just confirm what documents have been made available to the Panel so far?

D THE CHAIRMAN: Behind me there are seven lever arch files, labelled A+BI, A+BII, C+D, E, F, G and H, per Panellist. We have not seen them.

E MR ATHERTON: I am grateful for that. As I am going through my submissions I may be referring to pages in the hearing bundle and it may be that you have my references in separate documents, particularly there are references to the determination made by the original Panel in 2007 and, also, a reference to the determination that was made in July of this year when a reviewing Panel adjourned this case for a period of three months. Perhaps I can see how I get along and if we need to pause to look at the hearing bundle separately I can let you know that.

THE CHAIRMAN: Yes. We also, of course, have the yellow sheet which details a note of the result of the short hearing in July and the findings on fact and the determinations on impairment and sanction that was produced at the end of the original hearing in 2007. We do have all those details.

F MR ATHERTON: That may be sufficient. Sir, by way of background, you are probably aware from the reading that you have already done that Dr Skinner has worked in private practice as a specialist in the treatment of thyroid deficiencies and disorders. In 1997, in a letter published in the British Medical Journal, Dr Skinner and a number of GPs postulated the benefits of thyroxine replacement in clinically hypothyroid but biochemically euthyroid patients. In that letter it was recognised that it was unusual for doctors to start thyroxine treatment in such circumstances and he proposed a three-month clinical trial to test his hypothesis. He suggested that the occasionally quoted risks of osteoporosis and cardiac catastrophe were unfounded and particularly in such a short trial. A response to that letter was published in the BMJ in September 1997, to the effect that it would be unwise for practitioners to support the views expressed in Dr Skinner's letter.

H In 2001, a paper was published in the BMJ following a randomised double-blind placebo

A controlled crossover trial, which concluded that thyroxine was no more effective in improving cognitive function and psychological wellbeing in patients with symptoms of hypothyroidism but whose thyroid function tests were within the reference range. However, notwithstanding this difference of published views, Dr Skinner put his hypothesis into practice by prescribing thyroxine on the basis of his clinical assessments and without regard to blood chemistry results. This duly led to concerns for patient safety, complaints and a referral to the General Medical Council.

B

In 2007 a Fitness to Practise Panel sat for 22 days to determine the allegations concerning the care of four patients who were treated by Dr Skinner. At the conclusion of the case, in its determination on sanction, the Panel recognised that Dr Skinner is a caring and compassionate doctor whose overwhelming concern is the care and wellbeing of his patients, many of whom pleaded that he should be allowed to continue in practice. Then, as now, Dr Skinner was able to demonstrate formidable support from his patients for his unorthodox methods of treating their complaints. However, the Panel also found that Dr Skinner's fitness to practise was impaired because he had harmed or placed patients at risk of harm and had shown deliberate or reckless disregard of his clinical responsibilities towards patients and also because he had rejected a request to agree to an assessment of his professional performance. Of the four patients (anonymised as Patients A, B, C and D) in the case of Patient A, Dr Skinner prescribed Sodium Thyroxine before obtaining blood results and failed to investigate and refer the patient to an endocrinologist for a suspected B12 deficiency.

D

In the case of Patient B, Dr Skinner, it was determined, had failed to monitor the patient, after he had prescribed Sodium Thyroxine. She then became biochemically thyrotoxic, and although he was aware of the blood results and that she had exhibited palpations, he issued a further prescription for Sodium Thyroxine and Tertroxin, and the Fitness to Practise Panel determined that Dr Skinner had, thereby, placed Patient B at risk of harm.

E

In the case of Patient C, the Panel concluded that the doctor's prescribing was inappropriate and unnecessary but, applying the higher standard of proof, which was at that time the requisite standard, was not satisfied that those actions would place the patient at risk of harm. After receiving blood results that the patient had become thyrotoxic, he failed to reduce her thyroid medication and failed to refer her to an endocrinologist for suspected adrenal failure.

F

In the case of Patient D, the Panel found that Dr Skinner had suspected a diagnosis of B12 deficiency but had failed to perform any investigation or to inform her general practitioner.

G Can I then take you, please, to the determination on impairment made by the Panel. My copy is paginated by reference to the hearing bundle, but if I could ask you to find the reference or the heading "Patient D".

THE CHAIRMAN: Page 13 on our yellow sheets.

