GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Tuesday, 3 July 2007

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

Case of:

GORDON ROBERT BRUCE SKINNER MB ChB 1965 Glasg SR
Registration No: 0726922
(Day Two)

Panel Members:
Mrs S Sturdy (Chairman)
Dr M Elliot
Mr W Payne
Mrs K Whitehill
Mr P Gribble (Legal Assessor)

MR A JENKINS, Counsel, instructed by RadcliffesLeBrasseur, Solicitors, appeared on behalf of the doctor, who was present.

MR T KARK, Counsel, instructed by Eversheds, Solicitors, appeared on behalf of the General Medical Council.

Transcript of the shorthand notes of Transcribe UK Ltd
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THE CHAIRMAN: Good morning, everyone. My name is Sandra Sturdy and I am now the Chair of this Fitness to Practise Panel which is considering the case of Dr Gordon Robert Bruce Skinner. What I would like to ask first is are there any further legal arguments?

MR KARK: Madam, I hope there are no legal arguments but there is one matter to raise and that is the question of amendments to the heads of charge. Could I ask you to take up your heads of charge, please, and could I ask you to go, first of all, to 28(b) and I am going to ask to insert a date into 28(b), which is that:

> "You provided Mrs D with a prescription dated 17 November 2004 for Sodium Thyroxine",

- and that is based on a document that we have in the bundle which you will see eventually at 8.23. That is the first matter.

The second matter is that if you go to your heads of charge, and just by way of example if you go to 2(b) you will see that allegation:

> "The letter of referral contained the results of two previous blood tests showing Mrs A's Thyroid Stimulating Hormone (hereinafter referred to as TSH) to have been within the normal range."

I am going to ask to delete the word "normal", and this occurs on a number of occasions that I will take you to, and replace it with the word "reference". I should say that I have made Mr Jenkins, who defends, aware of all of these amendments. I do not think there is any objection but, of course, we will hear from him.

The next time that next same word appears is at 4(a), so, again, I would ask to delete the word "normal" and insert the word "reference", 8(b), 16(e), 25(d), 27(a) and 31(a).

Madam, your powers of amendment flow from rule 17(3), which provides that:

> "Where it appears to the FTP Panel at any time that
>
> > (a) the particulars of the allegation or the facts upon which it is based, of which notice has been given under rule 15, should be amended; and
> >
> > (b) the amendment can be made without injustice,
>
> it may, after hearing the parties and consulting with the Legal Assessor, amend the particulars on appropriate terms."

It is my submission that there is no injustice and indeed, I do not think there is any objection to the amendments.

THE CHAIRMAN: That is fine. Is there agreement with that?

MR JENKINS: Madam, certainly there is no objection to the amendments being made. So far as, thereafter, the amendments to change the word "normal" to "reference", again, whilst I am comfortable that the amendment should be made I have not had time to

discuss with Dr Skinner whether that series of allegations are admitted or not. I am entirely content that we start the hearing and if we are to admit those allegations I can do so in the course of the hearing. I know there are witnesses waiting. We have had a rather slow start to the case yesterday and I am entirely content that we start now. There are a number of admissions that I shall be making (*speaking off microphone*), as I say, it may be that I will add to them during the course of the hearing.

I do not think it affects the evidence Mr Kark is going to call whether those specific new amendments are admitted or not. I think he will have to call the evidence either way. I see him nodding. Certainly, you have power to allow amendments. I am perfectly content that those amendments should be made.

THE CHAIRMAN: Thank you. Are the Panel members happy and agree with that?

THE LEGAL ASSESSOR: Madam, you have been referred to the relevant section of the Rules. You have power to amend. There is no objection from both parties. Under those circumstances, it is a simple matter for the Panel. You, properly, do not need to retire in that case.

THE CHAIRMAN: That was what I was just asking. Thank you.

At this stage could I ask you, Dr Skinner, to stand and give your name and registration number?

DR SKINNER: Yes, thank you, madam. Gordon Robert Bruce Skinner, 0726922.

THE CHAIRMAN: Thank you. Do be seated.

The Panel Secretary will read out the allegation on the yellow pages.

THE PANEL SECRETARY: The Panel will inquire into the following allegation against Dr Gordon Robert Bruce Skinner, MB ChB 1965 Glasg SR.

"That being registered under the Medical Act 1983

1. At all material times you were practising as a private doctor from 22 Alcester Road, Moseley, Birmingham, B13 8BE.

PATIENT A

2. a. On 20 December 2002 Mrs A was referred to you by her NHS General Practitioner, Dr Cooke,

b. The letter of referral contained the results of two previous blood tests showing Mrs A's Thyroid Stimulating Hormone (hereinafter referred to as TSH) to have been within the reference range;

3. a. On 16 January 2003 you saw Mrs A as a private patient,

b. You took an inadequate history,

c. You carried out an inadequate examination,

d. You took a blood sample for thyroid chemistry results to be obtained,

e. You provided Mrs A with a prescription for Sodium Thyroxine 25µg per day for seven days followed by 50µg for four weeks,

f. Your prescription was provided prior to obtaining the biochemical results of the blood test,

g. You suspected a diagnosis of B12 deficiency,

h. In the light of your suspicion you failed to perform any investigation on Mrs A to assess a B12 deficiency,

i. You suspected a diagnosis of secondary hypoadrenalism,

j. In the light of your suspicion you failed to refer Mrs A to an endocrinologist or other relevant specialist for evaluation;

4. a. On or about 24 January 2003 you received the biochemical results for Mrs A's blood test that showed her TSH and Thyroxine level (hereinafter referred to as T4) to be within the reference range,

b. On 6 February 2003 you prescribed Mrs A with ½ Grain Armour thyroid per day for one week, followed by 1 Grain Armour thyroid per day for two weeks, followed by 1 ½ Grain Armour thyroid per day for six weeks;

5. Your prescribing to Mrs A was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

6. Your conduct set out above was

a. inappropriate,

b. unprofessional,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

7. a. Between 16 January 2003 and 6 February 2003, you spoke to Mrs A on the telephone who complained of new symptoms that could have been an adverse effect to your prescription,

b. You made no record in the patient medical notes of such conversations,

c. You failed to assess Mrs A or arrange for her to be assessed by her general practitioner;

PATIENT B

8. a. On 20 March 2003 you saw Miss B as a private patient without a referral from her General Practitioner,

b. At that consultation you became aware of the fact that results of her blood tests showed her thyroid chemistry to be within the reference range,

c. You took an inadequate history,

d. You carried out an inadequate examination,

e. You provided Miss B with a prescription for Sodium Thyroxine 100µg per day until 17 June 2003 to be followed by 125µg per day for the three months thereafter;

9. Your prescribing to Miss B was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

10. a. After 20 March 2003 you next saw Miss B on the 21 January 2004,

b. Between 20 March 2003 and 21 January 2004 you failed to monitor Miss B adequately or at all,

c. On or before 21 January 2004 you were aware of the results of a blood test set out in a report dated 9 December 2003, obtained by Miss B's NHS General Practitioner, Dr Blair,

d. The results of the above report showed that Miss B had become bio-chemically thyrotoxic,

e. This over replacement was a result of your prescribing Thyroxine,

f. On 21 January 2004 you provided Miss B with a prescription for Sodium Thyroxine 150µg per day for 150 days and Tertroxin 20µg per day for one month and thereafter 40µg per day;

11. Your prescribing to Miss B was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

12. a. On 18 March 2004 you saw Miss B again,

b. You provided Miss B with a prescription for Sodium Thyroxine 75µg or 100µg on alternate days and Tertroxin 20µg per day for an unknown period of time;

13. Your prescribing to Miss B was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

14. On 14 July 2004 you provided Miss B with a prescription for Sodium Thyroxine 150µg per day for three months;

15. Your prescribing to Miss B was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

PATIENT C

16. a. On 6 March 2004 you saw Miss C as a private patient without a referral from her General Practitioner,

b. You took an inadequate history,

c. You carried out an inadequate examination,

d. You took a blood sample for thyroid chemistry results to be obtained,

e. On or about 16 March 2004 you received the results of the blood test of Miss C which showed her TSH and T4 to be within the reference range;

17. On a day unknown before 8 May 2004 you prescribed Miss C with Sodium Thyroxine at an unknown dose and for an unknown period of time;

18. Your prescribing to Miss C was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

19. a. On 8 May 2004 you saw Miss C again,

b. You provided Miss C with a prescription (or agreed to the continuing of a prescription) for Sodium Thyroxine 150µg per day and Tertroxin 20µg per day for an unknown period of time;

20. On 8th May 2004 your prescribing to Miss C (or allowing the continuation of a prescription) was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

21. a. On 7 August 2004 you saw Miss C again,

b. You provided Miss C with a prescription (or agreed to the continuing of a prescription) for Sodium Thyroxine 150µg per day and Tertroxin 20µg per day for an unknown period of time;

22. Your prescribing to Miss C (or allowing the continuation of a prescription) was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

23. a. You suspected a diagnosis of B12 deficiency,

b. In the light of your suspicion you failed to perform any investigation on Miss C to assess a B12 deficiency;

24. a. On or after 16 August 2004 you received the blood test results for Miss C from the blood sample you had taken following the consultation on the 7 August 2004,

b. The blood test results demonstrated that Miss C had become bio - chemically thyrotoxic,

c. You failed to take steps to reduce or stop her thyroid medication,

d. You suspected that Miss C might be suffering adrenal failure,

e. You failed to refer Miss C to an endocrinologist to assess your suspicion;

PATIENT D

25. a. On 24 August 2004 you saw Mrs D as a private patient without a referral from her General Practitioner,

b. You took an inadequate history,

c. You carried out an inadequate examination,

d. She informed you that her recent blood tests had shown her TSH level to be within the normal range,

e. You took a blood sample for thyroid chemistry results to be obtained,

f. You provided Mrs D with a prescription for 25µg per day for seven days, followed by 50µg per day for twenty one days, followed by 75µg per day for twenty one days, followed by 100µg per day for sixty days;

26. Your prescribing to Mrs D was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

27. a. On or about 3 September 2004 you received the results of Mrs D's blood test that showed her T4 and TSH levels to be within the reference range,

b. In a letter dated 3 September 2004 you wrote to Mrs D's NHS General Practitioner enclosing the above results stating that you "would be quite prepared to institute a 4 month trial of thyroid replacement but will not proceed thus for 10 days to allow you the opportunity to comment on this strategy",

c. In a letter of response dated 7 September 2004 the three doctors at Mrs D's General Practice stated that (inter alia) "We do not feel it safe or appropriate for her [Mrs D] to have Thyroxine";

28. a. On 18 November 2004 you saw Mrs D again,

b. You provided Mrs D with a prescription dated 17 November 2004 for Sodium Thyroxine 125µg per day for three weeks, followed by 150µg per day for three weeks, followed by 175µg per day for six weeks;

29. Your prescribing to Mrs D was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

30. a. You suspected a diagnosis of B12 deficiency,

b. In the light of your suspicion you failed to perform any investigation on Mrs D to assess a B12 deficiency;

31. a. On or about 6 January 2005 you received a further result from the blood sample taken by you on 24 August 2004, namely the level of Tri-iodothyronine (hereinafter referred to as T3) which was within the reference range,

b. On 23 February 2005 you provided Mrs D with a prescription for Sodium Thyroxine 125µg per day for three months,

c. On 13 May 2005 you provided Mrs D with a prescription for Sodium Thyroxine 150µg per day for three months,

d. On 16 August 2005 you provided Mrs D with a prescription for Sodium Thyroxine 175µg per day for six weeks followed by 200µg per day for six weeks,

e. In a letter to you dated 31 August 2005 Mrs D's NHS General Practitioner stated that the doctors at the Practice did not agree that Mrs D should be taking Thyroxine and requested that you discharged Mrs D from your care,

f. On 18 November 2005 you provided Mrs D with a prescription dated 16 November 2005 for Sodium Thyroxine 200µg per day for three months,

g. Between 17 November 2004 and the 16 November 2005 you failed to monitor Mrs D adequately or at all,

h. On or about 24 November 2005 you received the results of a blood sample taken by you on 18 November 2005 which showed that Mrs D had become bio-chemically thyrotoxic,

i. This over replacement was as a result of your prescribing Thyroxine;

32. Your prescribing in relation to the dates set out in head 31 (individually and/or cumulatively) was

a. inappropriate,

b. unnecessary,

c. irresponsible,

d. not in the best interests of your patient,

e. to place your patient at risk of harm;

33. a. In a letter dated 1 September 2004 the General Medical Council, in the light of information it had received, invited you to agree that an assessment of the standard of your professional performance be carried out,

b. In a letter dated 3 October 2004 you agreed to undergo a performance assessment,

c. In a letter dated 10 November 2004 you returned the PDL1a and PDL1a2 forms completed which contained an acceptance of the invitation from the screener to undergo an assessment of the standard of your professional performance,

d. In a letter dated 6 January 2005 the solicitors acting on your behalf, Radcliffes Le Brasseur, wrote a letter to the General Medical Council stating that they had "received specific instructions" from you to the effect that you no longer agreed to an assessment of your performance being carried out,

e. Accordingly you have failed to submit to an assessment."

And that by reason of the matters set out above your fitness to practise is impaired because of

a) your misconduct,

b) your deficient professional performance.

MR KARK: Madam, before you ask whether there are any admissions, there is just one further amendment that I noted as the Secretary was reading the heads out and that is in 31 (a) just really to make better sense of it, I think. It reads at the moment:

> "On or about 6 January 2005 you received a further result from the blood sample taken by you on 24 August 2004, namely the level …"

I do not really think that makes much sense. It should be "… showing the level of, was within the normal range". So, can I read that again:

> "… the level of Tri-iodothyronine (hereinafter referred to as T3) which was within the reference range".

I think that then makes sense.

MR JENKINS: Again, I have no objection to the amendment. I do not think for the sake of completeness it needs to be read out again.

MR KARK: No.

MR JENKINS: Can I deal with admissions. I make it that there are about one hundred and ---

(*A short discussion then followed between the Chairman and the Panel Secretary*)

THE CHAIRMAN: Excuse me one moment. Could I just ask Mr Kark a question. At 25 (f) you say, "… provided Mrs D with a prescription of …", etc, but you do not say of what?

MR KARK: I think I know exactly what it was, it was thyroxine, but can I just check that from the documents and I will come back to you. Thank you for pointing that out.

MR JENKINS: That can be amended in later once Mr Kark checks it, but again I am entirely comfortable that amendments can be sought throughout the hearing just to adjust the notice of hearing as may be appropriate according to the evidence.

MR KARK: Yes. Can I say it was indeed thyroxine sodium and so could I ask that the - I am sorry to interrupt Mr Jenkins. So, could I ask that the word "thyroxine" be inserted between "for" and "25". So, "… with a prescription for thyroxine …" and then it just reads on. Thank you.

MR JENKINS: It seems to be a constantly changing picture, but we will have this typed-up, I am sure, and we will all be working from the same document very soon.

Madam, I make it about 140 separate allegations and so what I am going to do, if it is appropriate for the Panel, is take you through those heads of charge that are admitted and then go through the whole document again to indicate those that are not admitted and I hope I will have dealt with every single one of them.

THE CHAIRMAN: Thank you.

MR JENKINS: Can I start with head 1, which is admitted. 2 (a) is admitted. 3 (a) is admitted, as is 3 (d), (e), (f) and (g). 4 (b) is admitted.

I then turn to Patient B: 8 (a) is admitted and 10 (a) is admitted, as are 10 (c) and 10 (f). 12 (a) is admitted and head 14 is admitted.

Then Patient C, please: head 16 (a) is admitted, as is 16 (d). 19 (a) is admitted, 21 (a) is admitted and 23 (a) and 24 (a) are admitted.

Patient D: 25 (a) is admitted, as are 25 (e) and (f), which I think has just been amended. 27 (b) and (c) are admitted. 28 (a) and (b) are admitted. 30 (a) is admitted. 31 (b) is

admitted, as are (c), (d), (e) and (f). 33 is admitted in its entirety, (a), (b), (c), (d) and (e).

Can I go back to the start, as I indicated, and I hope indicate all the outstanding allegations that are not admitted. Those should be 2(b), 3(b), 3(c), 3(h), (i) and (j). 4(a), 5 in its entirety (a) to (e) inclusive. 6 in its entirety (a) to (e) inclusive. 7 in its entirety, (a) to (c).

Patient B, 8(b), (c), (d) and (e) are not admitted. 9 in its entirety, (a) to (e), is not admitted. 10(b), (d) and (e) are not admitted. Head 11 in its entirety, (a) to (e), not admitted. 12(b) is not admitted. 13(a) to (e) not admitted. Head 15 in its entirety, (a) to (e) not admitted.

For Patient C, 16(b), (c) and (e) are not admitted. 17 is not admitted. 18(a) to (e), that is the whole of 18 not admitted. 19(b) not admitted and head 20(a) to (e) not admitted. 21(b) not admitted and 22 in its entirety, (a) to (e), not admitted. 23(b), again, not admitted. 24(b), (c), (d) and (e) not admitted.

Patient D, head 25(b), (c) and (d) not admitted. Head 26 in its entirety, (a) to (e) not admitted. 27(a) is not admitted. 29 in its entirety, (a) to (e), not admitted. 30(b) and 31(a) not admitted. 31(f), (g), (h) and (i) not admitted. 32 in its entirety, (a) to (e), not admitted.

Madam, I hope that is the lot.

THE CHAIRMAN: Thank you for that, Mr Jenkins. I am assuming we have all got that now. I will go through all those that have been found proved in the allegations. Number 1, 2(a), 3(a), (d), (e), (f) and (g). 4(b). 8(a). 10(a), (c) and (f). 12(a). 14. 16(a) and (d). 19, 19(a). 21(a), 23(a). 24(a). 25(a), (e) and (f). 27(b) and (c). 28(a) and (b). 30(a). 31(b), (c), (d), (e) and (f). 33(a), (b), (c), (d) and (e) and that is it. It that agreed?

MR JENKINS: It is, thank you.

THE CHAIRMAN: These alleged facts have been found proved. Mr Kark, if you could open the case for the GMC?

MR KARK: Yes. Madam, this case concerns Dr Skinner's practice of prescribing thyroid treatment to patients who are not biochemically in need of it. Unnecessary treatment with thyroxin is capable of causing harm to the patients even though in the short-term the patient may feel better and their quality of life may temporarily improve.

It is the GMC's case that in respect of four particular patients, A through D, Dr Skinner's practice was both inappropriate and irresponsible. Dr Skinner is no doubt perceived by many of his patients as the man who helped to relieve their symptoms and he has no doubt helped a number of people to lead temporarily a higher quality of life than they would otherwise have led and he has no doubt a considerable following of grateful patients. However, his practice in respect of his treatment with thyroxin led him into conflict with a number of his professional colleagues and in respect of these four patients would not have had the support of any respectable body of opinion among fellow practitioners or endocrinologists.

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Although there may be wider issues as to the appropriate treatment of the patients who are symptomatic of thyroid disorder but are not known biochemically to be hypo, meaning too little, or hyper, meaning too much, thyroidic. That is not the issue in this case. This case involves these four specific patients. I expect that I will give this warning again in the future: that this Panel must concentrate on the specific charges laid before it and decide whether they are proved to the appropriate standard or not.

B

A brief explanation of the function of the thyroid gland and hypo and hyperthyroidism will no doubt assist and I will give such assistance as I can. However, this is a plainly highly specialised and technical area and in due course I will be calling two expert witnesses to assist the Panel. For those on the Panel who are medically qualified, or at least have a good understanding of the function of the thyroid, can I apologise in advance for the explanation that now follows. The thyroid gland is in the front of the neck either

C

side of the windpipe and it makes two thyroid hormones: thyroxin, which is referred to as T4 because it has four atoms of iodine in each molecule of thyroxin and Triiodothyronine, which is known as T3 because it has three atoms of iodine.

The role of the thyroid hormone is to regulate the metabolism and is responsible for the normal working of every cell in the body. T4 is inactive and its most important role, so far as we are concerned, is that it is converted mainly in the liver into T3 by the removal

D

of an atom of iodine. About 80 per cent of the T3 which the body has is converted through T4. The remainder comes direct from the thyroid gland.

The activity of the thyroid gland is itself governed by the pituitary gland which sits towards the front of the brain and the pituitary releases a chemical called Thyroid Stimulating Hormone, or TSH as you have seen referred to in the heads of charge. It is the amount of TSH in the body that governs how much T3 and T4 the thyroid gland will

E

produce. One of the most accurate ways in which the activity of the thyroid can be assessed is by an assessment of how much or how little TSH there is in the system.

Too little thyroid hormone is known as hypothyroidism and is manifested by various changes in the tissues and the functions of the body and the symptoms of hypothyroidism might include: lethargy; dry skin; increased weight; constipation; deafness; aching joints;

F

hoarse voice or tingling in the hands. The face may look puffy and the hair, including that of the eyebrows, might be very thin. Sometimes there is goitre, a large lump on the side of the neck, which forms.

Hyperthyroidism, attracts some of the opposite symptoms: low weight; loss of appetite; highly active metabolism and on occasions tachycardia or racing pulse. Possibly

G

consequent risks are stroke or heart attack.

Given the relationship between hyperthyroidism and loss of weight and greater activity certain patients might, of course, prefer to have too much thyroid hormone rather than too little.

One of the features of hypothyroidism is that many of the symptoms mirror those caused

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by depression and thus the most important diagnostic tool is checking the blood levels for T3, T4 and TSH. One common finding after blood tests is a normal T4 level but a raised TSH level. That can be a signal of future hyperthyroidism and is known as sub-clinical

hyperthyroidism. The study of this area of medicine is endocrinology, an area of medicine in which Dr Skinner has, no doubt, a keen interest but, we would submit, no formal training or qualifications.

Professor Weetman, who at the moment is the gentleman sitting next to me, is a witness. He is in the panel room because he is one of the GMC experts. He is a physician and a Professor of Medicine at the University of Sheffield and Dean of the Midland School. His main area of clinical practice is endocrinology and, in particular, thyroid disease and he is the President of the British Thyroid Association.

