Tuesday, 10th July 2007

(9.30 am)

THE CHAIRMAN: Good morning, everyone. I am Sandra Sturdy and I'm chairing this Fitness to Practise Panel hearing into the allegation against Dr Skinner.

I would like to ask you, it is very important to maintain the anonymity of the patients involved in this case. Should their names be mentioned in error, please do not refer to them outside of the room, and just to remind you about mobile phones, and if anyone does feel the need to talk, please could they do so outside of the room.

Mr Jenkins?

MR JENKINS: Madam, I am going to call Dr Skinner, as I indicated yesterday.

DR GORDON SKINNER (affirmed)

THE CHAIRMAN: I think you know everyone now, Dr Skinner, in the room so I will not bother to do the introductions, and I hand you over to Mr Jenkins.

Examination-in-chief by MR JENKINS

MR JENKINS: I am going to ask you to tell us your full name, if you would.

A. Gordon Robert Bruce Skinner.

Q. I am going to ask you to open file 2, please, at tab 4, at page 14. You should have part of the documents that

were prepared by you and sent back to the GMC when you were invited to undergo an assessment --

THE CHAIRMAN: Excuse me, Mr Jenkins, I am sorry, it sounds like one of the Panel members might not have the papers.

MRS WHITEHILL: Could I have the reference again?

MR JENKINS: Yes, of course, it is file 2, tab 4, page 14.

THE CHAIRMAN: Thank you.

MR JENKINS: I hope you will have your professional qualifications on the page.

A. Yes.

Q. Can you confirm that those are right, you qualified MB ChB, University of Glasgow 1965, and you then got an MD from the University of Birmingham in 1975. What was the subject of the MD?

A. It dealt with herpes vaccines and viral interactions in general.

Q. Right. We see you then obtained fellowship of two Royal Colleges: in 1985 the College of Obstetricians and Gynaecologists, and 1989 the Royal College of Pathologists, and the DSc in 1989 from the University of Birmingham. Tell us about that.

A. A DSc is awarded if it is deemed that your scientific works merit such. You usually assemble your papers you've published and it is then decided whether to award this. It is a kind of higher degree in science.

Q. I'm going to take you on to a rather fuller CV, if I may, and ask that this be circulated, please. I think D7 is the next one.

THE CHAIRMAN: Yes, D7.

MR JENKINS: Thank you very much.

(Handed).

I think this sets out again your qualifications. It sets out your earlier education. It gives your date of birth and your marital status and the position of your three children.

Over the page, on page 2, it sets out your career history, the medical jobs you undertook, and your teaching at the University of Birmingham between 1976 and 1999.

Can you just tell us, what was the teaching that you were doing then?

A. I was originally in obstetrics and gynaecology and I taught in that subject, and then latterly in virology and then I generalised to medical microbiology.

Q. You were treating patients as well, clearly.

A. Yes.

Q. At that point.

A. Yes.

Q. What sort of patients were you treating?

A. Well, initially, of course, it was patients with

obstetrical and gynaecological problems. I then had an interest for a long time in basically herpes virus infections, and I saw patients with herpes virus infections obviously, and other sexually transmitted diseases.

Then when in fact the remit of the department of the University of Birmingham, my honorary appointment changed, I saw patients with infectious diseases to a larger extent. I don't know if you're asking about my present work or not.

Q. I'm coming on to that. If we turn, firstly, to page 7, I think we see papers and other research which you have been involved in and that you published, going over a significant number of pages.

I wonder if you could summarise that. It goes over from page 7 to 15.

Can you summarise the range of fields that your published papers cover?

A. This is up to page 16.

Q. It is up to page 15, isn't it? The publications. Page 15, you deal with papers presented at scientific meetings.

A. I see, yes, sorry. Well, the body of papers which has been the body of my work in my life deals with microbiological matters. Latterly, I published in

thyroid-related work.

Q. I understand.

A. And a few kind of general papers as well.

Q. The papers presented at major scientific meetings starting at page 15 go on for many, many pages, I think. They go to page 30 where that ends. Then we come on to scientific meetings related to hypothyroidism.

You then deal on page 32 with lectures, and page 33 fellowship awards.

Page 34, with patents that you've sought, and page 35, patents that you've filed.

Then on page 36, you deal with membership of professional associations and the Panel will see various entries there.

Can I take you back to page 3, please. This sets out your present appointments, that you're a director of, is it a company, HIV-VAC?

A. Yes, it is a public company, the equivalent in the United States.

Q. You are also the chief executive officer of Vaccine Research International, which is a company in this country.

A. Based in this country, yes.

Q. You say what those companies are doing, pursuing research and development into two vaccines, vaccines

dealing with two sorts of matters, and you're involved in a trial in one of them. You are also the medical director of the Louise Lorne Clinic, which I think has the address of Alcester Road, that the Panel have heard about?

A. That is right.

Q. You say that this clinic obtained registration with the Healthcare Commission in April 2005. The clinic specialised in the diagnosis and management of hypothyroidism.

If we stay at tab 4 of bundle 2, I think you've attached, starting at page 76, a number of appendices to the material that you sent to the General Medical Council. We can see a significant number of policies and other documents. To take an example: Accident Procedure for Infection Control Policy, number 21 and 22. What are those prepared for? Are those for Alcester Road, the clinic?

A. Yes.

Q. Were those prepared for your accreditation with the Healthcare Commission?

A. Yes, it is a requirement.

Q. I think obviously in addition to a number of policy documents and protocols for the clinic, obviously you've attached, starting at page 128, articles that the Panel

have seen, or a paper that the Panel have seen before, that we may look at again in due course.

At page 138, a letter from 1997 that was published in the BMJ. You are the first signatory to that letter.

A. Yes.

Q. Then, 139, a letter of yours to the editor of the BMJ, and I think finally a letter of yours to Professor Sir Graham Cato, the president of the GMC?

A. I don't have that in the bundle, but I do remember it, I did write that.

Q. It should be 141. Do you have that?

A. My bundle stops at 141 but I can confirm I wrote to Professor Cato.

THE CHAIRMAN: Ours is the same.

MR KARK: We took that letter out. If it is wanted, then we --

MR JENKINS: I don't know that I need it at all, I was just going to the end of the bundle, but clearly I have gone beyond it.

I wonder if I can start at 1997 and page 138, your letter to the BMJ. Again, we've looked at it before, but some days ago.

This is you and six general practitioners from various parts of the country, one from Wales, another from Essex, another from Hayes outside London,

Leicester, London, Bolton, writing to the BMJ, questioning present medical practice, which considers abnormal serum concentrations of free thyroxine and thyroid stimulating hormone, those outside the 95 per cent reference interval to indicate hypothyroidism. But incorrectly considers:

"Normal free thyroxine and thyroid stimulating hormone concentration to negate this diagnosis."

It is unusual for doctors to start thyroxine replacement in clinically hypothyroid but biochemically euthyroid patients, and at the bottom of that column, it may be a passage that the Panel have already highlighted before:

"We contend that an incremental three-month trial of thyroxine treatment in clinically hypothyroid but biochemically euthyroid patients is a safe and reasonable strategy."

Can you tell us why you were writing that in June 1997? How much work with hypothyroid patients had you done up to that point?

A. I think we -- I had been working in a sort of major drive for about three years at that point.

Q. Right. Was that at the Alcester Road clinic in Birmingham? Where did you start?

A. I started at the University of Birmingham, about 94, and

then we moved to the clinic in Moseley in 1999 and continued the work there.

Q. How did you first start dealing with this type of patient?

A. I was involved in virology so I've seen patients with ME or chronic fibromyalgia, or fibromyalgia.

Q. Is that chronic fatigue by another name?

A. Yes, there is a kind of group of conditions. Some people argue strongly that they're terribly different, some people say they're all kind of the same, and thus I was seeing patients for that reason.

Essentially, a patient came who looked so hypothyroid, it wasn't true, if you like. That's based on the symptoms and signs. The general practitioner, Dr Selarajah(?), and I agonised long about this patient, eventually provided her with thyroid replacement, and she recovered completely. That's one patient, and that, I think, sparked my interest in this and the concern that the thyroid chemistry was misleading us seriously.

So that really was the sparking off of that one.

Q. Well, did you then deal with other patients --

A. Yes.

Q. -- who may have similar problems?

A. Yes, exactly.

Q. How did those patients come to you or how were they

referred to you?