H MR ATHERTON: Thank you, it is 14 on mine, so I think I must be a page ahead. Perhaps I can then take you on to page 14, please. You can see that the Panel referred to parts of the Indicative Sanctions Guidance of April 2005 and to *Good Medical Practice*

A 2001 Edition, from which it quoted:

“... in providing care

‘You must not give or recommend to patients any investigation or treatment which you know is not in their best interests nor withhold appropriate treatments or referral;’

B

Good Medical Practice also states that good clinical care must include:

‘an adequate assessment of the patient’s conditions, based on the history and symptoms and, if necessary, an appropriate examination’.

C

It went on:

“The Panel has not made its judgment based on your personal beliefs as to methods of treatment save in so far as these beliefs have shown disregard of clinical responsibilities towards patients. The Panel notes that every doctor who has given evidence at this hearing has indicated that they would undertake blood tests when assessing the patient’s condition and deciding on future management. You have indicated in your submission that you believe it is not always necessary to check thyroid chemistry prior to initiating or changing a patient’s medication. You have also indicated that you believe biochemical thyrotoxicity is a misconception. No other clinician at this hearing has supported this position. The Panel is most concerned that your rigid approach has put patients at risk of harm. The Panel has found that you have repeatedly breached the above principles contained within Good Medical Practice.”

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Could I ask you just to mark that passage, because it is the essence of the submission that I come to make with regard to admissibility.

F

Similarly, the next paragraph:

“The Panel has been concerned throughout this hearing that you have shown a lack of insight into your behaviour. This has been clearly demonstrated by the statement which you provided to the Panel, dated 7 September 2007 in which you set out your reasons for refusing to accept the findings of the Panel. For example, you state, ‘In fairness to myself, the text should be rewritten and the term biochemical thyrotoxicity, which is a non-concept, removed ...’ This approach has not been supported by any other clinician who has given evidence at this hearing. The Panel is most concerned that your refusal to acknowledge that this approach may be flawed demonstrates that you have failed to reflect on your practice.”

H

A The Panel then went on to consider the question of sanction and on my page 19, which may be your page 18.

THE CHAIRMAN: Sanction starting at the very bottom of page 16.

B MR ATHERTON: Yes, thank you. If I could ask you, please, to find the passage that begins towards the top of the page, there are two lines and then it continues, "However, the Panel remains concerned ..."

THE CHAIRMAN: That is halfway down page 18.

MR ATHERTON: Thank you:

C "However, the Panel remains concerned that, in the past, you have prescribed thyroxine without taking blood tests and without regular review and monitoring. In addition, it is concerned that you did prescribe, without review, knowing that a patient was biochemically thyrotoxic and had palpitations. The Panel considered whether conditions could be formulated which would protect patients."

D The Panel then went on to formulate the conditions which you see following that passage. For the purposes of this review the most relevant conditions are 5, 6 and 7. Condition 5 reads:

E "You must only accept new patients for endocrine treatment if they have been referred to you by a fully registered medical practitioner. On a six monthly basis, you must provide to the GMC anonymised copies of patients' referral letters in a separate, paginated and indexed bundle (patients being identified by initials and NHS number [only])."

Condition 6:

F "Prior to initiating or varying any treatment regime, you must ensure that you have communicated your diagnosis and suggested care plan to the patient, his or her GP, and any other referring medical practitioner. On a six monthly basis, you must provide to the GMC copies of the letters sent to GPs or referring medical practitioners in a separate, paginated, and indexed bundle [again with] (patients being identified by initials and NHS number)."

G Then condition 7:

"You must keep a contemporaneous logbook of all patients seen in relation to work carried out as a registered medical practitioner. This book must identify the patient only by their initials and NHS number and the name and contact number of the referring practitioner and [it] should be initialled and dated by the patient. The logbook must indicate:

H

A

- in the case of a new patient, the reason for the consultation;
- in the case of all patients, the reason for any prescribing outside of UK recommended guidelines.

On a six monthly basis, you must provide the GMC with a copy of the logbook.”

B

The case was due to be reviewed in July of this year. It was scheduled to last for five days but the hearing was adjourned on the GMC’s application due to issues that had arisen with the GMC’s expert witness. The position was helpfully explained in the determination of July, if I could ask you, please, to turn to that.

THE LEGAL ASSESSOR: Which lever arch file is that in?