The standard treatment of thyroid hormone deficiency (or hypothyroidism) is with a drug thyroxine (or Levothyroxine), and it is a drug which in the body can readily be converted into T3, which is the active ingredient.

The goal of treatment is recognised by endocrinologists to be the normalisation of the TSH level. Using T3 in the T4 levels in the body to monitor thyroid activity is not recommended as those levels will change during the day, and so the level of TSH is generally regarded as the more reliable test.

One of the issues which may be raised by the defence in this case is that the standard applied for the lower and higher ends of the acceptable TSH level in the UK is wrong and is too wide, and I expect that we will hear that some in the US have argued for a narrower range. I will pause for a moment.

THE LEGAL ASSESSOR: As you have paused, I was reminding the Chairman, of course, that you do have to make an application in relation to your expert witness under rules of procedure 35(6).

MR KARK: In fact, I think the application has to be made when I call him, but you are absolutely right. I have mentioned deliberately that Professor Weetman is here. I would ask that he be allowed to remain.

MR JENKINS: There is no objection at all.

MR KARK: Thank you for reminding me and the Chairman. May I continue?

As I was saying, some may argue that the level at the lower and higher ends of what is said to be an acceptable TSH level is wrong and some in the US, for example, have argued for a narrower range. In the UK allowance is generally made up to 4.5 milliunits per litre but, nevertheless, in this case, as the Panel will hear, each of the four patients had a normal TSH level or, rather, I should say, a TSH level within the reference range, even applying the narrowest of American-based levels. In other words, all of these patients were within the reference range, applying any medically accepted range for TSH level.

When the thyroid level, or T3 and T4, is low the TSH produced by the pituitary gland will rise in order to activate the thyroid into producing more T3 and T4. When the thyroid level in the blood is high the TSH level will normally be suppressed and if the T3 and T4 level in the blood is too high the patient becomes thyrotoxic and the TSH level will be very low or undetectable.

Prolonged periods of over-treatment with thyroid hormone, which is associated with

those very low TSH levels, increases the risk of the patient developing atrial fibrillation and irregular heart beat associated with the risk of strokes and a lessening of bone density which can lead, in the long term, to fractures.

Although he regularly prescribed thyroxine when, we submit, it was not indicated, Dr Skinner does not appear to have warned his patients of those potential hazards. In addition to thyroxine, Dr Skinner also made use of an animal-based thyroid extract known as armour thyroid extract. Again, you see reference to that in the heads of charge, which is normally based on extracted and desiccated pigs thyroid. It is not normally prescribed in the UK, nor is it licensed, but it can be obtained from the US and it is certainly not unlawful to prescribe it here. It is not recommended in this country by endocrinologists as the levels of T3 relative to T4 in armour thyroid extract are higher, much higher than those naturally excreted by the body, but it is right to say that some patients appear to prefer it.

In the UK the typical adult range for TSH for a healthy individual would be regarded as being between 0.3 and 4.5 milliunits per litre. As you will see in due course when we look at some of the blood tests, you will see, in fact, that the reference range is given in each blood test.

Any patient with an elevated TSH level outside the assay level is likely to be diagnosed as having hypothyroidism and may require thyroid treatment, but any patient within that range, according to both of the GMC experts, should not, in normal circumstances, be placed on thyroxine.

At the heart of this case is Dr Skinner's belief that thyroid function tests based on blood tests are an unreliable measure of thyroid failure. I say that because he, in effect, declares that in a number of letters that he writes to general practitioners. His treatment in respect of these four patients and the comments he makes in various letters makes it clear that he believes that people with symptoms of hypothyroidism but normal biochemical tests, those who are known as euthyroid, should, nevertheless, be treated with thyroid hormone. That is a position which is not accepted by either of the GMC experts in this case, nor is it a position which was accepted in the GPs of these patients who had dealings with Dr Skinner.

One danger that Dr Skinner ran was that his patients would become thyrotoxic. In other words, that the thyroid T3 and T4 in their system was so high as to be capable of doing their bodies harm. Three of the patients about whom you will hear did indeed become thyrotoxic.

Only one of the four patients about whom you will hear complained about her treatment. Two are not willing to assist the GMC and one other will give evidence, but I expect you will hear from her some praise of Dr Skinner. She felt better under his ministrations. That does not alter the fact, as we suggest, that what Dr Skinner was doing was medically wrong and potentially harmful to his patients. Furthermore, it seems that on occasion he was so intent on prescribing thyroxine that he failed to make a proper examination to look for other causes of the problems that the patients were suffering from. He failed, say the GMC experts, to take a proper history and he regularly ignored the biochemical tests which showed that these four patients were euthyroid. He would also prescribe thyroxine without even waiting for the blood tests to come back and even when he got the blood tests back which showed that the patients were within the reference levels, or showed that

his patients had developed thyrotoxicosis because of his prescribing, he continued to prescribe his patients with thyroxine.

Once he had begun prescribing thyroxine to these patients he allowed them to continue with the drug without, we submit, ensuring that they were properly monitored. He did not put in place proper reviews. Even when he was warned by the patients' GPs to stop what he was doing he carried on regardless.

The second expert from whom you will hear comes from a different standpoint to Professor Weetman. Mr John Lynn has been a consultant endocrine surgeon since 1978 at the Hammersmith Trust in London and he has run a thyroid clinic for the same amount of time. He retired in 2006 and still practises privately. He has examined the papers in this case and will give his views. It is useful, in our submission, to hear from a different type of expert.

In 2004 Dr Skinner was invited by the GMC to undertake a performance assessment and, ultimately, he refused. However, before he decided not to undertake a performance appraisal he did fill in a portfolio and provided that to the prospective assessment team. That portfolio is revealing in that it lays out in clear terms Dr Skinner's beliefs and agenda. I am not in a position to pass that bundle to you just yet. It is not in your bundle 1, which I think you have already been given, but we will, I hope, be able to do that later today, but he makes it clear, first and foremost, that he does not act as a GP but simply as a secondary referral centre for the treatment of hypothyroidism. That may be thought to lead immediately to an issue of fundamental importance in this case. Without a proper and full examination Dr Skinner could not exclude alternative diagnoses. He jumped, suggest the GMC, into a diagnosis of hypothyroidism without taking a careful history in respect of each of these patients, without conducting a firm and proper examination and without considering the differential diagnoses. Thus, a constant refrain from Professor Weetman and one which is reflected in the charges is that he failed to examine his patients appropriately, which led to the possibility of the misdiagnosis of the immediate complainant.

Let me turn then to the background facts in relation to each of the four patients from whom you will hear. Could I ask you to take up the bundle you have been given? It should be marked on the front “file 1” and I would ask that that be given an exhibit reference C1.

THE CHAIRMAN: Thank you. That will be C1.

MR KARK: Could I just explain how it works? I hope you have an index in the front. Can I also ask you, in relation to the charges, have you got, behind the charges, the table of the real names of the patients with their anonymised letters? No. Then we must provide it to you. Apologies. We will provide, at lunch, a schedule of who we are actually dealing with.

What you will find in this bundle is tabs 1 and 2 both relate to Patient A. The first set of notes will be the GP records for Patient A. The second set of notes, at 2, will be Dr Skinner's private consultation records relating to that patient. So it goes on: 3 is GP notes for Patient B, 4 is Dr Skinner's notes for Patient B and so on with 5, 6, 7 and 8. In other words, they go in pairs.

A

The first patient from whom you will hear, Patient A, will, I hope, be giving evidence over a video-link. I will make an application for that to happen, but I am afraid that became necessary because of problems that we had, as you know, yesterday. The patient was here but she has been unable to return today so we would ask for her to give evidence over a video-link and, again, I do not think Mr Jenkins will have any objection to that.

B

She came to Dr Skinner back in December 2002 when her general practitioner, Dr Cooke, somewhat reluctantly it would appear, referred his patient to Dr Skinner. Can I take you to that referral, and you will find it behind tab 1 at page 44. That is a letter that you see is dated 20 December 2002. Her GP had tested her thyroid function and found it to be within the reference levels and the letter to Dr Skinner revealed that a blood test he had taken on 27 July, as you will see the second entry down, shows TSH 1.49, I think it is microunits per litre, and on 13 May TSH level 1.45, and, as you will hear, those were both within the reference level. However, the patient had been feeling exhausted and

C

lethargic and, in fact, she took advice from her reflexologist to go and see Dr Skinner.

That consultation took place on 16 January 2003 and you will find the notes in the Dr Skinner section at 2, page 12. We have been given, and I am very grateful to Dr Skinner and Mr Jenkins for this, some typed translations of these. I am going to suggest that you slip *these* into the bundle at the relevant places. Can I pass them out and then I will explain what to do with them. *(Same handed)* They are not, in fact, absolutely

D

complete. I do not make any criticism of that. I think there are one or two bits missing, but they are certainly very helpful.

Could you take up the first page and you will see, in fact, that does, rather helpfully, have the patient's name at the top and also "A" next to it. Can I suggest that you slip that in behind tab 2? Although it is not paginated we know what it is. I am not going to give it a separate exhibit reference. I do not think we need to.

E

THE CHAIRMAN: Shall we call that 12A, to keep it more simple?

MR KARK: 12A? No. If we can slip it right at the front. If you turn over tab 2. The first page at the moment is page 1, so can you just put it in front of page 1, and then you will know each time where that is, as it were. The same with the second in relation to Patient B. That is two pages. If I could ask you to turn to tab 4 and put it just behind tab 4. So, again, right at the foot of Dr Skinner's notes in relation to Patient B you will have

F

his translation of them. *(Same handed)*

At tab 6, if you take up the next two pages in relation to Patient C, may I respectfully suggest you pop those just behind tab 6, so right at the beginning of Dr Skinner's notes for Patient C.

G

Finally, for Patient D, if you could turn over to tab 8 you will find that those should be at the beginning of Dr Skinner's note in relation to that patient. So in future if one needs to serve what Dr Skinner has been writing in these notes then we just go to the beginning of that section each time.

Now, as I say, the consultation took place on 16 January. The notes you will find at page 12. I have just understood what your Secretary was saying, but the reason for not doing

H

that is because there are notes elsewhere in the bundle and we cannot match everything up quite so exactly.

THE CHAIRMAN: So, Mr Kark, just to keep it clear for everyone, we are under tab 2, page 12?

MR KARK: We are now under tab 2, page 12.

THE CHAIRMAN: Thank you.

MR KARK: If you want to have a finger in page 12, you can now actually also go back to the first page in tab 2 and you will be able to understand more readily what is written at page 12.

THE CHAIRMAN: Which really we could call 2 (a), could we not? Page 2 (a), is that what you mean?

MR KARK: I would simply call it (a), actually. I would not call it 2 (a). I would just call it (a), if you wish to.

THE CHAIRMAN: Yes.

MR KARK: As you see, the notes of the consultation appear at page 12, and you can see what that patient was complaining of if you go to the front of the bundle where the typewritten explanation is:

> "[Complaining of] 'feeling knackered, flat and lifeless' ... Scattered aches and pains, tightness of hands, brain in slow motion, Forgets names, side vision hallucinations, asocial and weepy, paraesthesia of hands and feet
> No libido, blurred vision …",

etc. Then there is an examination, which includes a reference to:

> "… voice hoarse, yellowish pallor, loss of outer half of eyebrows, tongue slightly enlarged, eyes slightly blood shot, skin dry with cracked heels, thyroid palpable (+). Blood pressure 105/60".

Well, Patient A attended the surgery. She was slightly surprised about the appearance of the surgery and we will hear a little more about that from her, but Dr Skinner commented almost straightaway on the fact that she had what he called "thyroid eyebrows" and he also asked if she had shadows in the periphery of her vision, which she confirmed that she did. He took a blood test from her, but he told her then and there that he believed that she had an underactive thyroid and that the blood test would confirm that diagnosis. He decided then and there to start her on thyroxine and he gave her a prescription for thyroxine that day before he had the results of the blood test. You can see that prescription at page 14 of tab 2.

The following day, 17 January, he wrote to Dr Cooke and that letter is at page 15. You will see that he thanks Dr Cooke for the reference and he writes in his second paragraph that:

> "[Patient A] has a history of six years utter fatigue, scattered aches and pains, occasional side vision hallucinations which I find to be quite common in hypothyroidism, absence of libido and blurred vision and all in all it sounds rather suspicious of hypothyroidism; she also has a hoarse voice, yellowish pallor to her skin and bradycardia of 56/minute with cracked heels and I think it is really quite likely that she is hypothyroid and perhaps B12 deficient ..."

The next paragraph:

> "I know that she has had one or two highish TSH readings"

- well, the TSH readings were not highish at all -

> "but unfortunately nobody seems to have carried out an FT4 which will be at the laboratory end of things ..."

He then writes in the third paragraph:

> "I really thought there was a good case for institution of thyroid replacement having taken a blood test and I have laid out a programme of thyroxine replacement …",

and he then sets out what it was.

The patient did start taking thyroxine and in fact she developed headaches and became very tense, although according to Mr Lynn, the second of the GMC's experts, that reaction probably had nothing to do with the treatment. However, when at first she tried to get through to Dr Skinner to talk to him about those problems, she spoke to a woman at his surgery who simply told her to stop taking thyroxine. She then managed to speak to Dr Skinner over the phone and he changed her prescription to armour thyroxine. It is right to say by that date in February that particular patient had lost confidence in him and wrote to tell him so. She wrote a letter which we will look at in greater detail when she is here, or rather there as we will be seeing her on the video link, and that letter is at page 20. Well, according to the patient, she had at least one telephone conversation with Dr Skinner which is not recorded in his notes.

The blood test came back on 24 January, so some seven days or so, or eight days, after he had started the patient on thyroxine. If you go to page 16, please. You will get used to reading these, if I may say so. They appear to be a bit of a muddle at first, but you will see the patient name and date of birth. In the bottom right-hand corner you will see the date of "24/01/2003" and then up above:

> "Tests Requested: T4 and & TSH.
>
> Specimen Type: Serum
>
> Date Received: 21/01/2003",

A

and so that was not received until five days after the treatment with thyroxine had begun. Underneath you will see on the left:

> "Results and Comments: T4 & TSH".

B Then reading along across the page:

> "T4 [equals] 12.2 … TSH [equals] 1.4 ...",

and in each of these blood tests, as I mentioned, you will see the reference range:

> "T4 [reference] range 9.0 - 20.0 ...
> TSH [reference] range 0.5(*sic*)-5.5 …",

C

and this TSH was at 1.4. That is one of the reasons for amending the heads of charge, because it is the reference range that is referred to in each of the blood tests.

That TSH range as demonstrated by the laboratory undertaking the test was not only within the range set in this country, but also (for what it is worth) within the range set in the USA as the proposed normal range.

D

In due course, Patient A was in fact referred to Professor Franklyn by Dr Cooke. You will be hearing from Dr Cooke later this afternoon.

Professor Weetman has also examined the notes of the original consultation, which you have been looking at at 112, and his view is that on the basis of the notes an inadequate history seems to have been taken and an inadequate examination carried out.

E

Although the patient will tell you that she spent up to 30 minutes with the doctor, the notes revealed that the history taken was inadequate and some of the most basic tests do not appear to have been carried out. There was no test of the abdomen, or respiratory system, nor were her hearts sounds concerned. Professor Weetman is also critical of the failure by Dr Skinner properly to reassess the patient when she telephoned him, having had these problems, complaining of what appeared to be ill effects from his medication.

F

By his letter to Dr Cooke of 13 February Dr Skinner appeared to be suggesting that in addition to her hypothyroidism she was possibly suffering from B12 deficiency, and you will see that in the second paragraph at page 15 where he writes two lines up from the bottom:

G

> "… it is really quite likely that she is hypothyroid and perhaps B12 deficient ..."

That is a condition which Dr Skinner failed, according to Professor Weetman, to address. He should either have referred this patient himself to an endocrinologist, or he should have advised Dr Cooke to do so.

H

Mr Lynn is also of the view that this patient was placed on thyroxine unnecessarily and

that this patient was, in all probability, depressed.

The GMC suggests that for Dr Skinner to have placed the patient on thyroxine when he did and in the manner that he did without waiting for blood tests and when he was in possession of two blood tests which revealed her TSH to be within the normal range was wrong and he failed to examine her, or make a note that he had done so. Even once he got the blood tests back, as we know he did, which demonstrated that the patient was euthyroid, he continued along the same set of tracks. This case demonstrates the essence of the complaint against the doctor, which is that he followed a pattern of prescribing thyroid hormones even when confronted with blood tests which did not support his diagnosis.

Can I turn to Patient B. Patient B is one of those patients from whom you will not be hearing. It may well be that she was happy with her treatment by Dr Skinner. Nevertheless, the GMC submit that his treatment of her was in the circumstances inappropriate and wrong.

Dr David Blair is a general practitioner in Gourock in Scotland. He saw his patient on 13 January 2003 and, if we turn over to tab 3, you will find his notes (which are fairly typically illegible) at page 27.

The patient provided him with a list of her symptoms, and you will find that I expect rather easier to read than these notes. If you go over to page 105 in the same section, you will see that it is dated at the top in fact 28 January. We will have to confirm if we can when Dr Blair received this, but the symptoms were:

> "LACK OF ENERGY/ENTHUSIASM/CONFIDENCE
> CHOKING FITS/AIR BUBBLES/DRY THROAT
> GRITTY, ITCHY EYES",

and I think it is:

> "HEAD NOISES
> FLAKING, BRITTLE NAILS
> SWOLLEN ANKLES
> OVERHEATING
> MEMORY LAPSES/CONFUSION
> PROBLEMS RELATING".

If you go over to page 107, as with many of these patients she had done her homework and she produced a further list of symptoms of hypothyroidism which appears to have been taken off the Internet and upon which, as you see, she had ticked those which applied to her. The symptoms from which she was suffering included lethargy, choking fits, brittle nails and overheating, among others.

Dr Blair asked for her blood to be checked and he asked for a full thyroid test. He saw his patient again on 28 January, when she was asking about Dr Skinner. Dr Blair believed her to be depressed, and by that time he had the blood test which you will find at 3/104. When I refer to 3/104, I mean tab 3/104 and I will use that shorthand if I may. You will

see that it is dated on the bottom of the page 15 January 2003 and you will see that the free T4 was - if you go to about two-thirds of the way down the page you should find the words "Free T4", underneath which you will find the reference range and underneath which you will find "16.8". I have made liberal use of a highlighter to make these rather easier. The TSH you will see is at 2.4, and you will see that in respect of both of those they might be thought to be bang in the middle of the reference range. The reference range for this test was for T4 between 10 and 24 and TSH between 0.4 and 4.

Dr Blair asked to see his patient again and he saw her on 28 January, when she was asking about Dr Skinner, and as I say he by that time had that blood test. In late March, his patient having gone from his practice, he received a letter from Dr Skinner which indicated that Dr Skinner had seen his patient. You will find that at page 113. It looks as if the patient had simply taken herself off to see him.

Dr Skinner writes:

> "I hope I would not be in the dog house with you as I thought this lady was bringing a letter of referral from your office but she told me a slightly complex story of eventually telling you not to bother with the letter so apologies if you did not intend her to come and see me.
>
> [She] is [in] one of these difficult situations where she seems almost classically hypothyroid".

Well, that is notwithstanding the thyroid chemistry and he describes her as "a very good case for thyroid replacement". He describes how he has given her - and this is in the third paragraph down:

> "… I have given her a prescription for thyroxine sodium but I have suggested she does not begin this medication for perhaps ten to fourteen days lest you do not wish her to come and see me and it would be discourteous to institute this without your knowledge."

His own notes appear at page 4/4 (so tab 4, page 4) and the date at the top I think is 20 March. If you go back in that section you will see that Dr Skinner had, or appears to have had, in his own notes those blood tests. If you look at page 2 and page 3 of tab 4, the first is dated 21 August 2002 right at the bottom side of the page (so tab 4, page 2) where the Free T4 and TSH is shown to be 16.7 and 2.3. Then over the page, page 3, dated 15 January 2003, showing that the Free T4 was 16.8 and the TSH was 2.4.

Well those were biochemically fairly and squarely within the reference range, but nevertheless Dr Skinner began prescribing her thyroxine.

Dr Blair, when he next spoke to his patient on 8 April, advised her against taking the thyroxine and did so repeatedly thereafter when he saw her, but she appears to have continued with the thyroid treatment offered by Dr Skinner.

By 5 December 2003, so at the end of that year, her blood levels you will find - if we stay in the same section it is easiest - at page 8. So tab 4, page 8. You will see this is set out

slightly differently but the date is in the bottom right-hand corner: 9 December 2003. You will see that free T4 is shown as being 39.0 whereas the reference range for this laboratory is between 10 and 24. So she is very excessively, one might think, outside the T4 reference range. Her TSH is less than 0.1 and that is well below any reference range. It is a negligible reading.

On 4 December 2003 when Dr Blair examined her he declared her unfit to work as a result of an effective disorder.

Six weeks after those blood tests, on 21 January 2004, Dr Skinner continued prescribing thyroxine. He prescribed a lower dosage of thyroxine, in other words T4, but added T3 to the prescription. He explained that by a letter dated 28 January 2004 to Dr Blair, which you will find at page 11. He said:

> "A note on [Patient B] who has noticed some improvements on thyroid replacement but is clearly still hyperthyroid notwithstanding highish FT4 readings."

They were not highish, they were very high indeed:

> "I think the obvious hypothesis is that she is not converting T4 to T3…",

You will remember that is T3 which is active and T4 which requires conversion:

> "…and thus back stacking T4."