A. It was a very slow process because essentially you don't like, if you can avoid it -- it is perfectly legal to see patients without a referral and people didn't know of my work then, so it was a very trickly kind of business until about 1997 when we saw patients almost entirely by referral from the family practitioners. But basically it was by referral from, not necessarily the family practitioners, any other medical practitioner.

Q. What were you able to do for the patient?

A. I mean, it's axiomatic but I believe I've helped the patients and returned them to health.

Q. You've written a book, the Panel know that you have, and we're going to distribute copies in a moment. But tell us, why did you write the book?

A. That's a difficult question and I haven't thought about it until you've asked me. I think I don't want to overstate the case, but I do feel strongly that there is a serious shortfall in medical care here and one way to, sometimes almost a marginal way, to improve or stimulate professional public perception of a problem is to write a book.

I think that's why. I think if you kind of feel strongly about something and many people are motivated to write about it.

Q. Let's have a look at the book. I'm going to ask that it be distributed, please. We have five copies, which is certainly enough for the Panel. I don't know if Mr Kark would like a copy for Mr Lynn to look at.
A. I can get more copies, if need be, in the boot of my car.
Q. You need a copy as well, you don't have a copy in front of you.
A. I would quite like one.
Q. We will make sure you have one.
A. If it is possible.
Q. I wonder if that extra one could be given Dr Skinner. We will ensure the Panel have an extra one for the Committee secretary. This is D8, I think.
MR KARK: If we could have another copy at the next break.
MR JENKINS: We'll organise it.
I think you published this yourself.
A. Yes.
Q. Louise Lorne Publications, and Louise Lorne is the name of the house or the building in which your clinic is.
A. Yes, it is the name of the clinic. Louise Lorne is a street next to our clinic in Birmingham.
Q. I understand. You have your qualifications, the Panel will see the acknowledgments, some three or four pages in, and particularly the last one.

I wonder if I could take you to the introduction. You say:

"This book has two purposes, namely to provide a detailed account of the diagnosis and management of hypothyroidism and to reassert the importance of clinical observation in medical practice."

We should note that this book was published in 2003, I think we see --

A. Yes.

Q. -- from the reverse of the first page.

You go on to say of the importance of clinical observation:

"The latter seems to be an outmoded concept, replaced by evidence-based medicine, 'which does not mean evidence-based medicine but laboratory-based medicine to provide protection against possible litigation'. It is unclear why evidence relating to a patient's clinical features is less weighty than a laboratory test, which is de facto an indirect measurement and was originally derived and developed from clinical features."

You go back to 1891 and refer to, is it a man, Murray?

A. It is a man.

Q. Just tell us what we need to know about Murray.

A. This is a research worker, he worked in Newcastle, and what in essence he did was he took an extract from a sheep's thyroid gland and put it into patients that he thought were hypothyroid and cured them. In fact the first patient was -- he did this for some, I think, nearly 20 years. It is something you couldn't do now at all, ever, to do what he did, and that's basically and essentially what he did, it was as simple as that. Later on it was possible to grind up sheeps' thyroid glands and give it as an oral preparation.

Q. Let me take you on. Was that the first practitioner dealing with thyroid problems?

A. There was someone before who had drawn attention to the condition, he was the first practitioner to do anything about it.

Q. So the treatment of thyroid problems on that analysis has been going on for about a hundred years or so, slightly more?

A. Yes.

Q. Can I take you on, page 3. You say in this book:

"I'll provide a detailed account of the clinical features of hypothyroidism with discussion on the usefulness of laboratory information towards its diagnosis followed by a discussion on the management of patients with hypothyroidism."

You say:

"This section is based on my own experience."

You have tried to address problems which arise in everyday practice and are often not examined in standard textbooks on the subject. The management of proven hypothyroidism is not straightforward and there are a number of interesting issues concerning the particular types of replacement preparation."

You go on in the next paragraph to say:

"The book will hopefully be of interest to professional thyrologists and other physicians and the laity. It is written in the style which represents ..."

I think you later say it is a fairly light-hearted tome so as not to get bogged down. I paraphrase.

A. Yes.

Q. Let me take you on, if I may. I don't think we need deal with paragraph 2. Paragraph 3 is of importance, page 18.

A. Sorry, Mr Jenkins, page what?

Q. 18, chapter 3:

"The diagnosis of hypothyroidism should be made on clinical grounds. This is the most important statement in this book."

You go on to make three general points, and firstly:

"While thyroxine deficiency will ultimately effect

everybody system with consequence on physical, mental, sexual, immunological, emotional and spiritual life, clinical manifestations vary quite notably from patient to patient. In some patients the effect is predominantly physical with lack of stamina following exercise and for other patients it may be mental with loss of memory for recent events or can be present as reduced or absent libido or recurrent sore throat."

You go on to say:

"The problem of symptom diversity is compounded by personal reaction and concern of the patient over any given symptom."

You go on to give an example.

Secondly, you say on page 19:

"Certain patients volunteered no specific complaints and the problem is drawn to the doctor's attention by a marital partner, relative or friend or even a professional acquaintance, and the patient herself assumes or has often been told by her family practitioner that she is depressed, menopausal or overeats. It is frequently stated that hypothyroid patients are uncomplaining and compliant."

But that has not been your experience:

"If one takes a careful history, it will become clear that almost every hypothyroid patient has sought

medical attention on a number of occasions but has often been given the big DMO [you've explained earlier what they are] rebuff, which is daft."

You talk of women. Tell us, what's the preponderance of women to men with hypothyroid problems?

A. I think most people would agree it is about 9 to 1, that's certainly the ratio in my own practice.

Q. You then go on over the page, paragraph 20, to deal with the third point of the three:

"Finally, the diversity of symptoms can lead to the pseudo-cure phenomenon, this occurs when the patient quite properly consults a variety of specialists, most usually a rheumatologists, because of scattered aches and pains, a gynaecologist because of heavy or absent periods, or a psychiatrist because of psychological or emotional problems."

You say:

"Some symptoms are, of course, alleviated by antidepressants or hormone replacement therapy but the fundamental problem remains, and if the patient should dare to complain that she still does not feel well, she is well in line for a reprimand."

You say right at the bottom of the page:

"I know this will make me unpopular with my endocrinological colleagues but there seems to be an

almost perverse pleasure in dealing with a patient who is not hypothyroid, usually on blood test results, of which more anon, but also on a new principle that if other than an endocrinologists considers a patient to be hypothyroid, then that patient is not hypothyroid."

You go on to talk about your old mum, that even though she would make the diagnosis.

You go on to make an observation that it is staggering how many patients are patently hypothyroid but an endocrinologist pronounces, often with some irritation, that the patient is definitely not hypothyroid, and you go on to make an observation about the quality of the evidence, evidence-based medicine having omitted to take the patient's pulse or temperature or even listen to the woman.

You go on to say:

"As always in medicine it is necessary to be alert for any diagnosis irrespective of the nature of the referral from a family practitioner, consultant or specialist colleague, it is now my invariant rule, with rare exception, to see patients only by referral from family practitioners where you are pre-provided with relevant history and background and you are then in a professional relationship with the family practitioner and you can thus work with him/her, in a congenial and

harmonious way, which is difficult if one springs on the family practitioner that you unsolicitously saw his or her patient."

Here's what you think should happen:

"Colleagues in family practice can and quite reasonably become a bit narked about this."

Well, can I break off. We have seen that in 1997, six years before this book was written, you were writing to the BMJ with six GPs. How did you come to meet those GPs and find yourself writing to the BMJ with them?

A. These GPs have worked with me on patients.

Q. I understand. Well, tell us, what we've just read, that patients may be referred to you by a family practitioner, consultant or specialist colleague, is that right? Is that what's happened over the years?

A. Yes, absolutely.

Q. You go on to deal with clinical features of hypothyroidism and I don't need to read it.

I'm looking at page 25 where you recommend younger colleagues to read some earlier works and some books which are not the latest books in medicine.

The Panel will see that you are somewhat dismissive of the meta-analysis or the computer search. Tell us why.

A. I think the problem there is that a meta-analysis,

unless the author -- or the reader rather, is very diligent indeed, they'll more or less take the conclusion of the meta-analysis without really, usually I suspect, looking into what each paper actually said, and then that view from the meta-analysis becomes enshrined for posterity, and that view will then be carried on and will gradually transmute into truth.

The whole principle that you read someone's meta-analysis, albeit perhaps constructed by a Panel, indeed we saw that with one of Professor Weetman's papers, that a Panel had made pronouncements like "fair" and "good". It seems to me to depart from the basic principles of good scientific practice which I tried to instil in the students when I was at the University of Birmingham.