C

MR ATHERTON: This would be found at page 423, if you bear with me for a moment, I will try to help you with that.

THE CHAIRMAN: We certainly do not have it on the yellow pages, we just have the fact that there was difficulty with regards to the expert witness.

D

MR ATHERTON: I see. May I just have a moment? *(Pause)* Yes, we need to distribute those bundles to you, sir. *(Same handed to the Panel)*.

THE CHAIRMAN: Thank you, we will label this C1.

E

MR ATHERTON: I am very grateful. Sir, if I could take you to page 420, please, if you find the determination on adjournment which sets out the background to the application. You will see that Mr Morwood, who then appeared for the GMC, made an application for the proceedings to be adjourned and for Dr Skinner’s conditions to be extended for a period of at least six months in order that further expert reports might be sought. The document then sets out the background, some of the history which I have just explained to you, and it goes on to give a little detail about the issues that had arisen had respect of the expert who had been instructed by the GMC in respect of that hearing. On page 423 you will see it states:

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“The Panel were concerned by the resultant lack of expert evidence available. This gives rise to a justifiable concern as to whether it could be fair to make a determination on a practitioner’s fitness to practise without such appropriate expert evidence.”

G

Then, again, a passage which I ask you, please, just to mark:

“It might well be the case that Dr Skinner had complied with the conditions on his registration. However, under Rule 22(c) the Panel also has a duty to make findings, not only on his compliance with conditions but also on his fitness to practise and, absent expert evidence, it cannot fulfil its obligation in this latter regard.”

H

The Panel then went on to consider the length of the adjournment, and decided that it

A should not be for the period of six months as requested by the GMC, but should be for a period of three months.

B The GMC is satisfied in light of expert evidence which it has received from the newly instructed expert, who is Dr Akintewe. He has reviewed the documents which have been generated as a result of conditions 5, 6 and 7 and has advised that Dr Skinner has been able to demonstrate compliance with those conditions. However, as was recognised by the Panel in July, there is also a question to be determined on review as to whether there is continuing impairment of the doctor's fitness to practise. Dr Akintewe reviewed the cases of 662 new patients which were the subject of the documentation provided by Dr Skinner and he was asked by the GMC to advise whether he had any concerns arising out of the documentation that he had reviewed. In response to that instruction he expressed concerns about the use of thyroxine in spite of normal thyroid chemistry and about the use of Armour Thyroid stating that that is unlicensed in the United Kingdom. **C** He also expressed concerns about repeated statements that he had seen in those documents, statements by Dr Skinner, to the effect that thyroid chemistry is a good servant but a bad master.

D You will have seen from the determination of the Panel in 2007 that it declined to make findings as to the propriety of the use or prescribing of thyroxine by Dr Skinner in accordance with his own beliefs.

The preliminary question which we have identified for this Panel is whether Dr Akintewe should be permitted to give evidence about his concerns following the reviewing of the documentation. The GMC's submission is that such evidence is relevant and admissible in light of the original Panel's concerns as they were expressed in those parts of the 2007 determination which I have asked you to highlight. The GMC submits that this evidence goes to confirm the concerns that were then expressed by the Panel, concerns that have arisen again over the intervening period, such that the GMC's submission would be that the doctor's fitness to practise remains impaired and that conditions continue to be necessary. **E**

I understand from my learned friend that he may wish to take a point about the late service of an addendum to Dr Akintewe's report. His report was served electronically by the GMC on Dr Skinner's solicitors on 7 October, so no time issue arises in respect of that. In that report Dr Akintewe expressed the concerns that I have mentioned to you. He was then asked to identify those cases within the voluminous documentation to which he was referring in making those concerns or expressing those concerns and he provided an addendum on 24 October which simply lists his references within those documents. The GMC submits that this is not a situation in which the essence of expert evidence has been served late, but it was served within time and that helpful particularisation was given. **F**

G Sir, that is the preliminary issue, and the argument in support of the GMC's position.

THE CHAIRMAN: Thank you Mr Atherton. Mr Foster.

H MR FOSTER: Thank you, sir. Dr Skinner's position is that the passage in Dr Akintewe's report, which expresses concerns is inadmissible for reasons which I will

A outline. Secondly, that the addendum to Dr Skinner's report which contains the patient particulars is (a) inadmissible for the same reason as the expression of concern is inadmissible and is also inadmissible because it is out of time.