According to Professor Weetman there is absolutely no evidence to support that whatever and Dr Skinner writes:

> "…I thought the solution was to reduce her thyroxine to 150 micrograms per day and supplement this with 20 micrograms of Tertroxin…",

in other words T3:

> "…for one month proceeding to 40 micrograms of Tertroxin…"

In fact, by this stage she was thyrotoxic. The pharmacist queried the prescription that was given, as you will see at page 18. The pharmacist when presented with this prescription noted on the bottom right-hand corner: "Dispensed thyroxin only". In fact, according to Professor Weetman, there was no evidence of back stacking, she had simply been overdosed with T4 and concerns were such that on 26 January Dr Jordan, Medical Director of the Argyll and Clyde Trust, brought that to the attention of the GMC.

When on 28 January Dr Skinner wrote to Dr Blair back on page 11 he described her, as I have mentioned, as having a "highish T4." She did not have a highish T4, according to Professor Weetman she was thyrotoxic.

On 27 February 2004 Dr Blair brought the matter to the attention of the GMC. You will find his letter at page 19 of tab 4. I will not go through that now, we will hear from Dr Blair I hope later today.

Dr Skinner wrote to Dr Blair again on 22 March in which he mentioned that the patient had complained of a racing heart. Can I take you back to tab 3, page 115, I am sorry to keep jumping between the two sections. He writes, as you will see on 22 March 2004 - so that is post those blood tests:

> "[Patient A] visited my room today and indeed I saw her on a courtesy basis. … I am not sure how well alcohol goes with thyroid replacement.
>
> …
>
> As you know she is now taking 75 micrograms thyroxine per day 20 micrograms of Tertroxin and she seems in reasonable shape although I still think she is hypothyroid."

Again, according to Professor Weetman she was anything but hypothyroid. He responded to the complaint from the GMC. You have that, I hope, if you turn up tab 4, page 25, and he was plainly, if I may say so, slightly annoyed about the criticism from Dr Jordan and somewhat dismissive of it and he says in the fifth paragraph down:

> "May I respectively request that we have some precision in the nature of the complaint from Dr Jordan, the perceived shortfall in the prescription which the Tesco pharmacist deemed improper…."

According to Professor Weetman the Tesco pharmacist was absolutely right:

> "It is disappointing after 40 years of practice wherein I have had no complaint or litigious procedure that my professional reputation is being sullied by an uninformed and strangely adversarial communication to the General Medical Council."

If you could keep your finger there, bearing in mind that that comment was made on 23 March 2004, you might like to go back to tab 2, page 27, a letter which Dr Skinner wrote to Dr Cooke in relation to Patient A where again he repeats the observation in the last paragraph that he writes:

> "The outcome of the professional relationship with [Patient A] is of course very upsetting and indeed I have never had to date any complaint in thirty five years of practice...",

by March 2004 he had possibly forgotten that earlier problem with Patient A.

Eventually Dr Blair managed to persuade Patient B to come off thyroxine and by October 2004 she was off it and by November she was back to normal thyroid function as shown

by her blood tests. It is at page 118. The results also show the rapid decline in thyrotoxicity from December 2003 back to normal levels in November 2004.

Professor Weetman is very critical about a number of aspects of Dr Skinner's treatment of this patient. The record of examination, which you have at tab 4, page 4, is inadequate. Dr Skinner does not reveal either in his notes or in his letter to Dr Blair the dosage of thyroxine that he has prescribed. The dosage is only found at 4/ 7. Dr Skinner, according to Professor Weetman, should not have prescribed thyroxine in the first place. By January 2004, even when Dr Skinner was aware that his patient was thyrotoxic, according to the December results that you have looked at, he still stated she was hypothyroid and her results were entirely compatible with the fact of over-dosage of thyroxine.

When he saw the patient in March, despite complaints of racing heart, he still did not order any further blood tests. In July 2004 it appears that he increased the dosage of thyroxine and you have that at page 28 of tab 4, dated 14 July 2004: "Please supply sodium thyroxide". So that is despite the blood test, despite the complaint of a thudding heart Dr Skinner continues to supply thyroxine and there is no evidence that any new blood test was taken to justify that. Nor, indeed, did he write to the general practitioner to let him know what he was doing. All of that behaviour falls far below the standard of acceptable practice by a medical practitioner according to Professor Weetman.

Mr Lynn also takes the view that this lady was unnecessarily treated with thyroxine. She did not need thyroid replacement. She was placed on a high dose which was inappropriate.

Let me turn to Patient C. You will not be hearing from Patient C. I am going to try and, if I can, deal with Patient C then perhaps we could have a break. Patient C's GP was a Dr David Summers of the Belgrave Medical Centre. He has no record that this patient ever consulted his practice about her thyroid function and he did not refer this patient to Dr Skinner but nevertheless it seems that this patient went to see Dr Skinner and Dr Skinner began treatment with thyroxine. The first Dr Summers heard about it was when he received what I will refer to as the 'dog house letter' on 10 March 2004. I do not have a reference for that at the moment but I will find it in a moment.

MRJENKINS: Tab 6, page 2.

MR KARK: I am grateful. Thank you. Yes, thank you very much. This is the letter dated 10 March 2004 written to Dr Summers at the Belgrave practice in Pimlico Road stating:

> "I may be in the dog house as this lady came to my rooms and was meant to be bringing a letter of referral."

When he received that letter from Dr Skinner which revealed that, in Dr Skinner's view, this lady was hypothyroid and that Dr Skinner had taken a blood sample, in due course Dr Summers agreed to prescribe thyroxine on the basis that Dr Skinner was saying that it was medically indicated but he never saw the results of the blood tests. Had he seen them he would not have been giving this patient prescriptions which he did and he, Dr Summers, will tell you relied on Dr Skinner acting appropriately.

Dr Julia Ince became this lady's general practitioner in Wimbledon Village when she registered as an NHS patient in September 2004. By that time she was already seeing Dr Skinner, of course, who had diagnosed her as hypothyroid back on 6 March. You can see his notes, it is perhaps easier to go to his typewritten notes, which you will see right at the beginning of tab 6 in the extra documents that you put in earlier. It seems that, in fact, the patient was started on thyroxine.

The patient first saw Dr Ince on 7 September 2004 when she was concerned about her treatment and blood was taken from her for the purposes of checking her thyroid function. You will find that, or a note of that at the back in Dr Ince's notes. If I can ask you to go back to tab 5, page 1, you will see that the blood tests were taken on 7 September and then on 24 September there is the note of the result and you will see, I think it is the first entry for 24 September, that the TSH level is 0.01, so dramatically suppressed and that, we would submit, was because she was by then on Dr Skinner's doses of thyroxine.

Further blood was taken on 15 October 2004, we will see at page 1A, and those results showed that her T4 was slightly down, if you look slightly up from the middle of page you will see the TSH level as 0.01, still suppressed. She was advised to stop all treatment with thyroxine and, in fact, the patient appeared to have felt better off the medication.

When Dr Ince got hold of the full records from her previous practice which had the blood tests for March and August of 2004 she was concerned to see that there was no biochemical evidence of hypothyroidism and that as a result of the prescribing by Dr Skinner by August this patient had become thyrotoxic. So she wrote to Dr Skinner, you have her letter at page 9 of tab 5, on 11 January 2005, she wrote:

> "I would be grateful if you could provide me with more information about the diagnosis of hypothyroidism in this lady. Could you please confirm the symptoms that she was suffering from and also any blood test results which you have which confirmed the diagnosis. Could you please clarify the dose of thyroxine?"

She received a reply to that dated 2 February which you will find at page 11 of the same tab. There had been a bit of confusion about finding Patient C's notes. In the third paragraph he writes:

> "As you say, [Patient C] had a number of features and I thought her thyroid chemistry was suggestive of hypothyroidism but as the years go by I have become less and less reliant on thyroid chemistry as an index of diagnosis for treatment level in hypothyroid patients."

First of all, Dr Ince had not said anything about there being a number of features of hypothyroidism and the chemistry did not support his diagnosis.

If you go to page 3 of tab 6 you will find the blood test which resulted from that first consultation between Dr Skinner and Patient C. The consultation, you will remember, took place on 6 March 2004. You find that in your typed notes right at the beginning, which are a reflection of page 1 of that tab. Here you have the blood test, dated 16

March, which reveals that the patient's T4 was at 11.6, the reference range being between 9 and 20, and the TSH was 2.2 milliunits per litre, the reference range being 0.4 to 5.5. So, again, well within, we would submit, the reference range. There was nothing, we would suggest, in the patient's chemistry suggestive of hypothyroidism.

Dr Ince, thereafter, wrote to a consultant endocrinologist for advice and Dr Prentice, from whom you will hear, wrote back to say that in his view prescribing was inappropriate.

Dr Skinner saw the patient again on 8 May and you have his notes at page 4 and, again, the type-written notes, for which we are grateful, are helpful. You can see that in the middle of the page in the typed notes there is reference to a follow up consultation on 8 May 2004. He sets out his treatment plan in a letter to Dr Summers, you will remember, the patient's GP, dated 10 May, so two days after that consultation, and if you go to page 6 of the same tab you will see that he writes, on 10 May, and this is, of course, three weeks after he has had the blood test which you had back at page 3:

> "A note on [Patient C] who I think is already improving on thyroid replacement although she has recently and off her own bat put her dose up 200 micrograms ..."

Again, he writes:

> "I thought we need to rationalise and stabilise the situation and perhaps add in some T3 if there is a conversion problem ...
>
> In spite of ups and downs, I think we are on a fairly decent track with [Patient C] and I will keep you abreast of developments."

Can I just mention in passing, I am trying very carefully not to mention patient names but can I ask that there be, through you, Madam Chairman, no press reporting of patient names if they are mentioned?

THE CHAIRMAN: Thank you. Yes, I would like to, obviously, suggest that. Is that something you say or I say at this stage?

MR KARK: Once you have said it the press are normally very good about it.

THE CHAIRMAN: I would request, please, that no patient names are mentioned during this evidence giving. Thank you.

MR KARK: Following that letter, we know that Dr Skinner saw his patient again on 7 August, and you have his notes at page 8 of this section, tab 6, and he appears to have taken another blood test, and a further blood test dated 16 August, so after some five months of treatment by Dr Skinner, you will find at page 10. You will see at tab 6, page 10, that by that stage her T4 is 25.5 and her TSH is below 0.1. So she is above the reference range for T4 and well outside the reference range for TSH.

According to Professor Weetman, not only were those outside the reference range but they demonstrated that the patient had become bio-chemically thyrotoxic.

He described the results in a letter at page 18 and he writes to his patient, on 1 September

2004, telling her:

> "Here are your thyroid chemistry and cortisol which indicate that the level are a little on the high side but if you are not feeling any adverse effects then I think you should stay at the same dose ..."

Dr Ince, because this patient had by now passed on to Dr Ince, consulted a Dr Cundy, a partner at the practice, who reviewed the case and he also reported the matter by letter to the General Medical Council.

Professor Weetman has, you will not be surprised to hear, a number of criticisms in relation to Dr Skinner's prescribing to Patient C. Once again, on the basis of the notes, the examination and history appear to have been inadequate, he is critical of the doses of thyroxine given to the patient. He does not understand how Dr Skinner could write on 10 May, at page 6 of your bundle, that there was no evidence of her being thyrotoxic when he does not appear to have a blood test to support that observation, the last test having been performed back in March.

The notes that you have at page 8 of 7 August reveal that Dr Skinner appeared to believe, in addition, that the patient was B12 deficient, because you will see the reference to B12 at the top right-hand corner of page 8, and according to Professor Weetman there appears to have been a failure to deal with that deficiency or make a proper investigation of it. Again, Mr Lynn is of the view that treating this patient with thyroxine was inappropriate and totally unnecessary and could put her at risk of harm.

As ever, this opening is taking longer than I hoped. I wonder if now would be a convenient moment to take a break?

THE CHAIRMAN: Thank you for that. I think we will break until twenty-to twelve. Thank you.

(*The Panel adjourned for a short time*)

THE CHAIRMAN: Could I just mention, please, to the public if by any chance a patient's name is mentioned by mistake would you please, obviously, not take that outside of this room? Thank you very much.

MR KARK: Madam, I was going to turn then to Patient D, who is a patient from whom you will be hearing. She may be supportive of Dr Skinner, I do not know, but she is called in order to present a full picture before you.

She had suffered from a lack of energy since having her third child in 1999. Her weight increased and fluctuated and she became lethargic and emotional, and she had a family history of thyroid problems and she certainly believed that her problem might stem from a thyroid condition. A blood test, which you will find at tab 7, page 81, revealed that her TSH level at 1.1 microunits per litre was, again, within the reference range.

Her regular GP was a Dr Stewart and it is fair to say that she had a difficult relationship with that particular practice but she does appear to have trusted Dr Stewart to treat her.

Her thyroid function was tested again in July of 2004. That blood test we are looking at

the moment, as you can see at the bottom, is November 2003 and her blood was checked in July of 2004, which you will find at page 83. Again, TSH was found to be within normal limits, but she wanted a referral to Dr Skinner. Dr Stewart was very loath to give her one and in his letter he made plain his views about Dr Skinner, which you will see at page 86, and he writes to her in the July following that blood test:

> "I am pleased to tell that your thyroid function tests, including Free Thyroxine, are completely normal, indicating good thyroid function at the present time. In addition, your tests for Hashimoto's thyroiditis is also negative ...
>
> It would neither be safe nor wise for us, Dr Skinner, or anyone else, to start you on Thyroxine. Undoubtedly, this would give you more energy and make you feel better but it would cause your thyroid gland to switch off and would cause you to have overactive thyroid disease ..."

He finishes this letter:

> "We are not sending any patients to Dr Skinner at the present time and I trust he will be investigated by the General Medical Council to see if his practices are appropriate and safe, although I myself am not able to comment on this."

Well, perhaps he did, but, in any event, that was his view and he was trying, plainly, to dissuade his patient from taking Thyroxine or from seeing Dr Skinner.

Nevertheless, in August of 2004 she did get in touch with Dr Skinner and went to see him. She went, of course, without a referral. She had also done some homework on the internet and she felt that she had symptoms of hypothyroidism. She saw Dr Skinner on 24 August, and if you turn over tab 8 you will have the typewritten notes of that first consultation. In effect, he told her that if she was feeling low she should try Thyroxine and his note at the end of that, which is the typewritten note of that first consultation, is interesting. You will see, "Treatment/blood tests", "FT4 and TSH blood tests and then thyroxine". Not, "Let's wait and see", but, "then thyroxine", and he agreed to prescribe Thyroxine, took blood from her, but apparently wanted her to wait a week to see what her own GP thought, and he wrote accordingly to Dr Stewart via Dr Blanchard and you will find that letter back in the GP notes at page 87. He writes at the bottom of that letter, dated 25 August 2004, tab 7, page 87:

> "Her hair was rather thin and rough and she has a chunky tongue and I thought an enlarged thyroid gland which seemed smooth and non sinister and moderate bradycardia of 65 per minute. Her TSH is perfectly normal but TSH levels are good servants but bad masters and I have taken a blood sample for FT4 and should have the results in a few days time.
>
> On balance and if the blood test results do not show anything au contraire I think there is a good case for thyroid replacement in this patient whose quality of life at the moment seems low and of course she has three young children to look after ..."

The blood tests, dated 26 August, that letter being the 25th, you will find at page 90 and you will see that it reveals that all of her thyroid levels are normal. T4, at 14.2, with the reference range, you will see just below, 9 to 20, and TSH of 1.9 with a reference range

A

0.4 to 5.5.

Dr Skinner wrote again on 23 September to Dr Stewart, page 89, the page before, saying:

> "Further to my last note I enclose [Patient D's] thyroid chemistry ... While her FT4 is a little low albeit within the 95% reference interval I would be quite prepared to institute a 4 month trial of thyroid replacement but will not proceed thus for 10 days to allow you the opportunity to comment ..."

B

Dr Stewart did comment. His letter is at page 91. I am not going to take up time now to go through the letter in any detail, but if you go to page 92 it says:

> "We feel that it would be medically and ethically safer in future if you would wait for a referral letter to arrive before seeing patients",

C

- and -

> "We wrote directly to this patient on 19th July explaining why she did not need to see you and why it was not appropriate for her to take Thyroxine ... so we would be grateful if you could discharge her from your care ..."

D

Dr Skinner did not do so. After a week she did start taking thyroxine and, indeed, she began to feel better, she was more energetic and she was happier, and she had been told to start on a low dose and gradually increase it. In fact, she increased it herself to 200 micrograms daily, which is a very high dose indeed, and she would return to Dr Skinner every three months for review, and that state of affairs continued until November of 2005.

E

Dr Skinner wrote letters that you will find from page 93 to 97 of the bundle. Over to page 97 you will see the letter dated August 2005 to her GP's practice, talking about her weight had increased but he was going to proceed with the dose. He said:

> "I has planned that she increase to 125 micrograms per day but in fact she is still taking the 150 micrograms thyroxine per day and I have suggested she proceed to 175 micrograms per day for six weeks and then 200 micrograms per day ... I will review her in three months time."

F

Her last appointment with Dr Skinner was in November 2005 and that came about because on 31 August Dr Stewart wrote to the GMC to ask them to investigate what was going on, and on the same day he wrote to Dr Skinner asking him to discharge this patient from his care. On 25 November 2005, at page 108, he encloses the patient's thyroid chemistry, which in his terms, he says, "wherein the readings are on the high side", well,

G

again, T4 is above the reference range and TSH is very much below it.

According to Professor Weetman that test reveals, in fact, that patient had become bio-chemically thyrotoxic and Dr Stewart wrote again to Dr Skinner warning him that the patient was thyrotoxic and asking him to discharge her from his care, but Dr Skinner wrote back, you find the letter at page 113 in the middle of the page:

H

> "I also acknowledged that you asked her to discharge her from my care and my difficulty was that she did not wish this outcome ... I was not sure what to do ...

> The General Medical Council felt that they could not provide advice to a practitioner in these situations - fortunately this is the only time in my career when such a difficulty has occurred ..."

Quite what he is referring to there perhaps at some stage he will explain, but it certainly was not the first time that he was aware of complaints by other doctors about his practice.

In any event he did write to his patient eventually, as we can see at page 117, advising her not to become discouraged and saying to her (quite properly perhaps):

> "The most important issue is whether your thyroid status is properly assessed and appropriate treatment provided for you; I am sure Dr Stewart is working with your best interest at heart".

Well the position then unfortunately is that the patient is not now under the care of any doctor, but seems to be purchasing thyroxine from the Internet and is effectively self-treating; an unsatisfactory outcome perhaps from anybody's view.

Professor Weetman examined the records and correspondence relating to this patient. Again he took the view that the original consultation on 24 August was an incomplete examination, bearing in mind that the patient was suffering from multiple aches and pains. The 26 August 2004 blood reading at page 90 was not low, as Dr Skinner had claimed in his letter, but was in fact very normal, and by November by reason of the patient taking thyroxine daily her blood showed clear evidence of thyrotoxosis.

Again there is mention in the consultation notes of vitamin B12 being prescribed, but again there was no investigation as to whether she was B12 deficient.

His initiation - Dr Skinner's initiation - of thyroxine was according to Professor Weetman unnecessary, because the patient was in fact euthyroid and the result of his treatment of her was that she became thyrotoxic. Again Mr Lynn agrees, and in his view this patient was given thyroxin inappropriately and is now in danger of developing long-term problems in terms of decreased bone density, osteoporosis and cardiac arrythmias.

In summing-up Professor Weetman concludes that in his view, looking at Dr Skinner's prescribing practice in relation to these four patients, he is out of step with normal or accepted methods of dealing with hypothyroidism. He is not a trained endocrinologist and his theories of endocrinology fall outside accepted national practice. The excessive levels that the patients received would increase energy levels abnormally, it is likely their weight would decline and, although the patients may feel temporarily better, it is recognised in the medical profession that the risks of over treatment with thyroxine outweigh the benefits.

There was, as you know, a letter written to Dr Skinner asking him to undergo a performance assessment. I say you know because of course he has admitted this. In due course he refused to undergo a performance assessment and, when deciding in due course whether or not his performance is as the GMC alleges impaired, you can take that into account provided that his refusal was not a reasonable one. That is something that we will deal with obviously at a later stage of these proceedings should we get there.

So far as these allegations are concerned, as you know the criminal standard and burden of proof applies. The burden lies upon the GMC to prove all of these charges, which have not been admitted and found proved, and the standard is so that you are sure.

I hope that we will now have Patient A on the end of a camera. I ought to make formal application, if I may. Patient A was here yesterday, with her husband. As you know, we had a very disjointed day yesterday and she was not able to re-attend. I spoke to my learned friend, Mr Jenkins, and I think he is quite content with this witness - and, indeed, any witness - that they should give evidence over a video link. So, I formally make that application.

MR JENKINS: Can I confirm that.

THE CHAIRMAN: Fine, thank you. That is accepted.

MR KARK: Thank you very much.

(*The following evidence was given via video link*)

PATIENT A, affirmed
Examined by MR KARK

Q Patient A, thank you for joining us and apologies for the long wait that you had yesterday and today. Can you hear me?
A Yes, fine.

Q You can see me?
A Yes.

Q Okay. First of all, just to confirm that I think there is Miss Morris in the room behind you from Eversheds Solicitors. Is there anybody else in the room?
A No.

Q Obviously during the course of your evidence please do not talk to Miss Morris, or indeed anybody else. If there are any breaks, please do not talk to her about your evidence. Do you follow?
A No. Can you repeat that?

Q Yes. If there are any breaks, or even during the course of your evidence, you cannot speak to Miss Morris about it. Do you understand?
A No, that is fine.

Q All right. I want to ask you, please, about a visit that you made to Dr Skinner back in the beginning of 2003. Can you help us, please, as to when did you first hear about Dr Skinner?
A From a reflexologist that I see regularly.

Q Would you mind describing what your health problems were?

A I could not hear you. Could you say that again?

Q I am sorry. Would you mind describing what your health problems were?
A Yes, extreme tiredness.

Q I think you have three children. Is that right?
A Yes.

Q Had you had some problems after the birth of your first and second child?
A Yes. My first child I had glandular fever and also postnatal depression quite severely, and after my second child, which was a different delivery - Caesarean - I had a milder form of postnatal depression.

Q I think you consulted your doctor in Stourbridge at the time. Is that right?
A Yes.