Q. Can I take you on, later in that chapter, and if the Panel go back to the contents page towards the start of the book, they'll see the way in which that chapter's laid out.

I think you say at page 30, just before the passage under the heading "Fatigue":

"The following sections will examine the clinical features of hypothyroidism, these will be presented in order of frequency and not by systems, which may be more useful for the practising clinician."

I don't need to take you through what you say or the vast majority of those. I would like to look, if we may, at page 58, "Visual and other sensory disturbance".

You say:

"Visual disturbance is most frequent. Blurring of vision is often described an as general dullness, or a veil, or curtain over the eyes. The world seems grey, dull and out of focus yet many patients cannot tolerate bright light, for example, approaching car headlights, presumably from inadequate capillary contraction. Other patients report double or distorted vision where lines and printed words twist and merge into each other. This can be one of the earliest features to respond to treatment and indeed certain patients report that 'all of a sudden the world seems lighter, brighter and more colourful'."

Hallucinations you go on to deal with of a certain sort, particularly in the peripheral vision, and one word, which I would mispronounce if I tried:

"... represent perhaps the most poorly recognised feature of the disease occurring, in my experience, in approximately 75 per cent of patients and rarely in non-hypothyroidal patients if their history is taken in detail. Some patients rather baulk at the term

'hallucination' fearing, not without foundation, that a confession of this feature may result in their being committed to a psychiatric institution. There can be black floaters or silvery wiggly things in front or at the side of the eyes, but in more severe cases the patient is convinced that something is moving at the side of their vision or that somebody has passed by their side."

We know that certainly with one of these patients she thought -- A to D that the Panel are dealing with -- there was something at the periphery of her vision.

A. Yes, indeed.

Q. We have been told this symptom or sign is not reported in any textbook. Do you know if that is right?

A. Well, it is not right quite in the way I've described it, in quite detail I have described it, but certainly visual disturbances are reported in the literature in hypothyroidism.

Q. I don't think I need read on in that section, but later on you deal with headaches, page 68, and we will recall that Professor Weetman had never seen mention of headaches in any textbook referring to the symptoms and signs of hypothyroidism.

You go on to deal with them, but perhaps it is obvious, have you seen headaches or heard complaints of

headaches from patients who have symptoms of hypothyroidism?

A. Yes, I am surprised at Professor Weetman's testimony there, but I try never to criticise a colleague without any justification. I find it a pretty common feature in hypothyroid patients, and I think it is fairly well documented in the literature, indeed in fairly standard textbooks on the subject. Patients describe an exploding head sometimes or a tight band in their head, and I would say probably about 60 per cent of patients complain of that. It does resolve fairly quickly on treatment.

Q. I don't think I need take the Panel through what you've said in that section.

Can I take you on to the next chapter. The Panel will find it starting at page 85. It is under the title "Differential diagnosis".

You say:

"Hypothyroidism is usually a straightforward diagnosis, given that one listens to the patient and takes a little time and trouble over history and physical examination. I would be the first to admit that this is not too easily achieved in the hurly-burly of a busy family practitioner's office and I've never criticised a misdiagnosis of hypothyroidism by family

practitioner colleagues."

You go on to make a comment about endocrinological colleagues. You say at the bottom of the page:

"It is important to never initiate the consultation with a rigid preconceived notion of the diagnosis and to remember that hypothyroidism can appear somewhat ..."

And you refer to two other conditions in two different guises:

"It is quite common for there to be one or more glaring exceptions to perceived typical symptoms, for example weight loss or tachycardia, or a particularly confusing feature for the inexperienced practitioner, a rather shuddering frenetic manner, which often mistakenly leads to a diagnosis of the opposite problem, namely hyperthyroidism."

You say:

"A number of differential diagnoses can also be complications of hypothyroidism which can mask the diagnosis or make symptoms more severe. For example, fatigue associated with vitamin B12 anaemia or hypoadrenalism or thirst, and weight gain of mature onset diabetes."

You say further down:

"I've always dreaded that a young adult patient might have leukaemia or other malignancy but it has

never occurred in my practice. I am not sure I would deal with it well."

You go on to say:

"In this section I have discussed the likely differential diagnosis in more or less [I think that is what it should say] their order of likelihood."

You then encourage doctors to pay attention and be aware.

A. Yes.

Q. The Panel can see how you've chosen to put it. I think you slip into a Scots accent and then talk French and Latin all in two sentences.

A. I think that's a case, Mr Jenkins.

Q. You deal with anaemia and vitamin B12 deficiency.

I don't need to take you through what you say, but the Panel will see over the page, page 88, you say:

"I am quite prepared to carry out a course of B12 injections in patients with clinical features of B12 deficiency and suggestive but not conclusive laboratory evidence..."

Whatever that means:

"... and seeing what happens. The crucial matter in such decisions is the degree of safety in the intended medication, and I think most of us would agree that B12, rather like thyroid replacement, are spectacularly safe

medications. Patients are usually quite happy to be given a relatively harmless medicine like B12 and 'see how they get on', but less happy to be given, say, Prozac if they themselves don't believe that they are depressed. I tend to side with the patient on this one."

You say:

"If one can bung Prozac to an unwilling recipient and see if it helps, why in heaven's name is it a sin to administer B12 or thyroid replacement in sensible dosage and see if it helps? The former is considered reasonable practice and the latter quite reprehensible if not a matter for a GMC disciplinary report."

And you suggest that it is ridiculous.

You go on to say:

"A successful B12 replacement is usually a therapeutic joy meaning that the patients improve dramatically.

A. Yes, indeed.

Q. We did hear that vitamin B12 can only be given by injection at 1,000 micrograms. Is that right?

A. I think giving it by injection is the most rapid and efficacious way to do it, but the corollary that oral B12 doesn't do any good, I think -- I don't know where that actually sprung from.

I've measured B12 levels in patients who have been given oral B12, the level's gone up. I am not for a minute saying it is as quick, but it may not be necessary to always give injections.

It does raise the issue that the B12 we get per vias naturales is from a food. So the principle -- without getting into intrinsic factors and gastric cancers that is Professor Weetman drew attention to, the principle that you do not and cannot and it will do no good to take B12 by mouth, I think is insecure.

Q. I think one of the doctors said that they don't make it in tablet form, 1,000 micrograms, or if they do, it doesn't work.

A. Well, I think one of the doctors did say that, yes.

Q. That is a bottle (indicating) of B12, 1,000 micrograms --

A. Yes, it is made and manufactured.

Q. -- and it carries the name Holland and Barrett on the label, which suggests it is from a health food shop rather than a pharmacy. But it is made --

A. Absolutely, and a very respectable health food shop.

Q. Indeed.

Let's move on within that chapter because you also deal with one other matter which is of relevance, it is hypoadrenalism at page 107.

You say:

"In a practice where I see over 200 family practitioner new referrals per year, I doubt if I would see more than six patients in whom I feel the only problems is a primary under function of the adrenal glands. I will see perhaps one classical case of Addison's disease in two years."

You say:

"These patients tend to be rather sallow with a sunken kind of expression."

You go on to say what they may complain of.

Over the page you talk of:

"The standard laboratory test nowadays is a serum cortisol level wherein a fasting level at about 9 o'clock in the morning is deemed to be most helpful on account of the diurnal change in serum cortisol levels."

You say:

"If thyroid chemistry is a bit suspect the cortisol estimations are even more suspect, and I wonder if there have been sufficient patients with Addison's disease to even validate cortisol levels, which tend to bob up and down in the same patient with disturbing magnitude."

You go on to talk about your experience:

"Patients who have low levels, perhaps under 100, do tend to have hypoadrenalism."

You go on to talk about a Synactin test, which we have heard of elsewhere.

Tell us: if you do get a patient and you suspect that there is a problem with hypoadrenalism, what do you do?

A. It depends very much on -- this recurs in medical practice -- the extent of one's concern. If a patient is moving around in society and you think there may be hypoadrenalism, it is not a sort of crashing medical emergency. I would either take either a blood test or perhaps urinary 24 hours -- I think that's gone a little past, it's a bit of a bother for everyone, including the patient -- or flag this up to the family practitioner.

I think I've only seen two patients who had Addison's disease, in fact, in a decade. That's a condition which is life threatening and it's rare patients will be sort of not pretty ill. I know that sounds a rather lay term, but doctors understand what you mean if you say that.

There was something else I was going to say about that ...