B The first trite but central comment is that this is a review hearing, it is not a new hearing. If it were a new hearing there is a very well-trodden path down which the Council must go, it has to produce well-particularised allegations to which the practitioner has a chance to respond. What is the case which you are now reviewing? Answer: it is the case that was decided in November 2007. Anything which falls outside the ambit of that inquiry is off-piste for you. I, therefore, need to take you back to that November 2007 determination. It may be helpful, so we are all singing from the same hymn sheet if, instead of the yellow papers that you have, you use the passage which is set out in C1. If you are going to do that, can I invite your attention first of all to page 18 on C1, that is in the determination on sanction. Right at the top of page 18 you will see this:

C

“In deciding on the appropriate sanction to be imposed in this case ... the Panel has restricted itself to considering only your actions in relation to the facts found proved. It is not the remit of this Panel to decide on whether your approach to treatment is correct or incorrect ...”

D What my learned friend has done in the submissions just made to you is to seek to persuade you to consider evidence which goes crucially and only to the question of whether Dr Skinner's approach to treatment is correct or incorrect. He is perfectly entitled to do that, but not in these proceedings. If he wants to debate that issue then he is going to have to go down the fitness to practise route, we need particularised allegations.

E It would have been possible, within the ambit of these proceedings, for new allegations to be made. You will know from Rule 21(a) of the procedure rules, that new allegations can be added to a review hearing, they have not been. That allegation - and it is the only allegation to which the offensive comments of Dr Akintewe goes - is not before you. Accordingly, any evidence from Dr Akintewe to that effect is inadmissible.

F I need to take you to the recent adjournment. You have been taken to that already by my learned friend, but could I take you back, please, to page 422. You will see in the third paragraph down that Mr Haycroft, counsel then instructed for Dr Skinner, was concerned that Professor Bouloux was being asked effectively to conduct a performance assessment of this doctor. That would have been improper, and that Panel agreed. You will recall from your reading of the November 2007 determination that the Panel gave express consideration then to the question of whether there should be a performance assessment and decided that it should not order a performance assessment.

G In my respectful submission, what my learned friend is inviting you to do is to effectively to receive unilaterally and without the possibility of any contradiction by Dr Skinner, the evidence of Dr Akintewe as to the doctor's performance. That would be the effect of you receiving his evidence at this stage. It would be for you to allow the Council to do what both previous Panels have expressly declined to do, namely to put Dr Skinner through a performance assessment without any of the usual procedural safeguards for a performance assessment, namely the whole structure, namely the ability to call experts on the part of Dr Skinner to rebut the conclusions of the performance assessors and so on.

H

A

The point about timing. Those instructing me wrote to the General Medical Council on 3 August pressing for disclosure at least six weeks before the hearing and taking up the point that I have just made about performance assessment, saying, "Please be careful to ensure that any report that you put in isn't tantamount to a performance assessment." They pressed on 22 August, not having had any report from the Council at that stage, but after the matter was listed saying that they were anxious for expert disclosure by 30 September. They pressed for disclosure again on 2 September.

B

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The main report of Dr Akintewe - that is the one which contains the expression of concern - was received by the Council on 7 October. The Council originally said that they were not going to send it to us at that stage but wanted a further week. Those instructing me said, "That's not good enough, we need it now" and, indeed, an unsigned copy was sent that day. As far as the 28 days are concerned which the Rules require, that report is in time. The 28 days expired on 16 October. It was not until 24 October that we got the addendum. The addendum and the main report cannot be separated from one another. Until we got the addendum there was no way in which we could coherently question the basis on which Dr Akintewe was expressing his concern. The whole point of the 28-day rule is of course so that a practitioner has an opportunity to respond. We did not know what we were responding to until the service of the addendum on 24 October. Were you to admit the addendum, you would be denying Dr Skinner the protection which the Rules allow him.

D

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It would have been possible for the original Panel to implement six-monthly reviews, for example, so that Dr Skinner would have had an opportunity to be confronted with any concerns that the Council had at each stage. The original Panel declined to do that, saying that the matter would be reviewed at the end of the condition period. Because six-monthly reviews were not built in to the assessment, it was all the more incumbent, in my submission, on the Council to let Dr Skinner know of any concerns well in time to let him have the opportunity to deal with them; that they have not done.