Q Was that Dr Cooke?
A Yes, it would have been Dr Cooke.

Q Was that a practice where you always saw Dr Cooke, or were there other doctors that you saw?
A Yes, there are a number of doctors there. If I could not see Dr Cooke I would see another doctor, but generally I would try to see Dr Cooke.

Q Did Dr Cooke carry out various blood tests and come to the view that your thyroid function was all right?
A Yes, he did.

Q Having been recommended to Dr Skinner by your reflexologist, did you make an appointment with him?
A Yes, I did.

Q Tell us, please, what happened. If you turn - you have got a little bundle of documents in front of you, I think. Is that right?
A Yes.

Q I just want you to help us with this. Do you have the tab numbers 1 and 2 there?
A Yes.

Q If you turn over tab 2, please, I think you will find a number of letters from pages 1 to 10. Could you just leaf through those. Those are letters that found their way on to Dr Skinner's file. Did you take those with you, or were they provided to your knowledge by your GP?
A No, from memory I did not take any documents with me. My GP would have sent them to Dr Skinner, I would say.

Q All right. Could you turn, please, to page 9 of tab 2?
A Yes.

Q Do you see a letter there dated 20 December 2002 from Dr Edward Cooke to Dr Skinner?
A Yes.

Q Right. That was effectively a referral letter and then, if you turn over to page 11, do you remember that document being filled out?
A Yes, that is my writing.

Q Was that filled out, can you remember, at Dr Skinner's surgery?
A I would say so, yes. It seems like a form I would fill out at many surgeries, yes.

Q Tell us about your visit, please, to the surgery? I think it is 16 January, if we go to page 12 we can see Dr Skinner's notes. Tell us what happened on that day?
A What? From the beginning, you mean?

Q Yes, when you got to the surgery?
A I arrived at the surgery and met the receptionist. She was very - I do not know how to describe it - but I was a bit surprised by her appearance. She was barefooted and black nail polish and sitting very casually behind the desk and I noticed that she was actually reading my medical notes. I thought that was slightly out of order. Then I sat down and I met -- Dr Skinner came, I think, to the door, I went into his room and he asked me about first world war, I think it was the first world war, I thought something like who had won the first world war, who fought in the first world war and I cannot remember and then we sat down, he sat down behind his desk and I sat down in front of him. We talked a bit about sport. He seemed quite keen on sport. There was some pictures on the walls about sport. I cannot remember which one exactly, might have been cricket, I cannot remember.

Q Did he talk to you about your condition?
A Yes. Yes. It is such long time ago to remember all the details but, yes, he asked me, you know, why I was here and I said I was extremely tired all the time and nobody could seem to find out why and that my reflexologist had picked up from my feet that my thyroid was not working properly. That is what the reflexologists discovered from feet apparently and I was there to get an opinion from him.

Q What did he say to you, if you can remember, about the thyroid? I am going to lead you but if there is any objection I will stop straightaway. Did he ask you about your vision?
A Yes.

Q What did he ask you about your vision and what did you tell him?
A He said did I ever have shadows around the sides of my vision and I confirmed that I did because sometimes I would think I saw something move on the periphery of my vision and he said something like a mouse or something scuttle across the room and I agreed, yes.

Q Did he also mention or did you mention your eyebrows?
A He did. He brought up the eyebrow, yes.

Q Tell us about that?
A I thought that was quite interesting actually because one of my eyebrows was quite short, not very long and he said that that was an indication of under active thyroid in that the eyebrow is often shorter.

Q What did you tell him about your previous medical history? Did you mention your post-natal depression, for instance?
A I think I would have done, yes.

Q May I ask you this, had you ever taken anti-depressants?
A Yes. I did after the first two births but not after the third, if I remember rightly I felt fine.

Q Did you discuss that with Dr Skinner or mention that to him, the anti-depressants?
A I presume I would have done. I cannot remember exactly.

Q All right. What physical examination did he undertake?
A Again, I cannot remember clearly. I remember my blood pressure being taken but the rest is quite vague. Oh, he took some blood for a sample. He may have looked in my eyes but that was about all I can remember.

Q How long did the consultation with him take?
A 20 to 30 minutes.

Q What was his conclusion at the end of that, if any? He took a blood test from you. What did he say?
A He said that he felt that the -- I cannot remember the exact words but he felt that, yes, I would benefit from thyroid supplement, from taking thyroxine.

Q Did he say why you would benefit or how you would benefit?
A Yes, because he said because of the indications, from the way I looked and the vision and the eyebrow.

Q What about the blood tests? Was he going to wait for the blood tests to come back or not?
A No, he said to start taking the thyroxine now. It would not be a problem as he was very confident that that was the issue and he would send the blood off to be tested so I went and got the prescription that day.

Q Did you say anything about whether you wanted to take thyroxine or not?
A Can you say that again?

Q Did you say anything about whether you wanted to take thyroxine?
Did you comment? If you cannot remember do not worry.
A I made a comment, oh, because I do not like taking drugs specifically I did ask him about any side effects but I was happy to take the thyroxine. I was extremely ill, looking for a solution.

Q What did he say about side effects?

A He said: “Oh, you are not one of those are you?” He then proceeded to explain how miserable people are that go to health shops and how cheerful people are that go to McDonald's inferring that I was an alternative thinker.

Q Whether he was right or not about McDonald's did he say anything else about side effects?

B A No.

Q Did you discuss how long you were going to take the thyroxine for?

A No, not that I can remember.

Q Apart from his view that you suffered from a low thyroid problem did he discuss with you any alternative diagnoses? Any other potential problems?

C A Any other what? Sorry.

Q Potential diagnoses.

A Potential diagnoses?

Q Yes.

A No.

D

Q You tell us that you got a prescription and if you turn in that same section in front of you to page 14?

A Yes.

Q Is that the prescription you were given?

A That looks right, yes.

E

Q That was given to you on the day of your attendance at the surgery?

A Yes.

Q How did you feel about that as you left the surgery?

F A Well, I was in two minds about it. One, I was pleased that I had had something that might help make me better and the other side of me I was a bit hesitant about taking it because the blood test had not come back because the blood had not been sent off to be tested but I was willing to take the prescription because I felt so ill.

Q Did you start taking it?

A Yes.

G

Q What happened after you began taking it?

A I got severe headaches.

Q Any other problems?

A Yes, I had severe headaches and the best way to describe it is a very tense feeling.

H Q How long did you take the thyroxine for before trying to get back in contact with Dr Skinner?

A Almost a week, I think. Four days.

Q Then what did you do?
A I rang to speak to him about the headaches and he did not seem to acknowledge even the mentioning of the headache and I cannot remember what happened.

Q Did you speak to him straightaway? Was it easy to get hold of Dr Skinner?
A Well, no, I mean, I made so many phone calls that I cannot remember if I got through the first time because over those few days I made a number of calls to his surgery unable to get hold of him.

Q Did you speak to anybody else about what you should do about the thyroxine when you could not get hold of Dr Skinner?
A Yes, I asked his secretary for his mobile number because I was going on holiday, I was very anxious to try and get it sorted out before I went and she gave me his mobile number and she said he would have my notes with him and to ring him on that, which I did. Dr Skinner did not answer the phone, it was a woman and she effectively told me to stop taking it. I do not know who she was. She did not even introduce herself.

Q She said stop taking the thyroxine?
A She said stop taking the thyroxine, yes.

Q Eventually you did manage to speak to Dr Skinner?
A Yes.

Q Was that directly or by telephone?
A By telephone.

Q How long after your appointment was that, can you remember?
A I would say a week, seven days.

Q Tell us what Dr Skinner told you you should do?
A I just need to get my thoughts together here. It was quite a confused conversation. It was quite chaotic. Right, I eventually got hold of him and I was on some sort of a speaker phone, it was echoing. He sounded like he was walking around the room. I did not feel he was actually listening to me. I explained I had these headaches and this tension and he basically suggested that was I a danger to society and perhaps I should visit a psychiatrist.

Q Did you have any further discussion about the thyroxine or any alternative forms of thyroxine you might take?
A Yes, we did. I told him I had heard about a natural product; desiccated thyroxine and whether perhaps my reaction to the synthetic, whether I was reacting to the synthetic because he had not told me whether I was not or not, whether the natural thyroxine from pigs would be better for me and he said, yes, it might be and gave me the details of a company to contact to obtain the desiccated thyroxine.

Q Did that have to be on prescription?
A I cannot remember.

Q Was there any discussion about the blood test that had been taken from you and whether those results had come back?
A Yes, I did ask him for the results. I cannot remember what he said now. I do not think they had come back when, no, they had not. When I spoke to him the blood test results had not come back.

Q So when you were having this discussion about how you appeared to have reacted to the thyroxine and natural thyroxine as far as you know he still had not had the blood tests back?
A From memory, yes.

Q I think eventually you wrote a letter because you were unhappy with your treatment?
A Yes.

Q First of all, could we go to page 17 of the bundle. You have told us that you had this telephone conversation and spoke about natural desiccated thyroxine. Is that something you remember called Grain Armour?
A I did not know the name of it at the time but, yes, this is it, this is the Grain Armour, that is the natural thyroxine.

Q This is dated 6 February 2003?
A Right.

Q So it would seem that between 16 January, when you first saw him, and 6 February 2003 you seem to have had this discussion?
A Yes, must have had, yes.

Q If you could go, please, to page 20, I am not going to spend a great deal of time on this letter but just to remind you of certain sections of it. Can you first of all confirm, is this the letter that you wrote?
A Yes.

Q It is dated 6 February. So it is, in fact, the same date as the prescription you have just been looking at. Was this letter triggered, as it were, after your telephone call?
A Oh, yes. It was after the telephone call.

Q You write to Dr Skinner saying:

> "I am writing to advise that I can no longer be a patient under your care because I no longer have trust in you."

You then deal with the details of the consultation which you have spoken about and there are a number of complaints about the way the consultation went but you understand that those are not complaints that are being made about Dr Skinner which is why I pass over them. You deal in your third paragraph with the blood sample being taken. You say:

> "I was given a prescription to begin thyroxin and vitamin B12."

Can you remember what was said about vitamin B12?
A No, I cannot.

Q Were you given any vitamin B12 in tablet form or in any form?
A Not there, no. I would have purchased it myself.

Q At the beginning of the paragraph you said:

> "A blood sample was then taken to determine my current thyroid activity and I was given a prescription to begin thyroxin at 25 milligrams and vitamin B12."

You do not seem to have had a prescription for B12?
A No.

Q Looking at what you wrote in your letter does that indicate that there must have been some discussion about B12?
A Yes, the prescription did not have B12 on it. Dr Skinner would have told me to take B12 with the thyroxine.

Q Then over the page you deal with trying to contact Dr Skinner and you have dealt there with what you have told this Panel. Bottom of page 21, second paragraph up from the bottom you say:

> "Your response was to ask me if I felt I was a danger to society and that perhaps I should see a psychiatrist",

and you felt that was an inappropriate response. You felt that he had side-stepped your question of whether the prescriptions were responsible for your mood change over the page you say:

> "I mentioned desiccated thyroxin as an alternative to which you agreed. You said you would get your secretary to send a prescription."

Which he obviously did. Then you finally say this:

> I initially tolerated your manner because I believed you were a professional and we lay people look to you experts for guidance. I have spent the last seven years trying to find the answer to my shopping list of health problems and I placed my hope in you. I do believe there is a strong possibility that the answer to my health issues lies in my thyroxin level."

Can I ask you, please, how you continue to deal with your health problems?
A Well, I now take thyroxine.

Q At what level do you take it?
A I take 100 micrograms.

Q Per day?
A Per day.

Q Presumably you do that because you feel it has a beneficial effect?
A Yes, it does.
Q He wrote back to you as we see at page 24 and again I am not going to deal with that letter in any detail but he obviously apologised to you about the fact that you were upset following the consultation. He suggests that you should take armour thyroid and he was going to send you an order by fax and he returned your money to you and he finally says this:

> "Do not let the question of your thyroid status go by default. It is perfectly possible that your clinical features are a consequence of hypothyroidism."

Did you return to Dr Cooke for your treatment?
A Yes.

MR KARK: Thank you. Would you wait there, please?

<u>Cross-examined by MR JENKINS</u>

Q Mrs A, you can see a shadow which is me, I am afraid. I do not know if the lighting can be changed so you can see my face clearly, but are you content to keep going as we are?
A Fine.

Q Good. Can I take it that you have a tab 1 as well as a tab 2 in the documents that you have?
A Yes.

Q Forgive me, I should have said, it is obvious, I am asking questions on behalf of Dr Skinner.

If you have tab 1, Mrs A, I am going to ask you to turn, please, to page 4 which are the computerised records kept by the general practice where you were registered. I do not know if you have seen these documents before.
A I saw them last night.

Q Good. There is an entry for 5 June 2002 where a doctor, presumably with the initials EC, made a note that you were complaining of being tired all the time. Does that sound about right, that that was the first complaint you made of being tired all the time, at about that time?
A I do not think it would have been the first complaint.

Q Perhaps you are right. Perhaps I am taking it out of context. I suppose if you go back a page to page 3 you complained of similar matters in the middle of 2001, nearly halfway down that page.
A Yes.

Q I am going to take you back to 2002 because that runs us into the period where you saw Dr Skinner. All right?
A Yes.

Q There are further records under the date of 5 June 2002 in the entry I have just looked at, but I think you were referred to see a Dr Smith?
A Yes.

Q I do not think to read out all the entry on page 4, but if I can take you, please, to tab 2 at page 3, I think we have Dr Smith's response to the referral. Again, have you seen this letter before?
A Yes.

Q I do not need to read it out, but he indicated you felt tired all the time and he listed a number of other symptoms and concerns that you were complaining of.
A Yes.

Q I think if we turn over to the next page it takes us to 12 August 2002, after he had reviewed you, and he indicates that various tests have been undertaken which were, essentially, in the normal range.
A Yes.

Q Is that your recollection?
A Yes.

Q He says he had a long discussion with you and explained to you that all your symptoms were compatible with post viral fatigue syndrome. He reassured you that the ultimate prognosis was good and, hopefully, you will make a recovery. He did not see you again, I think, Dr Smith?
A No.

Q If we go back, please, to tab 1, page 4 again, we see that the next entry, after the referral to Dr Smith, was an entry for 16 October 2002. Do you have that?
A Yes.

Q There was a complaint of dyspepsia and an entry in the GP record, again, I think by Dr Cooke, his initials, talking of a long history of abdominal pain, various other matters about your medical health and, indeed, about a relative of yours.
A Yes.

Q Mention of constipation.
A Yes.

Q The suggestion was, I think, that an opinion should be sought from a Dr Veitch. Is that right?
A Correct.

Q We see that a few days later, 22 October 2002, there was a referral to Dr Veitch, a gastroenterologist.
A Yes.

Q Did you see Dr Veitch, and if we turn, please, to tab 2, page 5, we see Dr Veitch's letter back to the general practitioner after he had seen you?
A Yes.

Q Again, I do not think I need go through the detail of the history, but, plainly, you went through your family history with him, explained to him about your medical history and the symptoms you were then complaining of and I think we will see from the bottom of the page he examined you. Did he say to you that in his view you were clinically euthyroid?
A I do not remember that. I am sorry. Where are you talking about?

Q The bottom of page 5 of tab 2. "On examination she looked well and was clinically euthyroid".
A I do not remember him verbally using that word in the consultation but I have read this letter.

Q You have told us that you were, subsequently, to seek a referral to Dr Skinner because of concerns about your thyroid. When did you first start thinking that your thyroid might be involved in your medical problems?
A I had had a blood test previously, I am not sure exactly the date, with Dr Cooke, that had said that I was in the normal range and I was seeing a reflexologist who also had a medical background and had moved into alternative therapy. She picked up and drew it to my attention. From my discussion with her that it when I sought further help.

Q Can you put that into the context of the time-frame we are looking at? You saw Dr Smith in July and August 2002, you saw Dr Veitch in October, it would seem, 2002 and I think we will see that you saw him again at the beginning of December, if we turn to page 8. Do you have the date of the letter? It is 3 December 2002.
A Yes.

Q "This lady ... came up for review today"?
A Yes.

Q Are you able to tell us when you saw the reflexologist?
A I was seeing her regularly on a monthly basis. Sometimes on a two weekly basis.

Q You say she had a medical background?
A Yes, she used to be a nurse.

Q Can I take to you page 8, tab 2? It is the second letter we have looked at from Dr Veitch. He talks, some five lines down, about abdominal discomfort and bloating, "This is associated with fatigue and irritability", and your symptoms were making your life miserable. You had a long chat about your symptoms and underlying causes. They do not appear to be stress related, and you are not clinically depressed. That was what he said.
A Yes.

Q You told us that you then approached your GP, obviously Dr Cooke, and asked him for a referral to Dr Skinner.
A Yes.

Q What did you know about treatment for thyroid problems before you went to see Dr Skinner?
A Just some very basic knowledge about the thyroid being like the motor in the body and if the thyroid is not running at correct power other things in the body also do not run at the correct power, so that is basically all I knew about it.

Q Had you done some research on thyroid?
A I have looked on the internet, I think. I might have looked on the internet but not in any great depth. Just to find out.

Q I am going to put a sentence that you have in your statement. I do not want to take you at any disadvantage. If you want to look at your statement to confirm this is what you said you must just ask, but I am putting, for those who have the statement, a sentence from paragraph 13 of the statement. (*Document not available to shorthand writer*) You say:

> "However, I had done quite a bit of research, both on the internet and by speculating to others, and I was aware that there were two types of thyroxine, one of which was synthetic and one of which was taken from pigs."

When you say "quite a bit of research", what do you mean?
A Well, just looking on the internet and talking to that reflexologist.

Q When you went to see Dr Skinner how good a memory now do you have of the subject matters that were discussed?
A Which subject matters?

Q If I asked to you tell us everything that was discussed do you think you would be able to do it?
A No, it was five years ago.

Q Mrs A, do not think I am being critical at all. Of course it was a number of years ago, but I just want to have a feel for how good a recollection you have for the detail of what was said to you by Dr Skinner.
A Detail on what in particular?

Q Thyroxine. The way in which you could take it, the sort of dose that might be appropriate, the sort of symptoms that patients who have symptoms from thyroid problems might exhibit or might have.
A I remember him talking about the shadows, which if you mean symptoms - is what you mean?

Q Yes.
A Shadows around the eyebrow. I remember that much. I do not remember any discussion on the details of thyroxine and the various dosages.

Q Would you have talked about any other physical symptoms that you had, whether you had any aches and pains?
A I cannot remember.

Q Do you remember if you had any particular concern about your hands?
A My hands?

Q Yes.
A No.

Q Was anything said about your libido, so far as you recall?
A Yes, I would have mentioned that. I remember mentioning that.

Q Was anything said about whether you had problems with your hands and feet? Pins and needles in the hands and feet?
A I could have said something about that. I cannot remember.

Q Was Dr Skinner taking notes whilst you were talking to him?
A Yes.

Q Did you talk about the ages of your children?
A I cannot remember.

Q Was anything said about your voice?
A No.

Q Are you sure?
A Yes.

Q I am going to suggest that your recollection is not complete, it is far from complete, of the discussion you had with Dr Skinner about your signs and symptoms and it may be you would accept that?
A That it is not complete?

Q Yes.
A Yes, I cannot remember the details that far back. I am sorry.

Q You do not have to apologise. We all understand that it was a number of years ago. You have told us there was an examination.
A Yes.

Q Tell us what it involved so far as you recall?
A My blood pressure being taken, possibly looking in my eyes. I cannot really remember that. Possibly, there is some memory of that, and my blood being taken.

Q Did he measure your pulse?
A I cannot remember.

Q Did he take your temperature?
A No, I do not remember that being taken at all.

Q I suggest it was. What you told us was that you were very interested in some of the things that Dr Skinner was saying about the signs that you had, particularly your eyebrows. Did it appear he had predicted that you might have some slight disturbance of vision at the periphery of your vision?

A He might have predicted? I do not really understand that. What do you mean by that?

Q He asked you if you had some kind of visual disturbance at the periphery of your vision.
A He asked me do I sometimes see shadows in the side of my vision, yes.

B Q Did that come as a slightly surprising question to you?
A Yes, it did, but, as I said before, I did have shadows.

Q Yes. Did it appear then that he had thought you may well have such a symptom and he was right?
A I do not know if he thought that I did when he asked me. He just asked me, "Do you have shadows", and I said, "Yes, I do".

C Q Do you remember a discussion about him saying, "Well, you could have a trial to start you off on thyroxine"?
A No, I do not remember that. I am sorry.

Q What was said about the dose that you could start by taking as part of the trial?
A I do not remember a trial or the dose. I remember he gave me a prescription and
D that dosage would be on that prescription.

Q All right. You are now taking 100 micrograms of thyroxine a day?
A Correct.

Q Do you remember what it was when you first took the drug?
A I think it was 25 or 50.

E Q Can I suggest it was 25?
A Right oh.

Q Do you remember if there was a discussion about whether that could or should be increased?
A No, I do not remember.

F Q Do you remember if the dose was increased and, if so, when?
A The dose changed when I went onto the armour thyroxine, the desiccated, there was a change there.

Q In relation to that you have told us that this was on 6 February 2003 and we have
G looked at a document which shows us that that was the prescription. I have lost the page, I am afraid, but the Panel will recall it.

THE CHAIRMAN: Page 17.

MR JENKINS: Thank you. (*To the witness*) I think you have told us that was the date of the phone call you had with Dr Skinner.

H MR KARK: I am not sure she said it was actually the same day. I think she said it must have been before that or on the same day.

A I do not remember if that was exactly the day I wrote the letter after the discussion with Dr Skinner, but my letter is date 6 February.

MR JENKINS: But it is the same day as the date of the prescription?
A It is the same date as the date of prescription, yes.