Q. We will come back to it with one of the patients.

A. Thank you.

Q. I was going to come on to the next chapter, page 123, "Management of hypothyroidism".

You say:

"Management of hypothyroidism is a delight, allowing professional fulfilment through application of sound scientific principles and the art of medicine. It requires consideration of many factors, including the physical, mental, and emotional state of the patient, her family, and social circumstance.

"There are different types of patients with differing attitudes. Certain patients are nervous of thyroxine replacement, usually from exaggerated pronouncements by colleagues over perceived side effects, and will welcome a slower regime of thyroxine replacement, while other patients, for example business people, tend to be impatient and welcome a more rammed programme of replacement.

"Some colleagues believe that the patient's wishes or attitude are irrelevant to the replacement strategy, but I see no problem with reasonable limits (see above), particularly as there is already considerable variance in treatment regimes. It's not a dangerous medication and there is no need for undue anxiety from reasonable modification of treatment schedules."

You go on to make other observations about patients and you talk on page 124 about patients sometimes adjusting the dose.

You say about ten lines up from the bottom on page 124:

"I have never found a problem with any type of patient and quite enjoy an intellectual joust with patients who want to regulate their therapeutic regime or type of thyroid preparation, or fiddle about increasing or decreasing doses, but it does often earn a reprimand from my colleagues. I don't know why they are so sense about this, I have never known a patient do more than make minor adjustments to dosage and, as far as I know, they nearly always confess this to the doctor."

You say three lines before the next section on page 125:

"To date, I have never encountered a patient who was self overdosed on thyroxine to an extent that it was not reversible within a few days by a reduced dosage or withdrawal of the medication."

Can we deal with the initial consultation. You say that you give a brief rundown of the problem of hypothyroidism and its effect on different body systems and reasonable expectation of treatment in that patient:

"I always emphasise the relatively uncertainty of rate of improvement as there may be no perceptible improvement for perhaps five to six weeks and it may

take one to two years before the patient is euthyroid and returned to optimal health.

"It is also important to indicate that successful replacement and restoration of health will not make a 60-year-old patient feel like 16-year-old ... and it is useful to curb undue expectations ... I always emphasise that there may be some minor side effects at the beginning of treatment in the nature of headaches and occasionally sweating."

At the bottom of that page you say:

"As stated, it may be comforting to repeat that I have never observed significant side effect of any magnitude or importance from thyroxine replacement in a sensible incremental fashion ... Side effects can occur at three stages, namely at initiation of treatment, for reasons described. Secondly, when the dosage is increase from 25 micrograms to 50 micrograms per day, which I suppose is a doubling dosage, unlike other higher dose increases, and the patient is presumably not yet too justified to receiving thyroxine replacement, and finally, when one has reached a highish dose for that patient, when there may be evidence of clinical thyrotoxicity, which is not a big drama and is solved by reducing the dose. In essence therefore I indicate that there can be minor adverse effects being

on thyroxine ... and being on thyroxine will not preclude the patient from other incidental aches and pains, coughs, colds or flu."

You then go on to deal with availability meaning your availability if patients want to contact you.

A. Yes.

Q. "I used to tell patients they could contact me at any time with any problems but I'm not sure it was a good idea. The difficulty is that patients tend to believe you."

You give examples of times when you were called. You say:

"I now cut off non-emergency calls at perhaps 8.00 pm ... a system for emergency calls is important. Patients should be told you are available for emergency calls, but non urgent matters can wait until the next day."

You then go on in the next heading to deal with replacement of thyroid hormones:

"This is the essence of treatment and will restore the patient to optimal health provided the hypothyroidism is the only problem. Some patients have, for example, hypoadrenalism, which is usually secondary to hypothyroidism, and will be cured by providing thyroxine to the adrenals but rarely, in my experience,

is a result of primary hypothyroidism, which requires adrenocortocoid replacement."

A. If I could interrupt.

Q. Please do.

A. I apologise. That is what I forgot to say actually, that most patients I think a minor degree of adrenal insufficiency is because the adrenal is not getting enough thyroxine and thus itself is sorted by your treatment. Sorry to interrupt you.

Q. No, it's all right. You then go on to say:

"The only requirement for most, I emphasize most patients, is thyroxine, T4."

You go on to explain the chemical make-up of thyroxine and these are matters that the Panel perhaps are already aware of.

Over the page, you deal with the choice of thyroid preparation. You say:

"The choice of thyroid preparation was once a simple matter. There was essentially one preparation."

You then talk about a drug company and how sodium thyroxine was brought out decades ago.

You then talk of three types of thyroid preparation with different trade names in different countries, but you confine yourself to the names used in the UK and Ireland, that is sodium thyroxine, and the deiodinated

active Tri-iodothyronine, which has one of the iodine atoms removed, and the third one being the natural thyroid preparation, the most widely used of which is Armour Thyroid produced by Forest Pharmaceuticals in the United States.

You say in this book written in 2003:

"The question of which should be used and in what circumstances is a matter of controversy, although there is precious little evidence to support one preparation versus the other."

You then go on to say:

"I will try and give a balanced account of the pros and cons of each preparation."

I am going to step away from the book.

Are there circumstances in which you use Armour Thyroid and, if so, what are they?

A. I think there are two circumstances. One is if the other -- I would normally -- I normal start with thyroxine. If it's not working, and you're fairly sure there is no other problem present, I can see no problem, or in fact I do, introducing either T3 or Armour Thyroid.

A second situation I find is of patients who have had thyroidectomy, a lot of patients, these are the rather a high dose of thyroxine, or I have found over

the years Armour Thyroid seems particularly useful there.

On the not absolutely secure thinking but I suppose it's kind of common sense, if you've taken let's say someone with a total thyroidectomy, you've taken away everything. There is no evidence that thyroxine or even Tertroxin are the only useful thyroid or parathyroid related hormones.

Q. Tertroxin is the T3 preparation.

A. Yes, yes. So I suppose if you're taking everything away, it's not completely unreasonable to put everything back, which would be the rationale of Armour Thyroid.

Then thirdly, this might be moving out of strict medical considerations, some patients say: I don't like synthetic hormones. I would like to take the Armour Thyroid.

Q. Which is the dessicated porcine extract?

A. Yes. I know some of my colleagues get enormously tense about this, I'm not quite sure why, it's has been around for 120 years, and I can see no ethical problem in providing that preparation. It's has stood the test of time.

The main problem is that, of course, it's not usually prescribable by family practitioners and then the patient has to pay for it, which is a downside as

well.

Q. In what circumstances would you prescribe T4 and T3, the thyroxine and the Tertroxin?

A. Again, if the patient is essentially what I would call plateauing, you're putting the dose of thyroxine up, the patient says: I'm not feeling any better here. I think over the years I've found that many patients then subsequently improve because you've added in Tertroxin. Some practitioners actually use Tertroxin alone by choice. It seems to have no particular downside to it.

Q. Again, I don't need to take you or the Panel through the discussion in the book as to the pros and cons of the particular forms of replacement therapy, thyroxine as against T4 and T3, as against Armour Thyroid, because I don't know if that is right at the root of this hearing. I want to take you on, if I may, to page 156 in your book where you deal with the expected outcome of thyroid replacement.

You say:

"Thyroid replacement in hypothyroidism patients remains one of the most satisfying therapeutic exercises in medicine."

Can I break off there and ask you to explain why.

A. I think it's one of the few conditions where you can return -- well, you could convert a patient, for example

Patient D was living in an appalling quality of life, to complete health. That's enormously satisfying for a medical practitioner, that's what we're about.

Q. Well, is D the only case of that type that you've dealt with?

A. No, but, as Mr Gribble advised, it's within the context of what we're discussing.

Q. Absolutely, but have you dealt with a few other patients like D or many other patients? Tell us.

A. Yes, I have.

Q. Which, few or many?

A. Oh right, many.

Q. You go to say:

"It is true to say that in the majority of cases there will be no problems in management and the vast majority of cases are returned to optimal health within one year, after which it's usually only necessary to fine-tune the dosage, and many patients are able to fine-tune their own dosage. I am quite relaxed in general terms with the patient taking responsibility for her own medication."

You go on to say:

"It is sometimes inappropriate ..."

And you deal with one young man who was psychiatrically disturbed.

You go to say:

"The chronology of symptomatic improvement thus follows a general pattern with some variation from individual response to replacement and the dosage regime and particular type of thyroid preparation."

You go on to give an account as "a distillation of experience over many years".

You go on over the page, page 158, third line, to say:

"Interestingly, one of the first features to improve or disappear are side vision or floor hallucinations which can become quite infrequent by two weeks, often accompanied by other visual improvements in that some patients will say that a veil has been removed from their eyes or the world seems lighter and brighter and more colourful."