F

G

Can this new allegation - because it is a new allegation - be dealt with now? Procedurally there is no route for it to be dealt with. Even if I am wrong about that, what would have to be done? I would have to be in a position to cross-examine Dr Akintewe not only on the 662-odd patients who he says he has audited, but also on the other patients who it is said have benefited from his (that is Dr Skinner's) treatment over the years. In other words, we would have to make sure that there was a proper representative audit. Dr Akintewe did not have patient follow-up records, he did not look at anything outside the relatively small cohort of 662, he did not do a systematic trawl of the relevant literature. There is a very great deal more to be said on the authorities about the prescription of thyroxine and Armour Thyroid than appears in the very brief discussion. If the GMC want a debate about the propriety of this there are other ways of doing it, but this review hearing is not one of them.

H

Sir, for all those reasons, I respectfully say that to allow the Council's submission that Dr Akintewe's evidence be adduced would be wrong because of time, wrong most crucially because it does not arise from the original proceedings, and is relevant only to an entirely new issue, and wrong because Dr Skinner has been deprived of the protection which the procedural safeguards are put there to allow him.

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Sir, those are my submissions. Unless I can help you any further.

THE CHAIRMAN: Thank you very much.

B

MR ATHERTON: Sir, if I may respond very briefly? Dr Akintewe has expressly not expressed any opinion as to the competence of Dr Skinner in respect of the concerns which he identified. The GMC submits that the points that he has picked up as concerns reflect the original Panel's observations and concerns about Dr Skinner's rigidity of thought, his lack of reflection on his own practice and lack of insight. Dr Akintewe's report is not a performance assessment and is nothing like a performance assessment.

C

I would like to respectfully remind you of the guidance given about review hearings in the Indicative Sanctions Guidance.

THE CHAIRMAN: Tab E in the green folder.

MR ATHERTON: Thank you. The guidance on review hearings begins at paragraph 114 and reminds Panellists and others that Rule 22 sets out the procedure that a Panel must follow at a review hearing it states:

D

“The Panel will need to consider and make a finding as to whether the doctor's fitness to practise is impaired or he/she has failed to comply with any conditions imposed at the previous hearing ... before determining whether to impose a further order.”

Paragraph 116:

E

“It is important that no doctor should be allowed to resume unrestricted practice following a period of conditional registration or suspension unless the Panel considers that he/she is safe to do so.”

It is with those considerations in mind, and the passages from the determinations to which I have referred, that the GMC bases its application.

F

THE CHAIRMAN: Thank you very much. I now turn to the Legal Assessor who will advise us. Do you wish to have some time to think about things?

THE LEGAL ASSESSOR: Yes, I do. I have only been alerted to this this morning and I wish time to prepare my advice to you. It will be no more than an hour.

G

THE CHAIRMAN: In that case we will break now until the Legal Assessor is ready with his advice and we will use this time as the mid-morning break, thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Legal Assessor.

H

THE LEGAL ASSESSOR: Thank you. The admissibility of evidence begins with

A paragraph 34(1) of the rules which says that you may admit any evidence you consider fair and relevant to the case before you, whether or not such evidence would be admissible in a court of law.

B The starting point of your deliberations about this review generally is the previous Fitness to Practise Panel's determination. It is perhaps relevant that they fully considered everything, or certainly had time to do so, in a 22-day hearing.

C The determination indicates that at that time Dr Skinner's apparently unorthodox views on the general treatment of hypothyroidism were known to the Panel but the Panel specifically did not make any judgment thereon but concentrated on certain elements of his practice with regard to four patients which involved him prescribing before obtaining blood results, failing to investigate and refer onwards when he suspected a vitamin deficiency and failing to monitor a patient and/or take account of the effects of the treatment upon that patient or to modify the same. Those were the sum totals of the various allegations against him.

D You may feel that the conditions imposed upon Dr Skinner subsequently reflect this, as they dealt with, first of all, procedures on accepting new patients, secondly, the communication of his diagnosis and suggested care plan, not only to the patient but also to the GP or any referring medical practitioner and, thirdly, to the keeping and disclosure to the GMC at regular intervals of a logbook on all patients that he saw which had to, *inter alia*, indicate the reason for prescribing outside of the UK recommended guidelines.

The Panel specifically did not order a performance assessment which you may feel indicates that they considered Dr Skinner's apparently unorthodox views did not affect his overall competence as a doctor.