B Q I understand. What you told us was when the prescription was made he did not have the results of the blood test.
A I think though from memory ---

C Q I wonder if it would be fair for us to look at page 16 of tab 2 which shows, towards the top left, Dr Skinner as the requesting authority, requesting T4 and TSH serum tests. The laboratory received the sample of 21 January 2006 and this report is dated 24 January 2003. It is fair to say there is no date stamp to show when it was received by Dr Skinner, but certainly the report had been issued two weeks or so before the date of the prescription on 6 February. Would you agree with that?
A Are you looking at page 16?

Q I am.
A I am sorry, can you repeat it?

D Q Well, you have suggested that the blood tests had not come back when you spoke to him on the telephone.
A Yes.

MR KARK: I am sorry to correct Mr Jenkins, but this witness said he said that the blood test - she was not saying whether the blood test had come back, or not, but simply that there was no discussion about it I think on the phone.

E MR JENKINS: What she said was, on my note, "I did ask him for the results. I do not think they had come back. No, they had not". That was what she said about the telephone call.

MR KARK: From the conversation, yes.

F MR JENKINS: Yes, "I do not think they had come back. No, they had not":

Q (*To the witness*) However, there we are. Do you think you might be mistaken, Mrs A, about when the blood tests were available?
A No, no, because when I spoke to Dr Skinner he told me that the results had not come back.

G Q What you told us was that you told Dr Skinner over the telephone that you had tension?
A Yes.

Q You have told us he said did you feel you were a danger and did you need to see a psychiatrist?
H A Yes.

Q Was tension the way you described it to him?
A I probably used the word "tension". "Anger" might have been a word I used.

Q Did you say you felt violent?
A I might have said - yes, I think I would use the word "violent" and I clarified it by saying, "Not towards anybody, not as in violent wanting to be violent, but that sense inside of like a volcano erupting. That sort of violence within me - anger".

Q Can I ask you to turn to page 21, which is what is your letter. It is three paragraphs up from the bottom, this conversation, which you deal with in the letter. In this letter you say that you explained you were:

> "… experiencing extreme agitation and emotional feelings of a violent nature".

You say:

> "I have no desire to be violent towards any individual in society - I was simply trying to explain a distressing tension I was experiencing within my body."

What you then say is that Dr Skinner's response was to ask if you felt you were a danger to society. Is that a better description of the conversation; that you did say you felt violent?
A Well, I must have done if I have written it there.

Q I understand. Well, can I take you up to the top of the page. You deal there with the conversation you had with Dr Skinner at a slightly earlier stage when you were complaining of headaches?
A Yes.

Q What you have told us was that Dr Skinner - forgive me, the Panel will see what you have in your letter. You have said to us that you rang to speak about headaches and Dr Skinner did not seem to acknowledge even the mentioning of the headaches. Did he not say that it was unlikely to be connected to the drug that you were taking?
A I do not remember him saying that, no.

Q Can I ask about what happened after you left Dr Skinner. We have seen the correspondence from you and the reply from him. Were you then seen by Professor Franklyn at some stage?
A Yes.

Q Did you stay on thyroxine, having passed through Professor Franklyn's hands?
A I went on to a higher dose, if I remember rightly. No, that is not correct. I think I started off on a lower dose and it was slowly increased from memory.

Q Well, we have got your medical records. I was not going to take you through what they say. We can do so if need be, but you started off I suggest at 25 micrograms of

thyroxine and it went ---
A Can you tell me where you are looking?

Q Yes. Why do you not look at tab 1, page 6.
A Right.

Q If you look in the middle of the page, do you have it, "Levothyroxine tablets 25 micrograms, use as directed"?
A Yes.

Q At that stage I suggest you were taking one tablet a day of 25 micrograms?
A Yes.

Q It then goes on, I suggest, that you go up to 50?
A Yes.

Q Then if we go down to 30 June 2003, we will see that on that day you were prescribed a 25 milligram(*sic*) tablet, one a day, and a 50 milligram(*sic*) tablet - microgram, I am sorry - one a day. Is that right? On the same page, page 6?
A Ah, yes. Yes.

Q Yes. It is not entirely clear from this record and I am sure there will be others, but ---
A No, that is right.

Q You were plainly at 75 micrograms a day as at June 2003?
A That is right. I was taking two.

Q Now, that is several months after you have stopped seeing Dr Skinner?
A Yes.

Q If we go over the page to page 7, in December 2003 you are taking a 100 microgram tablet of Levothyroxine every day?
A Yes.

Q You stayed on that for the last three-and-a-half years?
A Yes.

Q Who is prescribing that for you, if I may ask?
A The Summerhill Surgery, depending on which doctor I see. It is normally a female doctor there. I cannot remember her name offhand. It will come to me in a minute. Dr Wiseman.

Q I do not know what the latest reading we have in the records that we have for your blood results, but do you know where your TSH reading would fall?
A I do not offhand, no.

Q What about your T4 reading?
A Well, when you go to the surgery they do not really give you that information

unless you - I did start off writing it down, but they just say that how am I feeling and I say, "I feel fine", and they say, "Your levels are normal".

Q Is that what you understand at the moment; that your levels are normal?
A Yes.

Q The suggestion being made about your treatment with thyroxine was that it should never have been started and that it was irresponsible to start treating you. What do you say about that?

MR KARK: No, it cannot be for this witness to comment on whether this doctor acted responsibly or irresponsibly given the information that he had at the time that he prescribed thyroxine. That is a question for an expert and not the witness, whether she felt better, worse, or anything else.

MR JENKINS: How do you think you would feel if you were not taking thyroxine now, Mrs A?
A I do not know. I have even considered coming off it as an experiment to see how I would feel.

Q Why do you take it now?
A Because I feel better than I did.

Q Do you attribute that to the thyroxine that you have been taking?
A I would say so.

MR JENKINS: Yes, thank you very much, Mrs A. That is all I ask.

THE CHAIRMAN: Thank you very much for your full answering of the questions.

Mr Kark, do you have any follow up questions?

MR KARK: I have no re-examination, thank you.

<u>Questioned by THE PANEL</u>

DR ELLIOT: Good afternoon. Can you hear me all right?
A Yes, fine.

Q I am not quite clear, Mrs A, about whether you discontinued taking thyroxine after your telephone conversation with Dr Skinner?
A Yes, from my memory I stopped taking the synthetic thyroxine and I started taking the desiccated thyroxine. I continued on that until I saw the people at the Queen Elizabeth Hospital that was mentioned before, the Professor, who said I should not take that. I should take the synthetic one.

Q So, how long was that after you had had the telephone conversation with Dr Skinner?
A I cannot hear you.

Q How long was that after you had had the telephone conversation with Dr Skinner?
A Was I taking the desiccated thyroxine?

Q You said that you saw ---
A No, I saw the - I cannot remember. I would have to look through the documents. I cannot remember without looking at the file.

Q So do I understand correctly, then, that you have been taking thyroxine in some form or other since your consultation with Dr Skinner?
A Yes.

DR ELLIOT: Thank you.

MR PAYNE: Good afternoon, Mrs A. I have just three small questions for you. First of all, on your initial consultation when you went in to see Dr Skinner did your medical notes accompany you into the room, or were they left with the secretary?
A I cannot remember, I am sorry.

Q When you had the telephone conversation with Dr Skinner and you asked about the blood test, is it your memory that Dr Skinner told you that he had not received the results of that blood test?
A That is my memory, yes.

Q You have told us that when you started with the medication you were having headaches?
A Yes.

Q You are still on the same medication, but are you still having those headaches?
A No.

Q I think you told my colleague that you have been continuously on that medication since the very first prescription. When did the headaches stop?
A They seemed to stop when I went on to the desiccated. I stopped taking - after I had had the conversation with the lady on Dr Skinner's mobile phone who said, "Stop taking it", I stopped taking it and then waited for the desiccated thyroxine to arrive and then I started taking that. So, from memory my headaches stopped when I stopped taking those initial doses of thyroxine.

MR PAYNE: Right, thank you very much. Those are all my questions, thank you.

THE WITNESS: Thank you.

THE CHAIRMAN: Hello, Mrs A. I wonder if I could just ask you one further question. While you were taking thyroxine over these periods of time via either Professor Franklyn or Dr Skinner, were you taking any other medication?
A No. Well I might have occasionally taken something for something else, like an antibiotic, but nothing regularly like thyroxine, no.

Q Thank you. Headaches obviously were a bit foreign to you and so you had not been taking medication for headaches before?
A Can you repeat that?

Q Headaches obviously were new to you when you started taking the thyroxine. Is that correct?
A Yes, yes.

Q You had not had them before?
A No.

THE CHAIRMAN: Right, thank you very much.

Unless there are any further questions, I want to thank you very much for participating in this video. I am sorry you were here yesterday and have had to then reappear today, but thank you very much and I think that closes your evidence. Thank you.

THE WITNESS: Thank you.

(*The video link was terminated*)

MR KARK: Madam, I appreciate it is ten-past-one, but I am going to ask the Panel to take a slightly shorter lunch break today. The reason for that is we have got Dr Cooke, who has been waiting in the wings. He himself has a medical matter that he has to attend and he needs, if possible, to be away from here by three o'clock. So, could I ask - and I am sorry. We have had a long morning of it. Could I ask that we sit as close as possible to two o'clock?

THE CHAIRMAN: Yes, two o'clock I think is fine for everyone. Thank you. That will be fine. At two o'clock we will return.

MR KARK: Apologies, Madam. We will not normally do that.

MR JENKINS: Can I just point to a page, or two. Dr Elliot raised a question about Professor Franklyn. If one were to look at tab 1, page 55, and the subsequent pages, I think that will assist in the chronology.

THE CHAIRMAN: Thank you for that.

THE LEGAL ASSESSOR: Can I just mention one thing. If you are looking through pages, if you look at tab 5, page 7, it is no relation. There is no doctor in my family and we have never met.

(The Panel adjourned for lunch)

THE CHAIRMAN: Good afternoon, everyone. We still start the proceedings with Mr Kark and your next witness.

MR KARK: Dr Cooke, please.

EDWARD COOKE, sworn
Examined by MR KARK

Q Good afternoon. Is it Dr Edward Cooke?
A Yes.

Q Dr Cooke can you tell us a little bit about your practice? You were a GP principal for some 38 years. Is that right?
A Yes, my wife describes me as a funny doctor in that I have dual qualifications. I have been a GP principal for 38 years until the advent of the new contract in 2004 when I retired from general practice but I am a hospital practitioner specialising in ear, nose and throat surgery. I hold a surgical appointment three days a week at Hartlands Hospital in Birmingham which is part of the University of Birmingham where I teach doctors, students, etcetera, and I still do that.

Q Do you have any particular interest in the thyroid gland?
A Well, as a GP I had the normal interest of thyroid as any other general practitioner. In my ENT practice we actually run a surgical thyroidectomy, partially endocrine clinic at the hospital where I work and I am mainly involved in thyroid surgery, not the management of thyroid disease, it is the removal of the thyroid gland and management of patients post operatively and I do that up to date.

Q Dr Cooke, I want to ask you about a particular patient who we are referring to as Patient A. Could you try, please, to remember at all times that we are not going to refer to her by her real name, simply Patient A. I think she was a patient of yours when you were in general practice back in 2002?
A Yes.

Q I am going to ask you to turn up a bundle that is just to your left-hand side, if you turn over to tab 1, I am going to ask you - you can look at your notes as you will find them behind tab 1, these are the notes that come from your original GP surgery. If you go to page 40?
A Yes.

Q If you turn that over you will find there is a letter, I think, to yourself from Dr Veitch who was a consultant gastroenterologist. I think this letter neatly summarises what this patient's position was back in the end of 2002. It is a letter written on 31 October 2002 you had referred Patient A to Dr Veitch. Is that right?
A Yes, that is right. She had also seen a consultant in general medicine earlier that year as well for similar symptoms.

Q She had a number of problems. She suffered from fatigue, she had been treated for depression, she had had problems with constipation, with abdominal pain and bloating. She had been on Prozac in the past, she had also suffered, we heard, from post-natal depression and at the bottom of that page Dr Veitch wrote:

> "On examination she looked well and was clinically euthyroid. Her abdomen was soft but a little tender."

That is really to bring back to your memory in very broad terms the problems that this lady was suffering. Have you reviewed these notes recently or not?
A I have reviewed the whole set and my statement.

Q There are further letters from Dr Veitch, we see one at page 43. Then at page 44 we will find a referral letter from you to Dr Skinner?
A Yes.

Q Can you help us, please, with how this referral came about? What was the patient asking you for and what did you decide to do?
A After seeing Dr Veitch at Wolverhampton Patient A read somewhere that she thought she may have symptoms of thyroid disease. She made herself a private appointment to see a Dr Skinner in Birmingham and she came to tell me this. I personally did not make her appointment but I thought it would be only prudent to give her a referral letter so the doctor concerned knew a little bit about her medical history, etcetera. Hence that referral letter of 20 December 2002.

Q We see that you refer on the first page of this letter to tests done back on 27 July 2001 showing that her TSH, her thyroid stimulating hormone, was measured then in July 2001 at 1.49 my milliunits per litre and there is another TSH level further down the page we see, May 2002?
A Yes.

Q TSH level 1.45 milliunits per litre. Was it your view that she did, in fact, have a thyroid problem or not?
A No. I agreed with that opinion of Dr Veitch that clinically Patient A was euthyroid but nevertheless she had made this appointment and I thought she should go along and see the doctor because a further opinion would have been helpful, I think.

Q So if we go over the page, bottom of page 45 we see the very last sentence reads:

> "P…",

that is presumably patient:

> "…wonders if could be EG autoimmune thyroiditis. Has had chronic Bar viral infection"?

A It means Epstein Bar viral infection.

Q

> "Ask opinion Dr Skinner who she says has an interest in this"?

A Yes.

Q So you referred your patient accordingly even though you did not think, in fact, the problem was thyroid related?
A That is correct, yes.

Q If you go to page 47 you will find Dr Skinner's response dated 17 January:

> "[Patient A] has a history of six years utter fatigue, scattered aches and pains, occasional side vision hallucinations which I find to be quite common in hypothyroidism; … absence of libido, blurred vision and all in all it sounds rather suspicious of hypothyroidism. She has a hoarse voice, yellowish pallor… it is really quite likely that she is hypothyroid and perhaps B12 deficient.
>
> I know that she has had one or two highish TSH readings but nobody seems to have carried out a T4…"

which he says would be helpful. He writes:

> "I really thought that this was a good case for institution of thyroid replacement having taken a blood test and I have laid out a programme of thyroxin replacement at 25 micrograms per day…",

and then he explains how the course is going to run. Do you remember that letter?

A Yes. He also sent me results of the blood tests that he had taken that day which is on page 48.

Q If we go over the page to page 48 we can see that the date of the blood report is actually 24 January 2003, so a week after this letter was written?

A Yes.

Q Indeed, the specimen was not received by the laboratory until 21 January and so can you remember when this blood test got to you?

A The blood test from Micropathology Limited came with a letter of 17 January. When my practice receives letters they put a stamp on the front of the letter. It is partially obliterated there but it says - can you say it says "Received."

Q Yes. Do you know what that date is there?

A I think it is 2 February.

Q So looking at that blood test that you see at page 48 what, if anything, did you make of it? Did you think there was thyroid problem here?

A Well, if you look at that report it gives you a reference range and as you can see the T4 and the TSH fell within the normal reference range of that report. So those were normal results as this laboratory, Micropathology Limited, stated.

Q Yes. I think you received copy letters from Patient A that she had sent to Dr Skinner and it was really a letter of complaint. I will not go into any detail of that, you have it at page 49, 50 and 51 of your section of the notes.

A Yes.

Q Could you go on, please, to page 53?

A Yes.

Q This is written to you on 13 February in which he writes as follows:

> "A note on [Patient A] whose thyroid chemistry is enclosed with this note. The clinical features and the lowish T4 reading do I think suggest that this lady may be suffering from hypothyroidism … while her T4 is within the 95% reference interval is significantly below the average for healthy patients and I would be very disappointed that we cannot return Patient A to optimal health..."

Again, if there was a further thyroid chemistry we do not have it and I presume it is referring back to the blood test we were looking at earlier?
A Yes.

Q As a GP and certainly you can only speak about it from the GP angle?
A Yes.

Q As you treated people presumably with thyroid disease, did you regard this first line of Dr Skinner's letter as accurate saying that the clinical features and the lowish T4 reading suggested that she may be suffering from hypothyroidism?
A Well, he actually says it is "significantly below" the average and I disagreed with that.

Q Where does it say significantly?
A On page 53:

> "It is significantly below the average for healthy patients."

Q I am sorry. You are absolutely right. Did you agree with that?
A Yes, I read that and also his comments about the institution of vitamin B12 therapy.

Q Did you agree that it was significantly below?
A No.

Q What do you say about the B12?
A Vitamin B12 deficiency had not been checked for by Dr Skinner but if you look back to the previous doctors who had seen her vitamin B12 deficiency is shown in a simple normal blood count where a patient has a macrocytosis, they have enlarged red cells. So any simply blood test shows a vitamin B12 deficiency, although patients can get symptoms before that clinically occurs. I see in my ENT practice a lot of patients with B12 deficiency because they have mouth symptoms which are the commonest presenting signs. This lady certainly did not have B12 deficiency. A thyroid deficiency perhaps one could argue about but certainly B12 deficiency she did not have and I would not institute vitamin B12 deficiency with a thousand micrograms of vitamin B12 daily, which incidentally you have to give by injection. So she would have had to have had daily injections of vitamin B12. So I did not start that treatment nor the thyroxine treatment.

Q He talks at the top of page 54 about some adjustment to thyroxine dosage with the introduction of Armour Thyroid:

> "…which is an excellent preparation used extensively in the US."

Did you know about Armour Thyroid?

A No, sorry, I am not aware of that.

Q The last paragraph writes this:

> "I think this is the way forward for this lady and I apologise I have not been able to take the matter through to completion. The outcome of the professional relationship with [Patient A] is, of course, very upsetting and, indeed, I have never to date had a complaint in 35 years of practice albeit we have a slightly unorthodox set up."

That was a reference to her complaint about the nature of the consultation with which this Panel are not primarily concerned. Can we go to page 55, please. Having received that letter from Dr Cooke I think you wrote this letter to Professor Franklyn asking her to see Patient A and writing:

> "You will see the following, as a self-request, she recently saw Dr Skinner who you may know who started her on thyroxine to which she has some reaction. I have explained that I am not entirely sure of the prescribing of this when her TFTs fall..."

TFT?

A Thyroid function tests.

Q

> "... within the range of accepted normality. I would thus value your kind opinion ..."

It may be obvious to all, but why did you write that letter?

A Because I was a little unhappy about the prescribing of endocrine replacement therapy, thyroxine, to a patient with normal thyroid function tests and steroids and vitamin B12. I have been a GP for many years and I have become much more conservative in my attitude to medicine over many years, and certainly in susceptible patients who see doctors privately as well as sometimes harmful side effects of inappropriate therapy, patients are given unrealistic ideas of how much improvement in their lifestyle they can obtain and all this together - the other thing is if a patient is hypothyroid, by the way, it also has an effect on the National Health Service because, the Panel may be aware, if you are receiving thyroid replacement therapy you qualify for free prescriptions. This lady was only in her 40s which meant she could have all the prescriptions for the rest of her life for everything, every drug. So there were a lot of implications here which I did not mention. So that is why I wrote a fairly short letter to the professor for the professor's opinion.

Q (*To the Chairman*) Madam, can I just mention one thing in passing? If there is any

A further reaction from the public gallery to any evidence being given I will ask that the public gallery is cleared. You can see it directly. It should not be affecting the Panel. If the public cannot keep a poker face, as it were, they ought not to be in the room. Let me move on.

(*To the witness*) You received a reply back, I think, from Professor Franklyn. If we go to page 56, she writes:

B

> "As you know you asked me to address the question of diagnosis of hypothyroidism and appropriate management. This lady really has quite chronic symptoms, including profound tiredness and bowel problems, for which she has seen Dr Smith in the past without any specific diagnosis being made. Having read that some her symptoms might fit for Hashimoto's thyroiditis ..."

C Can you just tell us very briefly, Hashimoto's thyroiditis?
A Patients have either an overactive or an underactive thyroid. Hashimoto's thyroiditis is an autoimmune disorder. It is an inflammatory disorder of the thyroid gland and it is characterised often by the gland itself becoming inflamed and eventually the gland itself - I am simplifying all this - becomes under-functional and the patient becomes hypothyroid. One of the classical things about an autoimmune disease is serologically one can do blood tests to test for anti-thyroid antibodies, you form antibodies against your

D own thyroid which destroy your own thyroid, and there is another blood test you can do called an ESR, an erythrocyte sedimentation rate, which is elevated. The patient had had those tests done in the past although they are not mentioned in these notes here.

Q Is this comment by Professor Franklyn based on those tests, do you know?
A Yes.

E Q

> "... she was subsequently seen by a practitioner outside the NHS and began treatment with Thyroxine. She did feel that her bowel symptoms improved, although on the higher dose of Thyroxine she did notice some emotional symptoms", et cetera et cetera.

F "Clinical examination",

- I am reading from the bottom of the page -

> "from a thyroid point of view is unremarkable, in particular she has no goitre."

G Over the page please. She brought along the thyroid function test, that is at page 16 of tab 2:

> "... which had been checked in January of this year, prior to starting thyroid hormone treatment. Free T4 was normal at 12.2pmol/l as was the TSH at 1.4mU/l. I did explain that given this extremely normal TSH one can be confident about ruling out a diagnosis of hypothyroidism. Since she did experience some improvement in her bowel symptoms after starting thyroxine treatment it is quite

H understandable that she would wish to pursue this. I explained that there is no specific indication as driven by her thyroid function tests for this to be continued, or

indeed expected to be helpful. Nonetheless, should she choose to continue with thyroid treatment, my advice was that she should revert back to Thyroxine and stop desiccated thyroid, and in addition that steps should be put in place to ensure she is not over treated. The latter recommendation is based on extensive evidence that over treatment with thyroid hormones, as indicated by suppression of TSH, is associated with long term adverse effects, specifically with development of atrial fibrillation and increased risk of osteoporosis."