You go on to mention a third early improvement, page 159:

" ... is more variable but in many patients who complain of constipation or constipation with diarrhoea ... it is not unusual for these patients to proclaim an improvement and sometimes for the first time in a life in unsatisfactory bowel habit. This is perhaps surprising ..."

You go on to talk about the intestine.

You say:

"It is usually welcome to the patient."

Then you go on to deal with other features that tend to show improvement, the emotional state of the patient and fewer mood swings, and you talk of headaches and patient's appearance starts to change.

Over the page, page 160, nearly halfway down:

"Most improvements occur at about four to eight weeks when the patient often notices that her skin is less dry and less flaky, particularly on the legs, and other related features like cracks on the heels start to heal. It is usually around this time that the patient notices she is thinking more clearly and can process information and hold information more easily and can now start to enjoy a book or watch a television programme without losing track."

You talk about six to eight weeks often a change in the patient's level of sociability, and then the next paragraph, improvement in swallowing and changes in voice. You deal with other changes, improvement in muscular strength and energy with improved stamina.

Over the page, a problem with weight or obesity, not usually resolved, in your experience, until the patient is euthyroid. Some patients do in fact gain weight on thyroid replacement, which is a favourable development

in thin, anxious hypothyroidism patients, arising from a general improvement in appetite and feeling of wellbeing.

You then go on to deal with loss or absence of libido, and the Panel will see what's said.

I don't think I need take the Panel to chapter 6, they can look at it, and you may be asked questions about it or the detail of it. It's headed "Difficulties in management of hypothyroidism".

You deal under various headings with non-response to medication with no evidence of thyrotoxicity, and then at 173 non response to medication with evidence of thyrotoxicity.

At 174 you break that down into thyrotoxiphobia, it being a possibility that the patient is so frightened of the medication that they interpret every life event to be a result of the medication.

On 176 you deal with "too much, too rich too soon back stacking of free thyroxine", which is a concept that the Panel have heard before.

At 177, halfway down the page, you talk of patients being rotten converters of T4 to T3 and thus the T4 back stacks. Again, I don't need to take you into it, you may be asked about it.

At 178 you deal with the concept of a coincident

undiagnosed condition. Again, I don't need to ask you about what is said, but the Panel will see that you have made some observations and you may be you'll be asked about them.

I then take to you 184, "Misdiagnosis". I want to return to misdiagnosis later, but let's just finish this chapter. Can I take you to 186.

Some six lines down the passage reads as follows:

"In summary, the most usual problem in management of hypothyroidism is therapeutic timidity arising from generalised fear of the medication and inexplicable belief in preordained levels of thyroid replacement and groundless faith in thyroid chemistry as a parameter of wellbeing in the treated patient.

"Abnormal adverse reaction of thyroid replacement is relatively unusual and is usually, but not always, a feature of rather anxious souls who interpret continuance of hypothyroid features during the early stages of treatment as adverse effects of thyroid replacement, for example headaches, insomnia, palpitations, and 'internal awareness'.

"The dangers of overreplacement have been exaggerated ad absurdum. In a sensible incremental regime a patient will never be seriously or dangerously thyrotoxic, and I have yet to encounter a patient who

had become thyrotoxic but had been keeping mum. You can be sure of it."

You then go on to say:

"Finally, I consider with extreme care the patient who fails to respond to thyroid replacement and seems to be slowly declining. In these circumstances I always contact the patient's family practitioner or specialist colleague for his/her feel of the patient to coordinate further investigation."

The last chapter, the faux pas of the decade, you are dealing with blood tests and is the thrust of it summed up at page 190 in bold capitals? Is the thrust of this chapter summed up in the passage in bold capitals at page 190?

A. Yes.

Q. I am grateful. I have no doubt you will be asked about the subjects dealt with in that chapter. But tell us: can you summarise your view of the usefulness of testing of patients' blood for measurement of T4, free T4 and TSH?

A. In the extremes of very low T4 or -- let me start again. If the thyroid chemistry is abnormal you will usually find the patient has a medical problem; not necessarily so.

I think the problem is the misassumption of the

reciprocal. But it has never been shown that if your thyroid chemistry is within 95 per cent reference intervals, you're well, and I think one could summarise the book basically asking for a trial, close scrutiny and debate, examining the question that normal thyroid chemistry -- I say "normal", I am bulldozed into saying that -- "reference", thyroid chemistry within reference intervals means you're well and not hypothyroid.

I say it's the faux pas of the decade, I think it's the faux pas of the last two decades, and it's something that is pursued with great enthusiasm and absolute assertion by colleagues who no doubt are working the patient's best interests into their beliefs but there is no evidence for it whatsoever.

Q. You have used the expression, I think in some of the correspondence that the Panel have seen, "blood tests are good servants but bad masters", what do you mean by that?

A. I mean that they shouldn't be ignored. No one has contended that they shouldn't be ignored, and you did quote "my old mum", but my old mum would come to the conclusion that, contrary to Professor Weetman's view -- he says if a test is in or out, that is all he cares about, but if we take the reference interval from 10 to -- let's say 10 to 22, it varies a bit, it doesn't

matter that much.

Q. Are you talking about TSH?

A. Sorry, let's talk about the thyroxine. It would stretch credulity that you would interpret 10.1 as the same as 19.9, they're both within a reference interval, and if that were the correct approach, it would remove from the vocabulary words like "tall" or "small" or "heavy" or "light".

So 95 per cent interval includes 95 per cent of the sample population. It would be very, very unlikely that everyone would -- that whole 95 per cent of people would be the same.

So there are many cases, of course, where thyroid chemistry is useful, but I think my cri de coeur is that pivotal reliance on it, and indeed we have heard that some authorities or colleagues are essentially saying if the chemistry's normal, the diagnosis can't be made. I think that is probably an error and must be explored in many, many patients' future health.

Q. We know you take blood tests and the Panel have seen blood results that you've ordered. Why do you do it?

A. Partly because of what I've just said -- well, I can think of two examples that spring to mind. First of all, it's quite useful to have a baseline; that's quite sensible.

There is the possibility, of course, that you're wrong, you've got the thing completely wrong and the patient is in some -- you have misinterpreted symptoms and the patient's, let us say, thyrotoxic, but I think you have to be not quite with the world to do that, but in that case the thyroid chemistry might come back with a very high FT4, in which you would obviously reconsider the matter.

I find blood tests particularly useful -- mind you, this isn't the brief of discussion in patients who are hyperthyroid or thyrotoxicosis, I do find it much more useful in that.

Q. Right. You said in the passage that we read that you deal with 200 new patients a year, or did when this book was published in 2003.

A. Yes, I would say it's now -- I would say it's less now, but it's not wildly different.

Q. I understand. We know from the material that you have sent to the GMC that you're involved in a vaccine scientific company?

A. Yes.

Q. Is some of your time spent dealing with that?

A. Yes. I have clinics three days a week, sometimes on a Saturday.

Q. To see patients?

A. Yes, at this clinic.
Q. And is the rest of your time dealing with the vaccine work?
A. Yes.
Q. Right. If you see a patient for the first time -- again, I don't think we've read that particular passage in the book, but if you see a patient for the first time, how long would you spend with them typically?
A. Typically, an hour.
Q. If it's a second or third or fourth consultation, how long typically would you spend with the patient?
A. Curiously, I thought it was typically half an hour, but it does seem to be longer than that, and I'm always getting into trouble for taking too long and rambling on, I think. I would say it's between 30 and 45 minutes for patients who are returning.
Q. Right. We know that the Louise Lorne Clinic is in Alcester Road in Moseley, Birmingham. Plainly you see patients there. Have you seen patients in other locations in the United Kingdom as well?
A. Yes. At the present moment we have an infrequent clinic, about six weekly, in the City of Glasgow.
Q. Right. Did you see patients in London at any time?
A. Yes. We used to have clinics in about six different locations in England. Shall I tell you why we changed

that?

Q. Do. Tell us where they were and then tell us why you changed it.

A. Stockport, Normington, the Leeds Normington, not the Derby one, Sway, which is a wee place near Lymington in the south of England, London, Stafford, and Chester. The difficulty was not that there was any problem, and it was very helpful -- the patients now troop to Birmingham from Tyne and Wear, which is kind of daft because we used to go to them. The Commission of Healthcare ask that you register your premises, which wasn't a difficult task, but it was rather a long task with a huge amount of documentation. You've provided a sample of it here.