E The procedure for the reviewing hearings is set out, as you have already been referred to, in paragraph 22 of the practice rules, and I refer you specifically to paragraph 22(c)(ii) which indicates that the GMC shall:

F “... direct the attention of the FTP Panel to any relevant evidence, including transcripts of previous hearings, and may adduce evidence and call witnesses in relation to the practitioner's fitness to practise or his failure to comply with any requirement imposed upon him as a condition of registration”

G You have heard that it is accepted that there has not been any non-compliance, so the only issue apparently before you is whether or not Dr Skinner is currently impaired. You have been told that the GMC expert, Dr Akintewe, expresses concerns about the use, by Dr Skinner, when prescribing of thyroxine and Armour Thyroid but you may feel it relevant that it was known to the previous Panel that Dr Skinner prescribed thyroxine to all four patients which were the subject of those charges and Armour Thyroid to Patient A, yet the Panel did not make any adverse findings on the principle of prescribing such. Without a specific and fresh charge on the point, you may feel that it is not appropriate to reopen such matters.

H In addition, concern is expressed about the use of his statement that thyroid chemistry is

A a good servant but a bad master. Again, you may feel that this is another way of expressing his unorthodox views on the subject.

B You have also heard that Dr Akintewe has specifically not expressed any opinion on whether Dr Skinner is currently impaired and if that is the case you may feel that unless he is prepared to express an adverse opinion on such matters which if that were the case in fairness ought then to be the subject of a fresh allegation, then his concerns over matters that have already been ventilated at great length before a Fitness to Practise Panel but not acted on should not be considered by you.

In the event that you reach a decision to admit such evidence then the addendum becomes relevant and the question of whether or not it is out of time. That is governed by paragraph 34(9) of the procedure rules, which indicates that:

C “... unless otherwise agreed between the parties or directed by a Case Manager, each party shall not less than 28 days before the date of the hearing -

(a) provide ...”

D - and then there is a list of various documents and so on which this addendum falls into.

You have heard that such was, as Mr Atherton said, helpful particularisation, namely the identification of those cases to which he was basing his already expressed concerns. If that is all it is, in those circumstances you may feel that it is appropriate to extend time to allow that to be admitted, but only if you accept his report in full.

E That is my advice.

THE CHAIRMAN: Thank you Legal Assessor. Do the GMC have any comments to make on the Legal Assessor’s advice?

F MR ATHERTON: Yes, please. Sir, it is clear from the original determination that on the basis of the facts found proved the Panel considered that the doctor’s rigidity, lack of reflection, and lack of insight, were all important factors in reaching their conclusions that his fitness to practise was impaired. In the absence of any evidence from the doctor to demonstrate reflection about his practice, in light of the very considerable weight of expert evidence led at the first hearing, this Panel could properly conclude, I submit, that the doctor’s fitness to practise remains impaired and that he has not demonstrated that the situation has changed from the time when the Panel expressed those views. In my submission, it would be right for this Panel to take those factors into consideration in reaching this decision.

G THE CHAIRMAN: Thank you Mr Atherton. Mr Foster?

MR FOSTER: Sir, that is an argument for the next stage, it does not go to admissibility.

H MR ATHERTON: I respectfully agree with your learned Legal Assessor’s opening comments that admissibility turns on relevance and, in my submission, those are relevant

A factors and having regard to the provisions of Rule 34, those are factors which the Panel should take into account in determining this preliminary issue of admissibility.

THE CHAIRMAN: Legal Assessor.

B THE LEGAL ASSESSOR: I do not think I have anything to add, the matter has been ventilated and argued before you. It is a matter for you

THE CHAIRMAN: In that case the Panel will go into *camera* to consider the matter. Thank you. If you can now leave us to discuss the matter privately.

MR FOSTER: Sir, I wonder if you would be prepared to indicate that there is unlikely to be a ruling, say, before two o'clock?

C THE CHAIRMAN: I think it is very reasonable to expect that we would not have reached a decision sufficient to be able to give a considered determination on this subject prior to the lunch break. We will run it into the lunch break and resume, at the earliest, at two o'clock. If it looks as if we are going to be later than that, we will send out a message to that effect.

D MR FOSTER: Thank you very much, sir.