She writes that she checked the thyroid tests again today and that Patient A was happy to stop the desiccated thyroid and would consider what she was going to do about thyroxine.

Help us. How did it go on from there?

A Patient A felt better on the small dose of thyroxine as prescribed by normal patients and she continued, whilst under my care, on a small dose of replacement thyroxine following all this affair. The normal prescribable Levothyroxine, which it is. I continued as her GP over the next two years and she was on a small dose then. This has been increased, I see from reading her full notes, since my retirement from general practice and as far as I am aware she continues on the normal prescribed dose of thyroxine up-to-date and her thyroid function tests are monitored still by my partners in that practice.

Q If you go over to page 58, which is the last document I am going to ask you to look at, you will see that you did get the blood tests and that the thyroid function tests showed that she had, as Professor Shepherd writes:

"... a completely normal free T4 at 12.6 ... and TSH at 0.4 ..."

So at the bottom end of the normal range.

A Yes. In other words, because she was taking thyroxine her T4 had gone up a little bit and her TSH had fallen, which one would expect.

Q Thereafter, when you treated her by prescribing thyroxine, can you remember if there were fairly regular blood tests?
A Yes, they are in her records.

Q If we go right back to the beginning, are these your practice's computerised notes?
A Yes. Unfortunately, they do not photocopy all the results from the lab.

Q Are you able to help us how often her blood would have been checked?
A It was standard, when I was in the practice, to check it every three months for one year. Once that was normal I would do it every six months for a further year and then at yearly intervals.

Q If you are treating somebody with thyroxine what would have been your aim?
A To make the patient clinically and symptomatically euthyroid and feel well. At the same time maintain her thyroid function tests within the range of normality serologically in her blood tests.

Q So the TSH level should remain within ---
A Within normal limits.

Q Within the assay range?
A Yes.

MR KARK: Thank you. Would you wait there, please?

Cross-examined by MR JENKINS

Q Dr Cooke, I am asking you questions on behalf of Dr Skinner. Can I just take you back to the records dealing with Mrs A at the start of tab 1? I am going to start at page 3, if I may.
A Yes.

Q I think wherever we see the initials "EC" ---
A That is me.

Q That is you?
A Yes.

Q I think you saw Mrs A in July 2001 when she complained of being tired all the time. Yes?
A Yes.

Q I think we see that you asked for some blood tests to be undertaken. 27 July 2001? Page 3.
A Yes.

Q She complained of being tired all the time and you referred her on for some blood tests.
A Yes.

Q TFT is thyroid function test?
A Yes.

Q LFT is liver function test?
A Yes.

Q FBC is full blood count?
A Yes.

Q It looks as if another doctor, initials NP, or perhaps a member of staff ---
A That is Dr Nick Plant(?), the partner. He recorded them on the computer.

Q Apparently the same day. We do not have the results typed in, it is not a problem, but we see the lab comment:

"Please note new reference range."

A Yes.

Q Is it right that different laboratories might have different reference ranges?

A Yes. The hospital in Dudley where these labs were done, you saw that the report we discussed previously, the laboratory that Dr Skinner sent his patient to?

Q Right.
A If I recollect, I am doing this from memory, Dr Skinner's lab said the normal was from 9 to 20?

B Q I think you are right.
A The laboratory in Dudley says that they are 10 to 23. Interestingly, the hospital I work at in Birmingham is even slightly higher. They say the normal is 11 to 25. There is a variation amongst laboratories as to what is their range of normality.

Q I understand that. I just want to take you on and use you, if I may, as a knowledgeable witness to ask your comment about documents later in the bundle. Can
C I ask you to turn to tab 3, page 102?
A Yes.

Q This is a patient you have never dealt with. This is Scotland, but I am just looking at the laboratory results in the middle of the page. We see a free T4 figure.
A Yes.

D Q A range for that laboratory?
A 11 to 23.

Q 11 to 23.
A Like the hospital in Birmingham that I just said.

Q Yes. The date of that, we will note, is 21 August 2002.
E A Yes.

Q This is Inverclyde Royal Hospital.
A Yes.

Q If I can ask you to turn on two pages to page 104, do we see that with the same hospital, the same laboratory, the reference range for free T4 has changed?
F A Yes.

Q It has gone from 11 to 23. It has now been moved to 10 to 24.
A They have widened the parameters, yes.

Q I ask you to look at it, Dr Cooke, just to ask whether that is an example of what we have seen on page 3, the reference range changing?
G A That is an example of all throughout the health service. The hospital in Dudley where, in general practice, I did my blood tests, Dr Skinner's lab in Birmingham where he did his and the hospital I work at now, all three hospitals have slightly different reference ranges. The reference is generally from 9 to 25. I have not seen anybody with a reference outside of those ranges.

Q Again, I was using you as someone who would be able to help us with those
H matters.

If we look on down page 3 we will see that you saw Mrs A again on 4 September. Tab 1, page 3. It is two thirds of the way down the page.
A Yes.

Q "Patient's condition the same", and there is reference to her mood.
A Yes.

Q Reference to counselling. Do you know what type of counselling that was?
A I think she was going to anxiety - it was not arranged by the practice. I think she was going to anxiety management counselling. Can I talk about her family history?

Q You can because she is anonymised.
A Patient A has three children and, unfortunately, her children, all three of them had a very peculiar prolonged gastroenterological disorder with very peculiar bacteria grown from their stools, and she had been to see various consultants and we were unable to clear it up, and it was quite worrying and she was very worried herself at that time. That is not mentioned in these notes.

Q No, it would not be because they are her notes rather than those of her children. If I can take you on. We know that you saw her again the following year on page 4, I think you have already been referred to it, the entry for 5 June 2002 about a third of the way down the page?
A Yes.

Q We know that you referred her to Dr Smith and we have seen the correspondence so far as Dr Smith is concerned. Again, I have taken the Panel earlier on to the documents that were sent and retrieved from Dr Skinner in tab 2. I think the Panel have been asked to look at them in tab 1 from Mrs A's medical records. The first letter from Dr Smith is at page 36 of tab 1.
A Yes.

Q I think you have another letter from him addressed to you, "Dear Ted", on the next page, page 37?
A Yes.

Q We know that ---
A Do you wish me to comment on that?

Q No, I do not, but if you feel you need to then now is the chance.
A Well, you will see the letter of 1 July 2002 which you raised there. I had not noticed that. You see that Dr Smith has actually checked, "immunological screen for autoimmune disease". Autoimmune disease includes Hashimoto's thyroiditis, so she had been tested for Hashimoto's thyroiditis.

Q Yes.
A With an ESR of 2. Remember I said the ESR was that test you did for it?

Q I think the Panel have already heard, through me, that a view was made by a consultant in 2002 that she was clinically euthyroid. Yes?
A Yes.

Q You then referred her, and I am going back to page 4, tab 1. You then referred her - is it Veitch or [Veetch]?
A Veitch.

Q Thank you. Again, the Panel have seen the correspondence. I have shown them the correspondence in tab 2. The first letter in tab 1 is page 40, October 2002. Do you have that?
A Yes.

Q The reference I have already made is the last paragraph on that page, page 40.
A Yes.

"... she looked well and was clinically euthyroid. Her abdomen was soft and a little tender in the right iliac fossa."

Q The next letter from Dr Veitch is two pages. There is one on page 42 talking about the endoscopy and the result of that, and then page 43, a review in December 2002?
A Yes.

Q What you have told us is that Mrs A told you about a Dr Skinner and that it was something she had read. Might she have been mistaken about that? It was actually something that someone had told her?
A It is such a long time ago I cannot remember how Mrs A got to know of Dr Skinner, but I personally did not know of Dr Skinner. I did not make the referral. She made the appointment herself.

Q I understand.
A And then told me.

Q What you told us originally was she read somewhere that she might have a thyroid problem?
A That may be inaccurate. She may have heard, or read, I am sorry.

Q Thank you. You have told us that she made an appointment with Dr Skinner and then asked you?
A Yes.

Q Are you sure that she had actually got an appointment before she asked you for a referral, or whether in fact she had made contact with Dr Skinner's clinic and she was told that she should have a referral letter from her doctor and that is why she came to you?
A Can I look in my notes? Excuse me. I wrote a letter on 20 December.

Q Yes, page 4, tab 1.
A Yes, but if I look back to 12 December ---

Q It is 18 December, may I help you, that Dr Veitch found no gastrointestinal causes?
A Yes.

Q It goes on to talk about other matters, including the patient wondering if it could

be auto immune thyroiditis:

"Ask opinion Dr Skinner who has an interest in this"?

A Yes. I honestly cannot answer that question correctly with honesty that whether she had the appointment at that time, or not. She said she was going to see Dr Skinner and I thought it would be appropriate then to take a referral letter from me.

Q Well, I understand. What I suggest was that it was not as you have told us that she had made an appointment and then asked you.
A Ah, that may be right.

Q But that she may have made contact with the clinic and was told …
A That she would need a referral letter.

Q … that she should have a referral letter from her GP?
A Oh, yes. That could well be so, yes.

Q I am grateful. We then know that you wrote a letter?
A Yes.

Q It was a letter setting out her relevant history?
A Yes.

Q Did you think that Mrs A might be depressed at that time?
A No, not particularly. She had not had any weight loss, she was not particularly anorexic, although she was tired, and she did not look particularly depressed, although she had lots of worries and concerns over her children at that time which in my opinion fell within the range of normality of a mother concerned over her children …

Q Well, I am grateful.
A … because all three of them were ill.

Q I am sorry, I do not mean to interrupt you. All three of them were …?
A Were ill.

Q Yes. Can I take you back to page 43, which is the letter from Dr Veitch, two weeks before you saw Mrs A on 18 December. In the middle of the page Dr Veitch, albeit he is a gastroenterologist, says, "… she is not clinically depressed"?
A That is right. I agreed, yes.

Q So, you referred her to Dr Skinner and you got a letter back from Dr Skinner thanking you for your letter of referral …
A Yes.

Q … and indicating the treatment that he was proposing?
A Yes.

Q Although you had reservations, is it right that in the records that we have, again at

page 4, the very next entry for 26 February 2003 is one of yours indicating that the patient's condition improved on a small dose of thyroxine?
A Yes, that is right. Yes.

Q Yes?
A Yes, and that is why we continued the small dose of thyroxine even after she had seen the Professor at the Queen Elizabeth Hospital, which is what you are leading to obviously.

Q Are we?
A Yes.

Q We might get there, doctor.
A You might get there. As I said before, as she felt well on a small dose of thyroxine and her thyroid function test fell within the range of normality, I continued to give her a small dose of thyroxine after she had seen the Professor, as did my partners after my retirement from general practice.

Q Now, what the Panel have been told is that the definitive diagnosis of hypothyroidism is a chemical result. It is a blood test result.
A Yes.

Q We have been told that that is the only thing that matters, effectively. They are my words and it may be that I will be corrected, but that is what we have been told.
A I very carefully to the Panel did not say that.

Q I am not suggesting you said it.
A I said it about vitamin B12 deficiency, but I did not say it about - certainly the symptoms of vitamin B12 deficiency are different, but with borderline thyroid function tests GPs are in a very difficult position with this because, as you can see, the hospitals keep changing the goalposts as to what are normal levels. You have pointed out three different levels this afternoon, and GPs are in a very difficult position as to what is a range of normality here and what is normal for one hospital is not for another. If the patient felt clinically well on a small dose of thyroxine then, in my opinion, it was appropriate to continue as long as she was well and she was - she did not have cardiac symptoms, obviously, and other symptoms and her thyroid function tests fell within the range of normality for the hospital she was going to at that time.

Q Let me ask you this, Dr Cooke. Is it possible for a patient with normal blood chemistry for results within the reference range to have symptoms of hypothyroidism?
A Well it is, because this lady had some symptoms which one could attribute to thyroid under function, but she did not have any abnormal clinical signs. Symptoms and signs are different.

Q The question I am really asking is whether it might ever be appropriate in your view to prescribe thyroxine, or thyroid replacement therapy, for a patient who had symptoms, but for whom the blood chemistry was apparently normal, or within the reference range?
A I would agree with you. Yes, it would be appropriate.

Q It would be?
A It would be appropriate at the lower end, yes.

Q That is what happened here, it would seem?
A Yes.

Q That this lady's blood results came back as within the reference range?
A I am sorry, I did not make myself completely clear to the Panel. She was given not standard thyroxine that is prescribable over the counter. She was given a format of thyroxine which I was unfamiliar with.

Q Is that the armour thyroid?
A Yes.

Q We will come back to that. Do not worry. We will go through the history. However, I think she was initially prescribed Levothyroxine?
A It said armour thyroid in the letter.

Q We will come to that. Let us take you on so that we try and follow the chronology. Can I take you to page 6 of tab 1, please?
A Yes.

Q I think in the middle of the page you have a prescription for "Levothyroxine tablets 25 micrograms" on 23 January 2003?
A Yes.

Q That was what Mrs A was initially put on?
A Yes.

Q Not the armour thyroid?
A No, that is what she had ---

Q She was initially on Levothyroxine tablets 25 micrograms?
A Yes, from us. Yes.

Q Yes. We know that at some stage that went up to 50 micrograms?
A Yes, Dr Dalton put that up in June 2003 to 50 micrograms. "PD" is Dr Dalton. Peter Dalton.

Q I think actually it went up to 50 micrograms at an earlier stage.
A Oh, sorry.

Q I can demonstrate that by reference to Professor Franklyn's letter, which we have at page 56. This is a letter from April 2003. Do you have it?
A Yes, yes.

Q Halfway through the paragraph?
A Oh, yes. I am sorry, yes.

Q

> "… began treatment with Thyroxine 25 micrograms and subsequently 50 micrograms daily"?

A Yes.

Q

> "She did feel that her bowel symptoms improved, although on the higher dose …",

which must refer to the 50 micrograms:

> "… she did notice some emotional symptoms emerging …"?

A Yes.

Q

> "… because of this she therefore swapped to an animal preparation of desiccated thyroid",

yes?
A Yes.

Q So going back if we can please to page 6, we know that in January 2003 she was started on 25 micrograms of Levothyroxine?
A Yes.

Q Which is the standard …
A It is the standing starting dose.

Q … form prescribed on the NHS?
A Yes.

Q It was increased at some stage - it is not entirely clear there from the prescribing, but it was increased at some stage - to 50 before April, which is the date of Professor Franklyn's letter. Do you agree? The letter we have just looked at?
A No, I am sorry, because on 15/04/03 it says, "Levothyroxine tablets [repeat prescription] 25 micrograms, take one daily … EC". That is me. I wrote that prescription. You see, it says "as directed" before. She may well have been taking more than one a day, but I prescribed her one a day, 25 micrograms, on page 6, 15/04/03. Again, in May I have prescribed them.

Q Well, again it may be that we cannot quite make sense of the records and square them up with Professor Franklyn's documents.
A Yes.

Q However, if we go on to June 2006(*sic*), we see two prescriptions for the same day?
A 2006?

Q 2003, I beg your pardon.
A I am sorry.

Q It is 30/06/03 on page 6?
A Yes.

Q We see two prescriptions for Levothyroxine?
A Yes.

Q 25 micrograms, one daily, and 50 micrograms one daily?
A Yes, that is right.

Q It is clear that is it Dr Dalton?
A Yes, I think it is Dr Dalton.

Q Yes, is prescribing 75 micrograms a day …
A Yes, he had increased the dose.

Q … as at that point?
A Yes.

Q We know that after that, if you turn over the page, Mrs A is prescribed Levothyroxine at 100 micrograms?
A In February 2004.

Q Well, December '03, February '04, February '05, May '05 and we have been told today that she is still taking the same dose?
A Yes, that is right. If you look at 17/05/05 it says, "Levothyroxine 100 micrograms, take one daily", and then four-fourths means she has been given four months' supply. So at that time, yes, which I think she continues up-to-date. I am sorry, I do not know up-to-date ---

Q Well, no, do not worry. Just remind us when did you retire?
A In March 2004.

Q Right. If I take you back to page 4, we see that your initials start to appear with decreasing regularity?
A Yes.

Q We have looked at the entry on page 4 for 26 February:

> "Patient's condition improved on small dose of thyroxine but [thyroid function tests] are within normal accepted range. P"

- for patient -

"request advice"?

A Patient, yes.

Q Then you wrote a referral to Professor Franklyn, as you have told us?
A Yes.

Q Is it your entry again on 15 April 2004, "Patient's condition the same …", again page 4, "… definitely felt better on small dose thyroxine"?
A This is this ---

Q Armour thyroid?
A Yes, this armour thyroid, which I was unhappy with her taking because I did not know what I was.

Q I understand. I think it is used in other countries like America?
A Yes.

Q Did you make any note about whether this lady had headaches?
A I did not at that time.

Q Would you have wanted to know whether she had headaches?
A Oh, yes. I would have done, yes.

Q And which form of thyroid replacement therapy that she was taking when she had any headaches?
A Yes. I would have done, yes. I would have done.

Q You would have wanted to know?
A I would have done, yes.

Q Is it your entry again on 27 May 2003:

"Patient's condition improved …"?

A Yes.

Q

"… finds feels physically better on increased dose … No signs of toxicosis [continue for one month]"?

A Yes.

Q

"Then check [thyroid function tests]"?

A Yes.

Q There are thyroid function tests there?
A Yes, the following month.

B Q How long would you have wanted to see her thyroid function tests continue?
A Continue? Lifelong continue. As I said before, if I had have stayed within the practice I would have done her thyroid function tests every three months for the first year, every six months for the second year and after that on an annual basis. That was my standard thyroid follow up at that stage.

Q Well, can we just look and see what happened. There were tests done at the
C bottom of page 4 in June 2003. Do you have those?
A Yes.

Q Over the page more tests - well, forgive me. Let us follow it through. 30 June 2003:

"lot better Periods regular and bowels regular"?

D

A Yes.

Q I think that was one of her main concerns - constipation?
A Yes.

Q October 2003:

E

"Patient feels well periods better"?

A Yes, that is Dr Wiseman another member of the practice.

Q Right:

F

"No more constipation"?

A Yes.

Q

G

"Due blood check next week but seems likely dosage correct"?

A Yes.

Q Then tests done in October 2003?
A Yes.

H

Q There is then an entry for 20 October 2003:

"… in view of lowish TSH still then [increased] to 100 [micrograms] daily"?

A Yes.

Q Then to check after three months?
A Yes.

Q Then there is a check in February 2004, which is three-and-a-half months I think after the last entry?
A Yes.

Q Then there is a gap of eight-and-a-half months to October '04 and then a gap of 15 months to January '06?
A Yes.

Q Is that what you would have expected?
A T4, yes, roughly that. I would have done it more frequently, but my ex-partners did not do it as frequently as me.

Q Would you accept it is …
A They are within normal limits.

Q … it is appropriate to test blood for a patient on regular repeat therapy once every eight-and-a-half months, or even 15 months, which is what happened?
A No, I would have done them more frequently if it had been me.

Q Well, that is your preference.
A Yes.

Q What would you say of your partners who did not organise tests until 15 months?
A Again, we did not have a protocol for treatment of thyroid disease. I do not think many practices do have. I would have certainly discussed it in inverted commas with my partners and would have done them more often than this patient had. However, they were all well within normal ranges and so I presume they did not do them because they were well within normal range and the patient felt all right. I cannot answer for other doctors what they did not do, unfortunately.

Q Do this lady's blood levels ever suggest that she was hypothyroid?
A Not really, no. At the very start, they were within that low range. If you look at the end there, where we are talking about on page 5, you will see a T4 of 19 and a T4 of 17.3. That is well within the normal range, but at the early stage her T4s were down to - I cannot remember, but it was much lower than that.

Q So, this lady has been on thyroid replacement therapy for four-and-a-half years?
A Yes, now. Yes.

Q She has never had a blood test that suggests that she is hypothyroid?
A Only at the very start. I would say it was border line at the start, depending what

reference range you were going to say - you were going to take. Remember we said there are different reference ranges?

MR JENKINS: Yes, thank you very much, Dr Cooke.

THE CHAIRMAN: Mr Kark?

Re-examined by MR KARK

Q Dr Cooke, just a few questions in re-examination. You sent this lady off to Dr Skinner and we have your reference letter, if we could just go back to it, at tab 1, page 44. You have told us that she had a number of different complaints?
A Yes.

Q We can see that there were TSH levels given in July of 2001 and another in May 2002?
A Yes.

Q You have just answered Mr Jenkins earlier, when he asked you would it ever be appropriate to prescribe thyroxine if someone fell within the levels, and you said, "Yes, as long as she remained within the reference range you might prescribe her thyroxine". I just want to ask in what circumstances and why did you not for this patient?
A I cannot honestly answer that question. It has been such a long time now since I saw - the problem with these notes is you have not got all her blood results, unfortunately, and when they did her TSHs they did not do - unfortunately, laboratories for economic purposes only do TSHs.

Q Instead of doing T4s.
A They do not actually do a T4 unless you specifically ask for it, which is a problem with a lot of our laboratories.

Q Let me broaden the question then. In what circumstances would you prescribe thyroxine if somebody did fall within the reference range?
A If they fell within the reference range of normality and did not have symptoms of hypothyroidism, I would not prescribe it. If they have specific symptoms of hypothyroidism and are at the very lower limit of normality for that laboratory, then I might well prescribe as what happened with this lady. Well, let us say hang on, I did not initiate the prescription. I continued Dr Skinner's prescription but changed it.

Q Let me ask you about this. You were sent page 48 which was the reading received on 21 January and dated 24 January. I just want to ask you this, would you in these circumstances perhaps have prescribed this woman?
A No, I would not have. On the lab result on page 48 I would not have prescribed thyroxine for this lady.

Q Why not?
A Because they were not at the lower limit of normality, in my opinion. You can see from the labs reference. If her T4 had been 9 which is within the reference range of that laboratory and she had strong symptoms and signs of hypothyroidism. We keep talking

about signs, nobody has asked me about hypothyroid signs.