Q. This is because you're running a clinic?

A. Yes, a private clinic.

Q. Outside the National Health Service?

A. Yes, exactly.

Q. So you have to comply and be registered by the Healthcare Commission?

A. Yes.

Q. We have seen some of the protocols in here, I think there are quite a few more.

A. Oh, books and books of intentions and things like that.

Q. Let's not go into them unless we have to. But you had

clinics in a number of locations?

A. Yes.

Q. And you then went on to say why you reduced the clinics.

A. Basically, the administration to become registered and a certain amount of cost, because they sometimes ask -- well, in Birmingham they asked for some structural changes, moving sinks and things. It just wasn't feasible to do.

Glasgow, however, is in Scotland, and the Commission of Healthcare remit does not extend outside of England.

Q. They have different arrangements in Scotland, I think.

A. Fortunately, yes. It doesn't extend to Wales either.

Q. So, presently, you have clinics in Birmingham?

A. And occasionally in Glasgow.

Q. I understand.

What should we have as the typical picture as a referral? Of the four patients where complaint is made about you, we've seen a couple of cases where the GPs didn't want the patients to come, and we've seen certainly the first case where Dr Cooke wrote a letter of referral enclosing a history and enclosing, it would seem, letters from correspondence, Dr Smith, Dr Veitch, who were doctors who had seen that patient recently.

What's the typical picture, if there is one, of referral to you?

A. Am I allowed to gainsay something you just said? Is that in order?

Q. Of course you can.

A. I'm not quite sure what the evidence is that the doctors didn't want the patient to come. One doctor didn't and was very clear in his evidence.

There was no evidence whatsoever that the other two doctors -- it was only one of these. Sometimes in retrospect GMC proceedings coming along, that might have been a slight influence.

Q. Typical picture.

A. Where were we, yes. The typical picture is we receive a letter from the family practitioner asking for an opinion. Occasionally other carers or specialists.

Q. Have there been occasions in the past where you've come to the view, having spent a lot of time with the patient and reviewed the history, that this is not a case of hypothyroidism?

A. Oh yes, yes. Or doubtful and requires more time and thought, in which case I write back to the family practitioner.

Q. Have there been occasions when you have taken a history, in examining the patient, when you have had reason to suspect some other pathology, perhaps even serious pathology?

A. Yes.
Q. What's happened in those cases or that case?
A. Basically, I've gone back to the family practitioner and he has taken the problem from there on, usually with referral to another specialist.
Q. Right. If you did suspect some serious pathology, what are you, according to the Healthcare Commission, supposed to do if the patient's been referred by a GP? Can you send the patient off to your local hospital or their local hospital on the NHS?
A. Yes. It would be perfectly legal so to do. Perfectly legal, if you like, to short-circuit the family practitioner and send a patient into either -- for a private or NHS referral, there is no bar on that. But good practice and what I have always done is refer the patient to the family practitioner and request that he refers the patient to the appropriate specialist, and I can't recall a sort of problem, if you like, in that direction, the family practitioner saying: no, no, I don't agree, this is nonsense, or something.
Q. I understand.
But what importance do you place on keeping in contact with the general practitioner and notifying him or her of what's happening with the patient?
A. I think it's crucial to any medical practice, and

that is my invariant practice, to write back not only at every new referral, but every time the patient comes.

Q. So we'll come on soon to the specific patients with which the Panel are concerned, but I'm still talking in general terms, if a patient is referred to you, do they make an appointment to come or can they just turn up?

A. Now, let me think. What happens is, when we get the letter of referral we contact the patient and explain what the clinic's about and then make an appointment.

Q. When a patient comes, if, let's say, you have a letter of referral --

A. We do.

Q. -- and the patient comes in to see you, can you take us through what will happen as the consultation go? We've seen what your book says.

A. Yes. The patient will be met by the receptionist who will offer the patient tea or coffee. Then the patient will fill in a kind of: what's my address? Where do I live? And so on.

Q. We'll see examples soon when we deal with the patients.

A. Right. Then in the last two or three years, to some extent motivated by the Commission of Healthcare's desire to see audits -- perfectly reasonable -- the patient will fill in a symptom sheet. I think Patient D

was in the symptom sheet error. Perhaps Patient B was.

Then, let me think what happens then. I'm not actually in the room at the time, and then the patient will simply wait and then will come into the consulting room.

Q. We have seen in your book your outline of what will happen when the patient comes in. There is a discussion of hypothyroidism, what it is. How will you start things off?

A. I'm not awfully sure -- how do you mean, start things off?

Q. The patient will could come in, you'll say, there will be a greeting on each side, I'm sure?

A. Yes, yes.

Q. The patient will be asked to take a seat. Yes?

A. Yes.

Q. Where do you go from there, on the basis that you've got some information about that patient, either the questionnaire or a referral letter?

A. Well, the crucial then, which I then do, in which 95 per cent of diagnoses, in my view, and in the old practitioners' view, will give you the diagnosis, is to take the history. That is absolutely crucial. Without that there is no medicine hardly. And having done that, which takes up quite a large part of the consultation --

and some patients I have seen are having slight cognitive problems and can be -- I'm a little conscious I have got patients behind, but sometimes they can be a little rambling and they like to give quite a long account of matters.

Then I'll conduct relevant examination and then discuss what I think is the way forward.

Q. Can I ask you what you mean by "relevant examination"?

A. Well, I wouldn't, for example, unless there was specific indication, conduct a respiratory examination or an abdominal examination or a neurological examination unless there was something in the history; it's all down to the history, what the patient tells you. I do listen to every patient's heart.

Q. Do we see temperatures recorded?

A. Oh yes, the things I do do, I always -- every patient's temperature's taken, pulse taken, blood pressure, of course, and inspected for all -- well, the usual things. This is kind of medical student kind of stuff: skin texture, hair, size of tongue, is there any swelling over the thyroid gland, nails.

Q. Perhaps you've effectively given the answer, but if among the symptoms was a complaint about respiratory issues, would there be an examination of the respiratory system or not?

A. Yes, yes indeed. More commonly the patient needs abdominal examination --

Q. I understand.

A. -- than respiratory, really.

Q. If you come to the view that the patient may benefit from a trial of replacement therapy, if thyroxine is the drug that's to be used, what level of prescribing might you or would you start the patient on?

A. Right. If I start anyway the patient, my preference is not to do that. It's for the family practitioner to do that.

Q. Right.

A. If I do, I would start in almost all patients at 25 micrograms per day for one week, and then 50 micrograms a day for three weeks, and then 75 micrograms a day for three weeks, and then 100 micrograms a day for four weeks. Something like -- and then I would normally try to see the patient or have the patient seen by the family practitioner in two months.

Q. The Panel saw -- can you turn to tab 2, please, in that bundle. Again we will come to the specific patients.

THE CHAIRMAN: Mr Jenkins, are we still in file 2?

MR JENKINS: We are, yes.

Dealing with Patient C, the Panel have the letter of

Dr Prentice at page 5, and it's his letter to Dr Ince. I think there was a letter written to the GMC as well, which the Panel have at page 6, written by Dr Cundy.

There was then your letter at page 7. The Panel have seen this before but they'll recall that in your letter of 18th June 2005, you say:

"I am disappointed that a practitioner, namely Dr Cundy with supportive evidence from Dr M Prentice have written to the GMC."

You go on that that paragraph to say:

"... with one contrived exception, every statement is untrue and would be known to be untrue if Dr Cundy or Dr Prentice had either contacted me or inspected the notes."

Over the page at page 8, at paragraph 4 you deal with the suggestion that you had started this patient on treatment at 150 micrograms of thyroxine a day; started treatment at that. You say there:

"... which I have never done in my professional life and didn't do with this patient."

Can I just ask: you have told us, if you do prescribe thyroxine for a patient, you would normally start at 25 micrograms for seven days and then 50 micrograms for three weeks, may there have been occasions when you started a patient at a higher dose

than 25?

A. I think there's a few patients I may have started at 50. Usually if it's rather a heavy person, I've sometimes sort of felt that would be quite in order.

Patients historically were started at 100 micrograms per day. I don't think that's necessary to do that, so really -- but I have never, ever started a patient -- I think about four occasions I've started at 50, never, ever started at 100, and to start at 150 would be quite wayward practice. I don't know where Dr Prentice got that from, not free in.

Q. Again, the BNF that we have seen, and the Panel have the extract, says under section 6.2.1 under the heading "Levothyroxine sodium":

"It is the treatment of choice for maintenance therapy, the initial does shouldn't exceed 100 micrograms daily."