D E T E R M I N A T I O N

E THE CHAIRMAN: Mr Atherton, this Fitness to Practise Panel is reviewing Dr Skinner's fitness to practise. In November 2007 Dr Skinner's fitness to practise was found to be impaired by reason of his misconduct and deficient professional performance. This finding was on the basis of his treatment of four patients for thyroid conditions. It determined to impose conditions on his registration for a period of three years. Three of these conditions (numbers 5, 6 and 7) are as follows:

F "5. You must only accept new patients for endocrine treatment if they have been referred to you by a fully registered medical practitioner. On a six monthly basis, you must provide to the GMC anonymised copies of patients' referral letters in a separate, paginated and indexed bundle (patients being identified by initials and NHS number).

G 6. Prior to initiating or varying any treatment regime, you must ensure that you have communicated your diagnosis and suggested care plan to the patient, his or her GP, and any other referring medical practitioner. On a six monthly basis, you must provide to the GMC copies of the letters sent to GPs or referring medical practitioners in a separate, paginated and indexed bundle (patients being identified by initials and NHS number).

H 7. You must keep a contemporaneous logbook of all patients seen in relation to work carried out as a registered medical practitioner. This book must identify the patient only by their initials and NHS number and the name and contact number of the referring practitioner, and

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should be initialled and dated by the patient. The logbook must indicate:

- in the case of a new patient, the reason for the consultation;
- in the case of all patients, the reason for any prescribing outside of UK recommended guidelines.

B

On a six monthly basis, you must provide the GMC with a copy of the logbook.”

You have applied under Rule 34(1) of the Fitness to Practise Rules to admit the full report of the GMC’s expert witness, Dr Akintewe at this review hearing.

C

You told the Panel that when a Fitness to Practise Panel first met to consider Dr Skinner’s case, it stated that it made no judgment with regard to his personal beliefs as to methods of treatment of clinically hypothyroid patients save in so far as these beliefs showed a disregard of clinical responsibilities towards patients. It was concerned, however, that Dr Skinner’s rigid approach put patients at risk of harm and that he had shown a lack of insight into his behaviour and a failure to reflect upon his practice.

D

At a review hearing of Dr Skinner’s case, which adjourned before it opened in July 2011, the Panel stated that it had a duty under Rule 22 (c) of the Fitness to Practise Rules to make findings on not only a practitioner’s compliance with conditions but also on his or her fitness to practise. That Panel considered that, in the absence of expert evidence, it could not fulfil its obligation in the latter regard.

E

You told the Panel that Dr Akintewe had been tasked with reviewing the information supplied by Dr Skinner as required in conditions 5 to 7. He reviewed 662 patient records in total and expressed concern about Dr Skinner’s use of thyroxine in the light of normal biochemistry, and about his use of Armour Thyroid, as it is not licensed for use in the UK. He also expressed concerns about Dr Skinner’s use of the phrase, “Thyroid chemistry is a good servant but a bad master.”

F

You submitted that Dr Akintewe’s full report should be adduced in evidence and he should be permitted to give evidence about his concerns. You submitted that such evidence is relevant to the Panel in its consideration of whether Dr Skinner’s fitness to practise is impaired by reason of misconduct and performance in the light of the original Panel’s concerns about Dr Skinner.

G

Dr Akintewe submitted an addendum to his report which did not satisfy Rule 34(9), which requires evidence to be disclosed 28 days before the commencement of the hearing. You submitted that this addendum simply references those patients of Dr Skinner’s about whom Dr Akintewe has concerns. You referred to it as “helpful particularisation” and submitted that the essence of the expert evidence had been submitted within the requirements of Rule 34(9) and that the addendum should be admitted also.

H

On Dr Skinner’s behalf, Mr Foster submitted that the passages in Dr Akintewe’s report which express concern about Dr Skinner’s practice are inadmissible. He submitted that

A the function of this Panel is to review Dr Skinner's case; a new allegation reflecting Dr Akintewe's concerns has not been particularised and therefore, anything outside the ambit of the original Panel's considerations is outwith the jurisdiction of this Panel. Mr Foster submitted that this Panel is not entitled to consider new concerns relating to Dr Skinner's practice at this hearing.

B Mr Foster also submitted that Dr Akintewe's report is tantamount to an assessment of Dr Skinner's professional performance; such an assessment was not requested by the original Panel and Dr Skinner has been afforded none of the safeguards of an official assessment of his professional performance.