Q I will. Tell us what you mean by hypothyroid signs?
A Signs of hypothyroidism are complex. They are a feeling of tiredness and lethargy which this lady had. They have weight gain. The patient develops a condition called myxedema which is a water retention like symptom where they get puffy and they get quite marked swelling of the lower limbs, which we call pre-tibial oedema, which when you press it leaves a dent. The patients become anaemic. They have hair loss. They feel slow and sluggish. They have inappropriate reaction to temperature. This lady had some of those symptoms but she did not have any of those signs. She did not have any normal physical signs. Dr Veitch said she was euthyroid. Euthyroid means on examination she was clinically not hypothyroid.

Q If in one of those circumstances where you have one of these people at the very end of the range of normality and they had those signs?
A Yes, I would have started on thyroxine.

Q But once you have started what would you be looking to do?
A To improve her physical symptoms, improve the physical signs and check that her serological blood tests remained within the range of normality.

Q What do you do with that patient if you find that they have fallen outside the range of normality?
A If their thyroid function tests continue to go down you increase the thyroxine. I have recently seen a patient on 250 micrograms of thyroxine a day. If their thyroid function tests go up you reduce the dose and you can even stop it sometimes. It is very rare that once a patient is hypothyroid that you ever stop thyroxine in my experience.

Q If you see the TSH level disappearing off down the bottom of the scale?
A The TSH level takes quiet a while. T4 is the one to watch. That changes quickly. If a T4 goes over 25 you would reduce the dose quite quickly.

Q If you do see the TSH level going down below the scale?
A Again, you reduce the dose of thyroxine.

Q Because you are trying to keep them within the assay?
A Roughly within the assay ranges, yes.

MR KARK: Yes, thank you.

<u>Questioned by THE PANEL</u>

DR ELLIOT: I think that I have interpreted your letter on page 55 of T1, your letter to Professor Franklyn, as asking for Professor Franklyn's opinion as to the advisability of continuing thyroxine treatment in someone who had normal TFTs. Is that correct?
A Yes.

Q Dr Franklyn's opinion is given in reply on page 56 and 57?
A Yes.

Q Dr Franklyn says on page 57 half way down:

> "I explained there is no specific indication as driven by her thyroid function tests for this [thyroxine] to be continued or indeed expect it to be helpful. Nonetheless, should she choose to continue thyroid treatment my advice was that she should revert back to thyroxine."

Can I take it that you interpreted that as Dr Franklyn saying although there was no biochemical indication for treatment on a pragmatic basis this patient could continue it?
A Yes. That is what I have been trying to get across for the last five, ten minutes.

Q You were reassured?
A I was reassured, yes. As long as she did not take a drug I did not know anything about, ie, desiccated thyroxine.

Q I take it from the notes from your practice that your partners have taken the same view?
A They have taken this over and continued her follow up, yes.

Q You yourself were not involved in increasing the dose of thyroxine to the present level?
A No, no.

Q So you do not know anything about the rationale behind that?
A No, I cannot comment on that.

Q As far as you are aware during the period of thyroid therapy there was no biochemical evidence of thyroid toxicosis?
A No.

Q No clinical evidence of thyroid toxicosis?
A No.

DR ELLIOT: Thank you.

MRS WHITEHILL: Really I want the clarify a particular point. Was Patient A's blood serum thyroid level, the TFT, ever at the lower end of normal?
A Before?

Q Before she commenced treatment?
A In all these notes there is not one blood test that she had done where her thyroid function tests fell outside the range of normality of the laboratories, various laboratories she had tests. You will see earlier on in her treatment her T4 was towards the lower end of that normal range, as she commenced thyroxine that put her level of T4 up to what it is at present but it was never outside the clinical range of normality from all the different laboratories.

Q But it was toward the low end?

A It was the low end at initiation, yes.

Q Your evidence was that if somebody was displaying signs and symptoms and their blood results were at the lower end you may commence them on thyroxine?
A As did the Professor say. I was concerned to give it without a higher authority and when I got that higher authority then I continued to do so.

B

MRS WHITEHILL: Thank you very much.

THE CHAIRMAN: One question if I could. Back to B12 deficiency which we have not discussed thoroughly. The letter on page 47 from Dr Skinner mentioned that perhaps she was B12 deficient?
A Yes.

C

Q What are the signs? I think I have heard but I have forgotten the signs of B12 deficiency and also did you see any of these signs in this patient?
A Signs?

Q Symptoms or signs.
Q The symptoms of B12 are complex. They are essentially those of a peripheral
D neuritis. I am m not an expert on peripheral neuritis. They develop tingling and numbness in their hands. I have seen lots and lots of cases of pernicious anaemia as a GP. They always have gastroenterological symptoms and they always have a smooth tongue, a very smooth tongue. Hoarseness of voice develops later. They have problems with surface mucus membranes. Sometimes they has dysphasia, difficulty swallowing and one of the irreversible signs of B12 deficiency is once it gets more developed their peripheral neuritis becomes irreversible. They develop visual disturbance and blindness and the
E blindness is irreversible even though you commence B12 deficiency. I do not really think this patient ever had any of these symptoms of any severity.

Q And signs?
A Or signs.

Q Signs of B12 deficiency?
F A The signs are those of a peripheral nerve palsy, visual disturbance, glossitis which is a soreness of the tongue, smooth tongue. Gastrointestinal disturbances. Malabsorption syndrome and other neurological palsies, mainly neurological palsies.

Q Thank you. In your impression or professional opinion did this patient have any of
G these signs of vitamin B12?
A She had none. It is not in all these notes. She had numerous full blood counts which were normal. I have never seen a patient with vitamin B12 who did not have a macrocytosis, that is abnormal large blood cells on their peripheral blood fill and she never had that at all ever. B12 administration can only be given by injection. There is not an oral therapy so to give 1,000 micrograms per day means an injection every day. So I never commenced that.

H

THE CHAIRMAN: Thank you very much. Are there any further questions?

Further cross-examined by MR JENKINS

Q Yes, one. There is an oral preparation of B12, 1,000 micrograms?
A If you go abroad you can buy many tablets of B12 but unfortunately it does not get absorbed by mouth. Gastric acid breaks it down.

Q I suggest there is an oral preparation?
A But it does not work. There is no point in giving it to them.

Q Can I ask why do the manufacturers make it if it does not work?
A Because you can buy it over the counter.

THE CHAIRMAN: Thank you very much, Dr Cooke, for your presence here and that is all.

MR KARK: Madam, we are going to try and squeeze two more witnesses in this afternoon. I appreciate the Panel may want a break at this stage.

THE CHAIRMAN: I would suggest until 3.30 if we could, please.

MR KARK: We have one doctor who has flown down from Scotland and we have another doctor who has travelled up from London. I might ask the Panel to sit a little later. I know this has been a long day but can I ask what time we have to rise?

THE CHAIRMAN: 5 o'clock. We will proceed with speed, I am sure, Mr Kark.

MR KARK: Yes

(*The Panel adjourned for a short time*)

THE CHAIRMAN: Mr Kark, your next witness.

MR KARK: Could we have Dr Blair, please. Could I ask that *this* is handed out. This is the schedule of patient's names. I am afraid it needs hole punching and it is a matter for you it could go in the front of C1. It can go behind the charges or at the front of C1 so it is easy to identify who the actual patients are.

THE CHAIRMAN: Thank you.

DAVID BLAIR ,sworn
Examined by MR KARK

Q I think it is Dr David Blair, is that right?
A Yes.

Q Thank you for joining us from Scotland this morning. I want to ask you some questions about a patient who we are referring to as Patient B. I am going to ask you to look at a schedule. (*Same handed*) Could you just confirm that Patient B was one of your patients without reading her name out?

A Yes.

Q I am going to ask you, please, to turn up the bundle that is just to your left-hand side and turn over to tab 3 where I think you will find your surgery notes. Could you tell me something about your practice, please?
A I work in a five partner practice in Gourock. I recognise these notes as being of the patient concerned.

Q How long had this lady been a patient in your practice? I think you have got notes going back to 1973. Is that right?
A I am not sure.

Q Page 1?
A 1992 to 1999.

Q 1992 she came over to your practice. Thank you. If we go to page 27 that is where I really want to start. I am not going to complain about your writing because it is no worse than any other doctor I have come across but if we look two entries up from the bottom is that your entry on 13 January?
A Yes, it is.

Q Could you just tell us what it says?
A

"13 January multiple symptoms. See sheet."

There is a sheet which was available in the notes.

Q If you turn over to page, I thought it was 105 but perhaps you can help us?

MR JENKINS: 107.

MR KARK: Thank you. We have got one at 105 dated 28 January and one at 107 which is typed.
A Yes, the type written sheet was certainly given to me by the patient.

Q Does that relate to this date on 13 January?
A Yes, it does.

Q The heading of the document is:

"Signs and symptoms of hypothyroidism...",

she has ticked the following: very, very tired; exhaustion, falling asleep all the time; puffiness, eyes, face, hands feet and ankles; muscle/joint pain; lower back pain; skin dry and flaky; flushed; nails brittle, flake off, soft; hair loss, pubic, underarm, eyebrows, outer edge; overheat; breathlessness; slow movements; insomnia; shaking fits; hoarse voice; dry mouth; thick tongue; carpel tunnel like syndrome. What is that, please?
A It is a compression of the nerve in the wrist which is sometimes associated with

hypothyroidism, I think.

Q Loss of libido, blurring - poor focusing is ticked, dry eyes, gritty eyes, sore eyes, itchy eyes, tinnitus, noises in ears. I think heavy periods is underlined and, right at the bottom, heavy eyelids, and then over the page, balance - disorientation, concentration poor, emotional state - cries easily, mood swings, angry, depressed, nervousness, anxiety, noises in the head, persecution complex, resentfulness towards friends, lack of confidence, wanting to be on one's own. A multitude of problems.
A That is right.

Q What was your reaction to that? What did you decide to do?
A At that stage when I first saw her I looked at her peak flow chart and repeated her bloods, I think, are the two things I have noted down in the records.

Q Can I ask you to look at some blood tests? If we go, first of all, to page 102 in the same section, that is a blood test that predates this consultation.
A Yes.

Q We can see halfway down the page, it is dated 21 August 2002, first of all, bottom right-hand corner, and we can see that the thyroid function is shown as her T4 was measured at 16.7 where the assay range was between 11 and 23 and the TSH function was of 2.3 where the assay range was between 0.4 and 4. So that predated your consultation. If we go to page 104 you will see a report dated 15 January, so that is two days after you saw her, so we can take it that that is the blood you took on that occasion?
A Yes, dated 14 January 2003.

Q We see that her T4 level is has not changed very much from the last, 16.8, and her TSH level is at 2.4, so that has not changed very much.

I think you saw her again on 28 January. Please have reference to your notes if you need to go back to page 27. I think on that occasion she had a cough and she mentioned a symptom like an air bubble swallowing, so problems with swallowing in the throat. Yes?
A Yes.

Q Did she ask you on that occasion about a Dr Skinner?
A She did.

Q Tell us, please, what you decided to do on that occasion?
A I understood she was seeing him privately. She described him as a consultant virologist, which I am not sure if it is correct or not, and I checked his status with the GMC and that he was registered to practise as a doctor.

Q What did her symptoms suggest to you?
A I thought she was depressed.

Q Did you give her a prescription that you thought would help her with that ...
A Yes, I did.

Q ... or not?
A Subsequently.

A

Q I think you gave her something for her cough. Is that right?
A That is right.

Q I think the local health visitor visited her and carried out a beck depression inventory test. Is that right?
A That is right.

B

Q How did she score?
A She scored in the moderate to high area, indicating some significant degree of depression.

Q Did you, at that stage, think that the problem involved her thyroid?
A No.

C

Q However, on 10 February, and your notes, I think, are at page 28, you had a further discussion with her. Did you discuss the thyroid function test we have just been looking at, dated 15 January?
A Yes, we discussed her thyroid function tests, among other things.

Q Did you make your views clear about whether it was a thyroid problem?
A Yes, I explained to her that she did not have a thyroid problem as far as I was

D

concerned.

Q But did you discuss with her the possibility of antidepressants?
A Yes, I did.

Q Also hormone replacement therapy?
A Yes.

E

Q I think you saw her quite soon after that on 13 February?
A Yes.

Q You had further discussions along the same lines. Did you give her a prescription for anything?
A Yes, at that point I suggested she started taking an antidepressant.

F

Q What was that?
A Sertraline 50 mg, one daily.

Q I think you saw her again on 13 March and she was no better, or little changed?
A Little change, and I increased the dose.

G

Q Did you next see her on 8 April?
A Yes.

Q Could I ask you to turn up page 113, please?
A Yes.

H

Q In between your last meeting with her, on 13 February, when you prescribed her antidepressants and this meeting on 8 April, did you receive this letter dated 26 March?
A Yes.

Q Dr Skinner writes to you. Had you referred your patient to him or not?
A No.

Q He writes:

> "I hope I would not be in the dog house with you as I thought this lady was bringing a letter of referral from your office but she told me a slightly complex story ... so apologies if you did not intend her to come to see me."

First of all, let us deal with that. Did you intend her to go and see Dr Skinner?
A No.

Q

> "[Patient B]",

- he writes -

> "is one of these difficult situations where she seems almost classically hypothyroid with a number of typical features including choking fits during the night and side vision hallucinations which I find to be quite common in hypothyroidism ... tired, gritty eyes, no enthusiasm ... puffy around the eyes ... bradycardia of 58/minute and I think that notwithstanding the thyroid chemistry she is hypothyroid which is of course a matter of some controversy these days."

As a general practitioner, and I appreciate you are not a thyroid expert - I do not suppose you hold yourself out to be a thyroid expert?
A Certainly not, no.

Q As a general practitioner did you think that this woman was classically hypothyroid?
A No.

Q He writes:

> "I really thought there was a very good case for thyroid replacement and I have given her a prescription for thyroxine sodium but I have suggested that she does not begin this medication until for perhaps ten to fourteen days lest you did not wish her to come and see me and it would be discourteous to institute this without your knowledge. I have a hunch this is the right way forward with her and I perhaps just need to see her once more in about eight weeks time at which point I hope we will have her well on the way to improvement."

Then he writes a note at the bottom saying that he might know one of your partners.

What was your reaction when you saw your patient to that note? Your notes, I think, are at page 328 of the consultation on 8 April.
A The note came in before I actually saw the patient, on whatever date it was. I took the opportunity of discussing the letter with an endocrinologist and when I saw the patient I passed on the information I gained from the endocrinologist specialist, Dr Thompson,

A that there was no basis or justification for taking thyroxine in the situation of normal thyroid function tests.

Q At that consultation on 15 May were you still prescribing antidepressants?
A I do not think I prescribed the antidepressants after 8 April. Although it is not absolutely clear from the notes whether that is the case, I certainly did not prescribe her anything from 15 May.

B

Q Were you willing, as her GP, to take over the prescribing of the thyroxine?
A No.

Q Did you think she should have thyroxine?
A No.

C Q I think you next saw her on 15 May. Your notes, again, at page 28. By then had she started on the thyroxine?
A Yes.

Q Despite your advice to her?
A Yes.

D Q She indicated, I think, she was stopping the anti-depressives in any event, and she said she felt better?
A Yes.

Q A little better. You had another meeting with her, I think, on 26 September of that year. Can you tell us, please, how that meeting went?
A She explained to me she was still taking thyroxine in a dose of 175 micrograms per day. She also wanted to restart taking antidepressants and at that point I warned her very clearly again against taking thyroxine and I declined to prescribe antidepressants along with other drugs.

E

Q Is that because you did not think that they should mix, as it were? What was your reason?
A I was unwilling to prescribe her antidepressant in someone who prescribing what I considered an inappropriate dose of thyroxine on the basis that the two might cause problems given together.

F

Q You repeated, as you have said, your advice to your patient against taking thyroxine?
A Yes.

G Q You saw her again, I think, on 4 December and she told you that she was taking - is it 225 micrograms daily?
A Yes.

Q Did you check her pulse?
A Yes, her pulse was normal at 76.

H Q Did you give her a certificate to indicate that she was unfit for work?
A Yes, I did.

Q Why did you do that?
A Because she was suffering, I think, from depression and I put in the note, the Med 3, affective disorder as a diagnosis.

Q In your view at that time was she still suffering from depression?
A Yes.

Q Did you make a note about what you advised her in relation to the thyroxine?
A On that date I have written in block capitals, "EVEN MORE CLEARLY ADVISED", with a mark after it, in relation to thyroxine.

Q That was to stop taking the thyroxine?
A Yes.

Q I think you checked her thyroid function test. If I could ask you to turn up page 114, we see that following five days after that meeting on 4 December you instituted a blood test. Is this your blood test or did this come to you by way of Dr Skinner?
A No, this is a single blood test dated 9 December. There was almost a cumulative report which I just included on it. I do not see it but there was a cumulative report.

Q We do have that and I will take you to it. There is one at page 118, I think, and one at 119.
A Yes. The report on the date 5/12 and the previous reports were blood tests I had either taken myself or asked to be done.

Q Can we look at page 114 then, because that is the single blood test, as it were?
A That is right.

Q This is now after she has been on thyroxine for eight or so months?
A Yes.

Q Having seen Dr Skinner, as I think we are going to hear, on 20 March 2003, and we see that her T4 level is shown at 39 where the reference range is between 10 and 24, and her TSH level is down below 0.1. We do not actually have the reference range on that document but I think we will see on others that the normal reference range for that lab, we will see at page 117, was 0.4 to 4.
A Yes.

Q When you received that laboratory report what was your view?
A That she should not be on the dose of thyroxine she was on, if, indeed, any at all.

Q As you say, we have cumulative values. If we go to page 118. Just to make it clear, are these all separate tests that were performed on those days?
A These are separate dates: 5/12/03, 1 September 2004, 11 November 2004 and, I think, in December 2003.

Q We can see that she started in December 2003 after nine months or so on thyroxine with a T4 at 39, and then she gradually comes down. In September she is down to 22.4 and in November she is back down to 13.5, both of the last readings within the reference range. When she next saw you, after 4 December, was that 5 January 2004?

A Yes, that is right.

Q Did she tell you that she had actually, at least in part, taken some of your advice? She was reducing her thyroxine?
A Yes, she had reduced the dose significantly.

B Q I think your next entry in the records is a conversation you had with somebody called Dr Liz Jordan?
A Yes.

Q Can you tell us who Dr Liz Jordan is please?
A I cannot remember the exact title. She worked in the public health department in the area.

C Q Was there a discussion about a prescription that Dr Skinner had provided the patient?
A I do not have any notes of the conversation but my recall was that Dr Jordan told me that a chemist or pharmacist had questioned the dose of thyroxine being prescribed for that particular patient.

D Q I think I can help you with the date of that. Just keep a finger where you are, if you would, and turn over to tab 4 and go to page 18.
A Yes.

Q It is slightly difficult to read, but it is a prescription for 20 micrograms of T3 and 150 micrograms, I think, of T4 and we see at the bottom right-hand corner that the Tesco pharmacy had declined to dispense the T3.
A Okay. I have not seen this before.

E Q No, I understand, but was that something of which you were made aware by Dr Jordan?
A I simply was aware of being told that a prescription for what appeared to the pharmacist to be an excessive amount had been presented for dispensing.

Q I think you next saw your patient, Patient B, on 23 March 2004?
F A That is right.

Q I think you had a letter from Dr Skinner. Can you turn up page 115 of tab 3?
A Yes.

Mike - he writes this to you ...
G A Yes.

Q He writes this to you:

> "[Patient A] visited my rooms today and indeed I saw her on a courtesy basis as she apparently is in dire financial straits. As you know we have been working on her dosage and she had a strange episode of racing heart at the weekend which has since disappeared without return but I wondered if this might be related to somewhat excessive intake of alcohol on the previous evening and she herself

H

fairly freely admits to this possibility; I am not sure how well alcohol goes with thyroid replacement and I have observed this phenomenon in a few other patients.

As you know she is now taking 75 [micrograms] per day with 20 [micrograms] Tertroxin ...

Did you know that until you got this letter?
A I did not know the exact dosage, no.

Q

"… and she seemed in reasonable shape although I still think she is hypothyroid …"

Now the most recent blood test that I think you had seen would have been 19 December 2003 at page 114, the page before?
A Yes.

Q It says:

"Suggests slightly over-replaced with thyroxine."

Well, that is the lab comment. Did you think - as a GP certainly, would you have treated this lady as being hypothyroid?
A No.

Q

"… she had a bradycardia …"

I am sorry, bradycardia?
A Bradycardia is slow pulse rate. That is not what I found when I examined her.

Q

"… of 52/minute - and I thought that perhaps the right approach here would be to alternate 75 [micrograms] and [100 micrograms] thyroxine per day but continuing with 20 [micrograms] Tertroxin and I think it would be possible in a canny way as they say to increase her input of thyroxine replacement as I personally doubt that the strange episode in the early hours of one morning was related to excessive thyroxine replacement. [Patient A] is a bit of a problem and is presently in confrontation vis-à-vis disability and income support etc the ins and outs of which I did not fully comprehend but in general I think she has notably improved since the institution of thyroid replacement."

Had you changed your view at any stage that this patient should not be on thyroid therapy

- thyroxine?
A No.

Q You saw her again I think on 17 May and I think on that occasion her thyroxine she was taking 150 micrograms daily, you repeated the certificate that she was unfit to work and in August 2004 did you have a conversation with her about the thyroxine again?
A Yes, she indicated that she had decided to reduce and stop the thyroxine and I advised her to do this slowly and issued her a prescription for a relatively small strength tablet so that she could reduce it gradually over a period of several weeks.

Q So, that is in August 2004. That was on 5 August 2004. If we go back to page 118 again, we can see that her levels relatively quickly seem to be coming back to normality?
A Yes.

Q You saw her again I think on 1 September and she was then down to 100 micrograms of thyroxine daily and I think you did then prescribe her thyroxine at 25 micrograms?
A Yes.