Over the page, dealing with the same drug:

"Dose: adult, initially 50 to 100 micrograms. 50 micrograms for those over 50, daily, preferably before breakfast."

Was your prescribing in line or not in line with what was suggested in the --

A. In the BNF? It looks in line.

Q. If you were treating a patient on thyroxine, tell us

what would you plan the prescribing to be? Starting off at 25 for seven days, then to 50 for three weeks?

A. (Witness nods).

Q. Would you plan that there should then be a continual increase?

A. Yes.

Q. To 75 and then 100?

A. Yes.

Q. And what's your view about whether there should be a review within that period of prescribing or any blood tests before the dose is increased?

A. I think to review the patient at two months and advise the patient that to let either myself or the family practitioner know if there are any problems, would be my strategy there.

Then, normally speaking, I would say about three or four months after that, it depends very much on your assessment at two months.

Q. Would this be something you would deal with in the initial consultation, set out what is proposed?

A. Yes, indeed. If it is proposed, absolutely, and patients will always ask you that anyway.

Q. What conversation, if any, would there be with the patient about possible adverse consequences or side effects of the medication?

A. That's always discussed.
Q. When you say that's always discussed, tell us what you say typically?
A. Typically -- in fact typically the patient will -- I cannot think of a patient who has not asked that of you anyway. I would, generally speaking, de-emphasise the dangers of the medication because the patients have often been wound up to a very anxious state about it.
I would indicate that -- I think the crucial message to the patient there is if she or he feels any adverse unusual effects, to let somebody know. Rarely does one see a patient that hasn't read that she will not get osteoporosis or atrial fibrillation or suppression of the thyroid gland and be fully cognisant of this perceived problem. So that is what I would do.
Q. Contact somebody if there is an adverse effect or side effect?
A. A family practitioner or myself.
Q. What contact details would the patients have for you?
A. My phone number.
Q. Is that the practice phone number?
A. The practice phone number and some patients phone me on my mobile phone. You've actually rather caught me unawares here. I'm not quite sure if I provide patients with that. I do get barraged on my mobile phone.

Q. Do you know how they get hold of the number? If they phone out of hours, is there an answerphone message?
A. Yes, there is.
Q. Do you know what information the answerphone message gives?
A. I don't think it gives a phone number out of hours. If they phone -- I'm not quite answering your question.

If they phone during the day, my receptionist will give them my mobile phone if I'm in Timbuktu or Manchester or something like that. This was -- we had very long discussions with the Commission of Healthcare on this particular point. Their view was in a sort of secondary referral situation. Now, I quite understand in days gone by if there was an occasional patient that hadn't been referred, then there could be a problem with a patient phoning a family practitioner and saying: I've got something wrong with me; and he said: I didn't even know you were seeing Dr Skinner.

But in a secondary referral their feeling was it wasn't necessary to provide 24-hour emergency cover.

Q. But if a patient phoned during surgery hours, they would be given mobile phone number?
A. Yes.
Q. And if a patient were to phone you on your mobile phone, would you deal with the call?

A. Yes, of course.
THE CHAIRMAN: Mr Jenkins, can I ask you --
MR JENKINS: Now is a convenient moment, madam, I'm going to move on gradually towards the patient, but I recognise we are approaching a time when we would normally take a break, and now is an entirely convenient time.
THE CHAIRMAN: Excellent, thank you. We will break then until 11.35, please.
(11.12 pm)
(A short break)
(11.35 am)
THE CHAIRMAN: Mr Jenkins?
MR JENKINS: We were dealing with a situation where you had planned out, Dr Skinner, a proposed regime of thyroid replacement for a patient. You told us that at the first consultation you would set out for the patient what was planned, namely starting for seven days at 25 micrograms, going to 50 micrograms then for three or more weeks, and gradually increasing the dosage.
A. Yes.
Q. We know that patients could contact you if there were any problems. But in what circumstances would there be a review of the patient?
A. Beyond the planned -- or as I said, two months, and normally speaking, about three or four months after

that. Each follow-up consultation is a review.

Q. I understand. Were those always face-to-face, the follow-ups?

A. Oh yes.

Q. Was it left to the patient to organise the appointment or would you or your staff contact the patient? How was it done?

A. The next appointment is made when the patient's completed the consultation.

Q. I understand.

A. At the time.

Q. So let's imagine you've spent an hour or so with a patient at their first consultation. If you are writing a prescription for the patient, how would that be done? We've seen some typed and some handwritten. How would it be done?

A. Since the last few years it's always handwritten, and if it's typed -- sorry, did I say -- I can't remember what I said there.

Q. I will remind you. You said for the last few years it was always handwritten?

A. That was diametrically opposite of what I was trying to say. It's always typed in the last two to three years, and this receptionist lady will type it out. She will give the patient a copy and a copy for the notes.

That's the present strategy with that.

Q. How will the receptionist know what to type out?

A. Because I will then go and tell the receptionist.

Q. Imagine the consultation is finished, you've finished discussing matters with the patient, and any examination, you've recommended that there should be a regime of prescribing. How do you tell the secretary what to type up on the prescription? Do you leave the room? Do you phone through?

A. I leave the room and go through to where she sits and tell her.

Q. Right. Is there a pro forma that's half completed, which the secretary completes, or does she type the whole thing out on headed paper? How is it done?

A. We are not terribly computerised, but we do have on the computer certain standard prescriptions. The most usual one being thyroxine, on the regime that I have heretofore described to the Panel.

That's -- so the secretary then -- I don't know how you do it, but she does something on the computer and it appears as a typed prescription which I then look at and sign.

Q. Right. Is the patient still in the consulting room or has she come with you out into the reception area at this stage?

A. The patient will have returned to the reception area. She's not, however, in earshot, so to speak, of myself and the receptionist.
Q. I understand. Now, plainly you're not treating patients on the National Health Service and you charge a fee for an initial consultation.
A. Yes.
Q. A rather lesser fee for a follow-up consultation.
A. Half the fee.
Q. How is that fee taken from the patient, and at what stage?
A. After I've dealt with the prescription, what I would normally do then is return to the consulting room and dictate the letter on -- the letter to the referring practitioner, and then the fee is collected by the secretary from the patient; usually there and then, sometimes not.
Q. How are patient records kept? We've seen the type of records that you have, we will come to look at the specific ones for the four patients very soon, but where are the records kept?
A. In locked filing cabinets.
Q. In your room, I think.
A. Yes, in the consulting room, yes. This again is advice from the Commission of Healthcare.

Q. Right. But again coming back, when the patient is given a prescription, if they are, at the end of the consultation, they'll be asked to make the appropriate payment, and any further appointments are arranged at that point?
A. Correct.
Q. Right. Can I come on to the general nature of the patients that you dealt with.
A. Yes, I'll try.
Q. You're not a GP.
A. No.
Q. Patients, certainly the ones the Panel have heard about, some of whom have heard your name through others.
A. Yes.
Q. One of them heard through her mother's friend, for example.
A. Right.
Q. If there is a typical case, what is the sort of history that the patients have before they come to you, so far as treatment is concerned, and their dealings with other medical practitioners?
A. I would say about 60 per cent of the patients are, of course, already on treatment.
Q. Yes.
A. And they have been sent to me, because the treatment's

not working, for advice on the dosage level, or perhaps a different preparation, perhaps because the diagnosis itself is under some scrutiny.

The background of these patients is usually that they have returned to the family practitioner, not in a confrontational sense, and said: I still don't feel well. And they may have heard of me through some mechanism or other and asked to have a referral to me. I suppose that is probably the most common sequence of events prior to the patient coming.

Q. So a patient's already on treatment under the care of other medical practitioners?

A. A fair proportion, I would think more than half.

Q. What about the other types of patients?

A. Well, these are new, what you might call new referrals, who are not taking medication.

Q. Right.

A. They will have the same sort of background, they may not have been feeling well for some time and they feel that they're not progressing, either under the family practitioner's care or sometimes they haven't agreed with the view of the endocrinologist or other specialists that they may have been referred to, hence they don't feel satisfied with their state of health.

Q. I understand. What sort of numbers of patients are we

dealing with in that category? Are we talking about tens of patients, scores, or hundreds?

A. I think I would do about a thousand consultations in a year, approximately, and about 200 of these are new -- something like, are new patients.

So there is probably less last two years. So in that 200, about a 100, let's say, patients are on medication.