C As regards the admission of the addendum report, Mr Foster submitted that the GMC has not given Dr Skinner's defence sufficient time to deal with the concerns set out in Dr Akintewe's report.

The Legal Assessor advised the Panel that the original Panel in November 2007 had made no judgment as regards Dr Skinner's "unorthodox views". The conditions imposed upon his registration reflected that fact. He also advised that the original Panel had not ordered a performance assessment to be carried out as regards Dr Skinner's practice and that, therefore, his overall competence as a doctor was unlikely to be a concern.

D The Legal Assessor advised the Panel that the original Panel had made no adverse finding *per se* in relation to Dr Skinner's prescribing of thyroxine and Armour Thyroid which are the areas of Dr Akintewe's concerns. The Legal Assessor advised that, in the absence of a fresh allegation relating to those areas of Dr Akintewe's concern in relation to Dr Skinner's practice, the Panel should not admit that part of Dr Akintewe's report into evidence.

E As regards the addendum report, the Legal Assessor advised that, should the Panel determine to admit Dr Akintewe's report in full, the addendum amounts to a particularisation of the main report and may be accepted by the Panel.

F The Panel has taken the view that, whilst the original Panel in November 2007 decided not to take Dr Skinner's personal beliefs into account in making its determination on impairment, it clearly had concerns about Dr Skinner's lack of monitoring prior to and during treatments and about his prescribing of thyroxine where it was not indicated by blood tests. It was also clear that the Panel was concerned about Dr Skinner's lack of insight, lack of reflection and rigidity of practice. The Panel's primary function is to protect the public interest and it is important, therefore, to take account of patient safety. It considers, from what the Panel have been told about Dr Akintewe's concerns, that they do impact upon those areas of Dr Skinner's practice that were the concern of the previous Panel and so are relevant to the issues before this Panel.

G The Panel accordingly believes that admission of this evidence would not be unfair to Dr Skinner and is not persuaded by the argument that Dr Akintewe's report equates to a performance assessment or amounts to fresh allegations. In these circumstances, the Panel has determined to accede to your application and admit Dr Akintewe's report into evidence in full.

H

A As regards the addendum report, the Panel considered that this did not meet the criterion of Rule 34(9) and that it should not, therefore, be admitted into evidence.

Are there any comments or any further preliminary matters that you wish to deal with?

B MR ATHERTON: No, sir, I do not believe there are any other preliminary matters. Mr Foster and I had discussed various possible outcomes of this application and felt that it would be appropriate really, whatever the outcome, to ask for some time so that we can take stock of the position and, having regard to the time now, we wondered perhaps whether you might wish to adjourn for the day while we can consider the implications of your determination and, perhaps, start again at 9.30 tomorrow morning.

C THE CHAIRMAN: I am not opposed to that but I am concerned that we have a certain set time put aside for the case, four more days. It was originally five days it is now going to be four days. Are you confident and you, Mr Foster, confident that we can proceed to the end of the matter within four days if we stop tonight now?

D MR ATHERTON: Reasonably confident. We will need to discuss, I think, the implications of the latter part of your determination which excluded the addendum to the report. I cannot really say very much more about that at the moment but, yes, I am reasonably confident, subject to my learned friend's views, that we would complete it.

MR FOSTER: Sir, I share that confidence and I agree with my learned friend that on both sides there will need to be some stocktaking in the light of your ruling but whatever the outcome of that stock-take I anticipate that we will finish comfortably within this week.

E THE CHAIRMAN: Yes, because the Panel is particularly concerned that we should not reach a stage somewhere later in the week where we have to adjourn to the distress and discomfort of Dr Skinner. The last thing we want to do is find ourselves in that situation.

MR FOSTER: We do not anticipate that, sir.

F THE CHAIRMAN: I think it would be useful then just to get the proceedings under way by asking Dr Skinner to give his name and registration number and then we can start again in the morning.

Dr Skinner, could you confirm your full name and registration number, please?

DR SKINNER: Yes, sir, Gordon Robert Bruce Skinner, 0726922.

G THE CHAIRMAN: Thank you very much. Unless there is anything else, we will now adjourn then and start again at 9.30 in the morning.

MR ATHERTON: Thank you, sir.

*(The Panel adjourned until 9.30 am
on Tuesday, 15 November 2011)*

H