Q What was the point of that?
A Just to reduce it gradually. The dose I was prescribing was small and reducing. If you stop thyroxine suddenly, it can be unsafe.

Q I think by 14 October have you noted that she was off thyroxine completely?
A Yes.

Q By 11 November she had, as we can see, a normal thyroid function test?
A Yes.

Q How was she managing?
A She was actually managing slightly better at that stage than she had been before.

MR KARK: Yes, thank you. Would you wait there, please.

THE CHAIRMAN: Mr Jenkins?

MR KARK: (*To the witness*) Oh, I am so sorry. There is one other document I should have shown you. Could I ask that you be given file 2 (*Same handed)* - I am sorry, Mr Jenkins - and could I ask for the Panel to be given file 2 as well. (*Same handed to the Panel*)

THE CHAIRMAN: This will be C2.

MR KARK: Thank you, Madam. File 2 as you will see at the moment has a missing section 3 which I am afraid we are still copying and sorting out, but you have sections 1, 2 and 4:

Q (*To the witness*) Have you been given it?

A Yes.

Q Can you turn up tab 1 and go to pages 2 and 3. Page 2 is a handwritten note saying, "Dear sir/madam", and it is dated 19 December 2006:

> "We sent this letter in October and have not received any acknowledgment yet from the practice. Just in case I am re-sending it",

and it is headed from Dr Gordon Skinner and then you have this letter. Do you remember receiving this?
A No, I had not received this letter when I received the handwritten note.

Q However, you did receive it with the handwritten note?
A With the handwritten note, yes.

Q All right. He writes to you on 25 October 2006:

(*This document was not provided*)

> "A note on [B] who did not specifically come for a consultation but came to see her friend who is our practice manager in Glasgow on 8 October 2006. As you know I have not seen [B] since she stopped her thyroxine, but it seems to me that she is still hypothyroid and that she still feels tired with scattered aches and pains, difficulty in cognition and I did check her pulse rate which was 62/minute and blood pressure at 150/80".

I am sorry, but again for the non-medical members is that high, or low, or normal?
A It is a slightly slow pulse rate and very marginally elevated upper blood pressure. Systolic blood pressure.

Q

> "She is of course notably overweight with dull puffy eyes and it is interesting that indeed her pulse rate was 62 when you kindly saw her when she was taking 200 [micrograms] thyroxine per day. I took a blood sample which is enclosed, and as so often happens in my view the thyroid chemistry was fairly normal but I know it is a controversial area. I really do think that [B] is hypothyroid, but of course I did not make any therapeutic suggestion as she is no longer under my care. I do understand that unsolicited suggestions can be somewhat irritating in medical practice, but I suppose she was once under my care and you will forgive this. I also understand that she is coming to see you in the near future and perhaps you might give some consideration to the possibility of reinstituting thyroid replacement."

Then over the page we have the blood report which shows that her T4 was 14.1, with the

reference range being between 10 and 22, and her TSH level was 1.92 with the reference range for that laboratory being between 0.3 and 4.5. You at that time did have the care of this patient at your surgery. Did you regard her then as hypothyroid?
A No.

Q Did you prescribe as Dr Skinner was suggesting?
A No.

Q There is one last document, I am sorry, I should have asked you about. Right at the back of the other file, tab 3, page 122, can you help us with any sort of date for this note?
A (*Pause*) I think that was on or about the beginning of '06, because when I last spoke with her, according to the notes 9 December '05, she had explained she was attending college and doing a course there. I am fairly clear that that letter followed that.

Q Right.
A I would not put an exact date on it, but recalling the details she gave me of her course, what she was doing and so on, it would fit in if that letter was after the last time I saw her?

Q So if we noted around or about the beginning of 2006, that would be fair?
A Yes, yes.

Q She writes:

> "Dear Dr Blair,
>
> I finished the pills I had and didn't make time to get more. As you can see I have now started running my own business. I am also doing a chiropody course with three full days a week for practical work. I have not noticed any difference since the pills finished, and feel that I am well on the road to recovery. I could not get an appointment to see you this week, so will hand this in when I go for my mammogram. Thank you for being understanding when I needed that."

The pills that she is referring to there, are you able to help us?
A These would be the thyroxine I gave her.

MR KARK: Thank you very much. Would you wait there.

THE CHAIRMAN: Thank you.

Mr Jenkins?

<u>Cross-examined by MR JENKINS</u>

Q I am sorry, the thyroxine you gave her?

A The reducing dose so that she could stop.

Q I understand. I understand. What this patient presented to you was the sheet that we have at tab 3, page 107, and you have told us that she gave you that sheet?
A Yes, she handed me the two sheets, or a double-sided one sheet of paper.

B Q In January 2003. What you have indicated on page 27 of the notes is "multiple symptoms"?
A Yes.

Q "See sheets"?
A Yes.

C Q You measured her peak flow, which is to check her respiratory function?
A Yes.

Q You ordered some blood tests?
A Yes.

Q Did you do anything else?
D A Yes. I spoke with her at some length on a few occasions, yes.

Q Right. Did you explore the symptoms that she was complaining of?
A I did not specifically explore each symptom. The group of symptoms were very long, widespread and non-specific, and the routine blood tests which I did did not suggest any need for further investigation and I felt that the symptoms she displayed could be explained most reasonably on a background of depressive problems.

E Q She has got from some source a list of what might be the signs and symptoms of hypothyroidism?
A Or very many other conditions, yes.

Q That may be right, but what she has got is a document headed "Signs and symptoms of hypothyroidism"?
F A Well, I believe incorrectly the "Signs and symptoms of hypothyroidism".

Q She has suggested that a significant number of them are concerns that relate to her?
A Yes.

G Q Did you explore those?
A We looked over the sheets, yes. I do not remember discussing each symptom in detail, no.

Q What you sought was a blood test, which suggested that her blood results were within the reference range?
H A Several blood tests, yes.

Q Does that mean that she cannot suffer from hypothyroidism?

A Well my understanding of thyroid function tests is that, if the thyroid function tests are normal, the patient is not suffering from hypothyroidism.

Q All right. Well, if you had a patient who was complaining of a number of symptoms and there were a number of signs which may be consistent with hypothyroidism and the blood tests came back to suggest that the patient's blood readings were within the normal range, would you think it might be appropriate to start the patient on a trial of thyroxine?

A No.

Q No. Tell us why not?

A On the advice of the endocrinologist, Dr Thompson, based at the hospital.

Q I am going to ask you to keep your voice up a bit.

A I am sorry, on the advice of the endocrinologist, Dr Thompson, who I discussed this with.

Q Do you think other doctors might in those circumstances start a patient off on a trial of thyroxin?

A I do not know of any doctors who would do that, no.

Q Can I suggest there are some that would and I daresay perfectly properly?

A I accept that there might be some doctors who would do that. I would not agree with that course of action. If you wanted a more relevant opinion, then an endocrinologist would be the person to ask about it.

Q Over the next months, in your notes did you keep track of how this patient was doing?

A Not very close track. I left it to her to attend me when she felt it was appropriate.

Q I understand that. On the occasions when she did attend you, and I am looking at page 27, have you gone through the sheet that she had given you in January 2003 to see whether she was still suffering from those signs, or symptoms, or whether there was any reduction in them?

A I do not specifically remember asking her that. My impression was that her condition did not change very greatly over that spell.

Q When you say your impression, can you point to any notes? Well, perhaps I should do this properly. Can I just ask you to take us through from March 2003 what you have got? 13 March "ISQ", page 28. "ISQ", in *status quo*?

A Yes.

Q Meaning things remaining the same as before?

A Yes.

Q What does that relate to?

A I do not remember what we discussed specifically on that date. I discussed her difficulties in terms of her social difficulties, I discussed her financial difficulties with her and I discussed all sorts of things over that spell. I do not remember that particular

consultation.

Q Would it be fair to say that your note does not actually help you as to what was remaining the same?
A No, it does not help me.

Q I understand. Well, you are not on trial here.
A No, I appreciate that.

Q Do not let me give you the impression you are, but it may be that your notes do not give you the best recall of quite what was said. Would you accept that?
A I do not remember what was said.

Q Right. The next occasion that you have got an entry is 8 April 2003, "See letter. Advise against thyroxine", yes?
A Yes.

Q Does it say how she was doing on the thyroxine?
A No, it does not.

Q Okay. The next occasion, 15 May 2003, does that say "On thyroxine"?
A Yes.

Q What does it say, "Stopping …"?
A "Stopping Sertraline".

Q Sertraline is the antidepressant you prescribed?
A Yes.

Q "Generally slightly better"?
A Yes.

Q Is that what it says?
A Yes.

Q What does that refer to, the "generally slightly better"? Does it refer to the list of signs and symptoms that she had given you four months earlier? Does it refer to the depression that you thought she may have? What does it mean?
A I think it reflects the fact that she was feeling slightly better than she had been.

Q Is that physically, or emotionally?
A I do not remember what it was.

Q Psychologically?
A I do not remember.

Q Let us go on. The next entry is September?
A Yes.

Q "Taking thyroxine" and you have put in the level?
A Yes.

Q "Wishes to stop the antidepressants"?
A No, "Wishes also to take antidepressants".

Q Oh, "… also to take antidepressants"?
A Yes.

Q How was she doing at that point?
A I did not think there was a further change in her situation at that point.

Q Did you have concerns about this lady being on thyroxine at this point?
A I had some concerns, but physically her pulse rate was not fast and her blood pressure was unremarkable.

Q Forgive me, did you take her pulse in September?
A I am sorry, I am looking at December '03.

Q I understand. Well, let us stay with September.
A I am sorry, I beg your pardon.

Q Did you talk her pulse?
A No, or if I did I did not record it.

Q You see, Dr Skinner was writing letters to you suggesting that she was improving. Were you making your own enquiries about that?
A Not between the time of May and September and not between the time of September and December, no.

Q December, as you rightly say, you have recorded a pulse and a blood pressure?
A Yes.

Q Pulses very slightly elevated and the first reading on the blood pressure slightly elevated. Can you just read the next couple of lines to us, please, and to be fair to you I think the photocopying is bad.
A 4 December?

Q Yes?
A Yes, "Taking thyroxine 225 micrograms daily. Pulse rate regular. 76. BP 150/70", and then "Affective disorder" in inverted commas which relates to her ---

Q That refers to the "C 8/52", which is the certificate for eight weeks that you gave her?
A Yes, sorry. That is also there, yes.

Q That is in the margin?
A Yes.

Q Just by the date, "C 8/52", which means a sick note for eight weeks?
A Yes.

Q Right. The quotations are there because that is what you put on the form, am I right?
A That is correct. "Affective disorder", yes. "TFT" is ticked. "Copy report to patient." I think she had asked for a copy of the report of the blood tests.

Q Yes.
A

> "Even more clearly advised…..",

which indicated I was advising against continuing with the thyroxine.

Q How was she doing on the thyroxine?
A I have not indicated any change from before when I said she was slightly better in May. So if I have not indicated a change I think it is unlikely that there was a great change in her overall situation.

Q You say unlikely. Were you asking her whether there was any change? If you were asking her why did you not put that there was no change?
A I tend to record positives rather than negatives. If it has not changed I very often will not record there was no change.

Q You could put "ISQ" as you had done earlier on?
A I might well have done, yes.

Q Let us turn to page 115, if we may, second paragraph, right at the end Dr Skinner says:

> "I think she has notably improved since the institution of thyroid replacement."

Are you able to comment on that using your notes?
A No.

MR JENKINS: Thank you very much.

THE CHAIRMAN: Are there any further questions?

MR KARK: No, thank you.

THE CHAIRMAN: Thank you very much and you are now released. Thank you.

MR KARK: Thank you very much. I would like to try and start and, I hope, finish Dr Summers. I see a nod from Mr Jenkins. I hope there will not be a problem. Should the worse happen and we go part-heard we may have to video link the rest of him. I see again Mr Jenkins does not seem to be concerned about that for which I am grateful. I think we will be able to get through Dr Summers but prefacing the situation.

MR JENKINS: I was going to ask could there be a short comfort break for two minutes, please?

(*The Panel adjourned for a short time*)

PHILIP DAVID SUMMERS, affirmed
Examined by MR KARK

Q I think it is Dr Philip David Summers. Is that right?
A That is correct.

Q I think you used, certainly I do not know if you still do, work as a GP at the Belgrave Medical Centre?
A That is correct. I used to but no longer do.

Q Where was that?
A In Pimlico.

Q In London?
A Yes.

Q Did you work there from May 2003 until October 2005?
A That is correct.

Q I am going to ask you very little about a patient. Could you, please, bear in mind that we are referring to this patient as Patient C. Could you have a look at *this* list of patients, please? (*Same handed*). Please do not read the patient's name. Could you confirm that that was your patient?
A Yes.

Q Thank you very much. Could you then take up the bundle to your left-hand side and if I could ask you to turn over first to tab 5 and you will find behind tab 5 the computerised records and those in 2003 and 2005 presumably relate to your surgery, do they?
A Yes, there is some, yes, page 8 I have here.

Q Sorry, page 8?
A Labelled at the bottom right-hand.

Q Yes. We can see this is headed an "Encounter book". Can you tell us what this document is?
A It is a computer generated print out of the database that was held at Belgrave Medical Centre.

Q You are not able to tell, I do not think, from this who else saw her? I think we see your name under: "Medical history"?
A Yes.

Q Are these just entries relating to you or would these be all of the occasions upon which she attended the practice?
A These would be all the occasions on which she attended the practice and a computer note was generated. So, for example, there is information about contraception consultation that she had with our practice nurse down at the bottom. So not just my consultations.

Q Your consultations appear in general under "Medical history", is that right?
A Yes, that is correct. Though some of those data entries were not necessarily occasions on which the patient consulted me. It would appear from this that the patient only consulted me on one occasion.

Q All right. Which one occasion was that?
A It would be 22 January 2004. Yes.

Q For general contraceptive advice and counselling?
A That is correct.

Q Could I then ask you to turn over, please, to tab 6, go to page 2. This is a letter dated 10 March 2004. Do you have it?
A Yes.

Q "Re [Patient C]", it gives the address:

> "Dear Dr Summers,
>
> I think I may be in the dog house as this lady came to my rooms and was meant to bring a referral letter with her but she was perhaps to timid to ask you for very referral.
>
> She has a history of being somewhat unwell since a late menarche at 14/15 years followed by irregular periods, poor energy and difficulty in concentration; she also catches grey objects on the floor out of the side of her eye which are all fairly common features of hypothyroidism. Her pulse rate was 60 per minute with rather dry skin and hair and I though it quite likely she was hypothyroid although not seriously hypothyroid.
>
> I have taken a blood sample for thyroid chemistry and should have this result in 10 days and I will let you know what goes forward at that point."

Then it talks about her family history of diabetes:

> "Again my apologies for seeing this patient without referral from your practice which is really our invariable practice these days."

Had you had any pre-warning, as it were, that that letter was coming to you?
A No. Not to my recollection anyway.

Q Had you, in fact, referred your Patient C to Dr Skinner?
A No.

Q If we go over the page to page 3 of tab 6 we can see this is a lab report dated 16 March 2004 which shows that her T4 was tested and found to be 11.6 with a reference range of 9 to 20 and her TSH 2.2 where the reference range was 0.5 to 5.5 for that lab. Can we take it when you received that letter you would not have had that blood test?
A I do not recall the case but I gather from GMC solicitors that whilst the letter that you read out was in the patient's file this lab report was not.

Q When you refer to the "patient file" you mean your practice patient file?
A Yes.

Q Could you turn page 6, please. Another letter to you. Do you recall this now? Does it bring anything back to mind or not really?
A Not since the case was -- I mean, I have seen the letter before, if that is what you mean, but I do not recall it from 2004.

Q I see. Okay. You recall it now having seen some of the papers in the case but you do not recall it from when it actually happened?
A I remember it from two or three weeks ago when I was first sent it.

Q Okay. This is dated 10 May 2004:

> "A note on [C]who I think is already improving on thyroid replacement although she has recently and off her own bat put her dose up to 200 micrograms thyroxine with (curiously) no thyrotoxicity which makes me wonder if perhaps there is a conversion problem here.
>
> I thought we needed to rationalise or stabilise the situation and perhaps add in some T3 if there is a conversion problem…",

in other words converting T4 to T3 presumably:

> "…and I have set her dosage at 150 micrograms thyroxine per day with 20 micrograms Tertroxin…",

which is T3?
A I believe so. I am not sure actually.

Q

> "…and I pleaded that she stay at this dose for four weeks at which point I will speak to her on the phone.
>
> In spite of the ups and downs, I think we are on a fairly decent track with [C] and I will keep you abreast of developments."

Can you help us, please, did you prescribe this lady thyroxine at some stage?
A I entered it on the computer as an authorised prescription thereby allowing her to, if she wanted, pick up prescriptions from the surgery for that medication.

Q Can you help us, please, where that is?
A That will be in tab 5, page 8, it is the repeat masters. So in other words, I set up a repeat master.

Q What caused you to do that?
A I presume that it was the receipt of that letter of 10 March.

Q What were you reliant upon in terms of prescribing thyroxine to this patient?
A That letter from Dr Skinner.

Q If you had had the blood test that you have just been looking at at page 3 of tab 6, would you have done that?
A No.

Q So why did you?
A Well, I had not seen the report. I had not received the blood test.

Q Did you know Dr Skinner?
A No.

Q Did you rely upon his letters?
A Yes.

MR KARK: Would you wait there, please.

Cross-examined by MR JENKINS

Q You do not remember this patient at all?
A No.

Q You do not remember any episode that you may have had with her?
A No.

Q It follows you do not remember whether there may have been a discussion with her about Dr Skinner before she went to see him?
A That is true.

Q It follows that you cannot tell us whether she asked you for a letter of referral?
A It would have been my usual practice to have noted something like that.

Q I hear that but can we take it that there may be occasions that you did not note things that you might wish you had?
A Yes.

Q I understand. You had told us that you did prescribe thyroxine. Can you tell us

when you first prescribed it? You have to tell me which page you are looking at, if you would.
A I am looking at tab 5, page 8. There is not a date on the repeat master.

Q From this, when do you think you did prescribe it?
A At the beginning of August 2004. I spoke to the acting practice manager at Belgrave Medical Centre.

Q When did you speak to them?
A Last week or the week before.

Q Were you trying to find out if there were any other records?
A Yes.

Q Are there any, so far as you know?
A No.

Q So the best we have, other than doing a search or some kind of EMIT test on the computer, is this document. Is that right? To help us when you prescribe.
A Yes, though there is a date. Apparently, when the database is open in front of you and you can see the full record there is a date associated with those repeat master prescriptions which is on or about the beginning of August.

Q If that is right it would tie up with problems higher up that page, page 8?
A That is right.

Q Then the entry for hypothyroidism is 2 August 2004.
A Yes.

Q Can we just identify what documents you would have received by that time from Dr Skinner?
A According to what I have been told within the Belgrave Medical Centre's records by the solicitors for the GMC, I would have had in my possession the two letters that have been read out.

Q The first of those talks of:

"I have taken a blood sample for thyroid chemistry you should have this result in 10 days and I will let you know what goes forward at that point in time."

That is a letter the Panel have, I think, in various places but I am looking at tab 6, page 2. It is the second page 2, not the first.
A Yes.

Q Then there was another letter, dated 10 May 2004, talking of Patient C putting her dose up. Do you know where the thyroxine came from that she was increasing the dose of?
A No, I do not where it came from but I can say it did not come from us.

Q I am going to ask for documents, if there are documents that can prove it, if it is possible to print out the screen from the practice. You are no longer there. You are in

Barnes in South West London now.
A True, but apparently when the prescriptions are issued on that, if you turn back to ---

Q Page 8.
A Tab 5, page 8, that is right. A date will appear after "Last issued", so on the "Repeat Masters" sub-heading, "Last issued" would have a date next to it and following a number of issues it would say something like 1 of 4 or 2 of 4, depending on how many she had picked up.

MR JENKINS: Thank you very much. That is all I ask.

Re-examined by MR KARK

Q Just very briefly, you say, so far as page 8 is concerned, the screen apparently demonstrates that the first time you did that must have been in the beginning of August 2004?
A Yes.

Q I have two questions about that. On the right we see "Number of issues", and "4". Does that tell us anything?
A It tells us that I said to the computer, effectively, that this patient can have 4.

Q I see, 4 repeats --
A Yes, and then stop, she needs a review.

Q Are these monthly prescriptions?
A I am not able to tell from this. It was our usual practice to give three months at a time, which would tie up with a yearly review period for hypothyroidism.

Q Where did you get your dosages from? Is it from page 6?
A Yes.

Q That was slightly leading and I did not mean to. Can you remember now where you would have got those dosages from?
A No, I cannot remember, but the only information of dosages I would have had available to me was that letter on page 6.

Q Finally this: if you did not put this onto the computer until August of 2004, as you have just told Mr Jenkins, what caused you to do it in August 2004 when you had the letter back in May?
A I may not have had the letter back in May if it took a long time to be delivered.

Q So you do not know when you actually received that letter?
A No.

MR KARK: Thank you very much.

THE CHAIRMAN: Thank you. Do any of the Panel members have any questions? (*No verbal response*) There are none from me. Thank you very much, Dr Summers. You are released.

(*The witness withdrew*)

MR KARK: Madam, I think we have made very good progress today. Tomorrow we will be finishing off with Patient C and then moving on to Patient D. We have two more witnesses to call on Patient C.

THE CHAIRMAN: Thank you very much. Just a bit of house-keeping. On Friday we will be finishing at 3.15.

MR KARK: Good. The first witness tomorrow, who we hope is a Dr Paul Cundy, again, we hope to arrange a video-link with him and I ought to ask your formal permission. I take it there is no objection from Mr Jenkins again?

MR JENKINS: None.

MR KARK: We have seen how well it works, in fact.

THE CHAIRMAN: Yes, I quite agree with that.

Thank you, everyone. We will adjourn until tomorrow at 9.30.

(*The Panel adjourned until 9.30 a.m. on Wednesday, 4 July 2007*)