Q. Right.

A. So then there is another 100 patients in the year, but I think perhaps less, it seems a lot, who are not receiving any thyroid replacement, so they're coming for advice on what might be wrong with them.

Q. So of the patients who come to you, about 60 per cent will be on treatment?

A. Yes.

Q. Is that thyroid replacement therapy?

A. Yes, that's what I meant by saying that.

Q. So a diagnosis has already been made by some other medical practitioner, is that right?

A. Absolutely.

Q. And of the other 40 per cent or so patients that you may see, they are new to you but may there be some of those who aren't referred by their GP?

A. No. No, in the last three years or since instruction or

advice from the General Medical Council and my conditional registration, none, and very rarely before that.

Q. I just want to make that clear. The Panel have seen letters from Sue Conway a little over a week ago. Sue Conway had written letters in, I think, 2005, 2006 to the GMC, and those were in anticipation of Interim Orders Panel hearings.

A. I think so.

Q. Yes? Again, Mr Kark I think knows that I'm about to say this: the Interim Orders Panel imposed some conditions upon you to ensure that you did keep contact with GPs and only accept patients with a referral from GPs.

A. Yes, the latter assurance was redundant as I always had done anyway, in fact both, if I may say so.

Q. I understand, but of those patients who are new to you, where the diagnosis hadn't already been made of thyroid problem, how many of those, roughly, will be patients where the GP is asking for your help with a thyroid problem or where the patient has said to the GP: I'd like to see Dr Skinner because I, the patient, think it's a thyroid problem and the doctor isn't agreeing? Are you able to break it down for us?

A. You mean between the two?

Q. Yes, between those two.

A. Well, that's a difficult question because the patient will have said this to the family practitioner before the patient came to see me.
Q. Sure.
A. And the family practitioner's unlikely to write a letter saying that, well, perhaps: I have been persuaded by the patient. That would be not really good practice, that this patient could come and see you. So to some extent you're asking a question that I can't answer.
Q. What I'm trying to elicit is what degree of selection has been made of the patients to come and see you?
A. Oh, massive.
Q. And who has done the selection?
A. There is a huge selection, it's a highly selected practice, because, for example, no patient de facto -- this is a matter I feel, I hope -- it sounds a bit superior, I don't think it has been made very clear to the Panel during the last week, I've seen no patients with what is called subclinical hypothyroidism, because that means essentially there is a bit of humming and hawing about it, but essentially means patients that feel well and their thyroid tests are not right or not within 95 per cent reference intervals.
Q. Again, subclinical hypothyroidism means that their biochemistry results fall outside the reference range.

A. Yes.
Q. But they don't have any clinical signs.
A. Correct. That is the strict definition, and I am moved to say that much we heard last week seemed to be irrelevant to the outlines which Mr Gribble kindly gave us at the beginning, which seemed to be focusing on the four cases, who are precisely the opposite problem. These are patients with clinical features and unremarkable thyroid chemistry.

So the latter group of subclinical patients are simply not going to appear in my practice, because the patient's not going to the family practitioner and saying: I think my thyroid chemistry is out but I feel wonderful.

Q. I understand.
A. Right.
Q. So of the new patients that you see, what proportion of those will have normal thyroid chemistry or, I say normal, forgive me, chemistry within the reference range.
A. I would say, and this is right off the top of my head, about 80 per cent.
Q. Right.
A. It's the usual situation, why there has been some difficulty in perhaps a patient obtaining the treatment,

the patient feels that it should have.

Q. Again, perhaps it's obvious from what you've said and what we've seen that you have written, what are you seeking to do with those patients if they have signs and symptoms indicative of hypothyroidism but normal -- reference range chemistry?

A. The first critical thing, as I've said before, as Sir William Osler emphasised time and time again: are the clinical features typical of hypothyroidism? As most practitioners and most medical textbooks would -- I would contest the contention that has been advanced that if you take the whole set of symptoms, that there is much dubiety.

Obviously we know one individual symptom, tiredness can -- a thousand reasons why somebody's tired. So that's the most important part of the consultation, is to examine the typicality of the patient's clinical features, their physical examination, and then if the patient's thyroid -- whatever the patient's -- well, that is too extreme.

If the patient's thyroid chemistry is within reference limits and the patient's clinically hypothyroid, it's my belief that patient should be given thyroid replacement.

Q. Is that as a trial or as maintenance therapy?

A. I hope it won't irritate you, but in a sense all medical treatment is a trial. It would only be a wayward, careless, irresponsible, unprofessional medical practitioner who would start a patient on anything and say: we're not going to see what happens. So the patient comes back at two months and you assess the situation. It's a trial in that sense.

Q. I understand. What you seeking to do long-term, so far as the patient is concerned? Render them euthyroid but what does that mean, in terms of the patient?

A. I think there are two aspects to that. First of all, if you have euthyroid, you feel well and you feel awful if you're not. But a second side of this, which has been very underemphasised in the proceedings so far, in my view, is that the risks to your health long-term of being hypothyroid are appalling, particularly cardio -- again, one of the most underemphasised aspects is cardiovascular problems. Cholesterol is high, with deep position of atheroma, relationships collapse. Many patients not only have no libido, they don't want to be touched at all, children, grandchildren, they want everyone to stay away, become very emotional and weepy, we saw that with Mrs D.

Q. Forgive me, you were talking about the health risks.

A. These are health risks.

Q. Indeed, but the health risks of a hypothyroid patient. One is cardiovascular disease.
A. Most certainly.
Q. One is cholesterol, which is involved perhaps in cardiovascular disease, heart disease.
A. Yes, I think most people.
Q. You then went on to the social aspects.
A. Yes, I was not sort of prioritising, but social aspects are very important. Many patients become recluses.
Q. Recluses?
A. Recluses. They won't go out of the house, won't answer the door, won't pack a suitcase, can't do anything. Family relationships suffer, social relationships suffer, marital breakdowns, a problem for various reasons, and of course, you get intestinal problems which long-term are disastrous, IBS, constipation. There is evidence that a quite high proportion of patients become B12 deficient. This is not pernicious anaemia as was alleged last week. The list is endless.
Q. Right.
A. Death, of course, is the final end point.
Q. Yes. In terms of risk that you might introduce by treating a patient, what is your assessment of the risks in putting a patient on thyroid replacement therapy?
A. If you treat -- if you have an incremental strategy of

dosage in the short-term, you're never -- anything significant above a level that was the patient felt all right at, because the patient, let's say, was at 50 micrograms, if they go to 75 micrograms and they develop some adverse effect, it is never going to be serious because you've gone up in a measured fashion.

Long-term detriment, I think the evidence is very, very insecure, and it certainly -- I'm sure Dr Hetroghe, an expert, will go into this. It's nothing like the detriment of being left hypothyroid.

The comparison is just -- and it almost stretches common sense or credulity that a patient who is sitting around, like Mrs D, as she said, she spent all day sitting on the sofa, will in ten years be in better health than a patient who is active, taking exercise, not worrying about every article of food, because a lot of hypothyroid patients do. I think it's not even common sense.

Q. I understand. Well, the evidence for osteoporosis or osteopenia, what evidence is there, so far as you're aware, that patients may suffer reduced bone mineral density from thyroid replacement therapy?

A. I think it has been shown to be not there, basically. Professor Franklyn, who works in Birmingham, was quoted in another context, I think it was part of a meta

analysis, which was actually to do with subclinical hypothyroidism again. Wrong subject. She has published, saying that there isn't a risk of osteoporosis.

Q. Again, it comes back to the questions asked of Mr Lynn yesterday. Are you aware of a study dealing specifically with patients on thyroid replacement therapy and the risks of reduced bone mineral density or some kind of osteoporosis or osteopenia problem?

A. Yes, I think there are some people who have alleged this and the literature is mixed. But I think the body -- I feel I'm going to irritate you slightly. I think the --

Q. Don't worry about me. Worry about you and the evidence you are giving?

A. All right. Thank you, Mr Jenkins.

The critical point is not to stray out of Mr Gribble's instructions, injunctions, I'm not quite sure what you say. There has never been a study on osteoporosis in the patients who are the focus of this hearing.

Q. I understand.

A. Completely different.

Q. What about the risks of atrial fibrillation and any consequence there might be?

A. I think the same considerations apply. Even perhaps the leading paper, if you like -- there is a paper by a colleague called Sawin, S-A-W-I-N, and that is generally flagged up as: look at these risks. Again, not in the patients, the focus of this hearing. I'm sorry to keep reiterating that.

But even the evidence he gives, which really only applies to over 60 year olds, is quite marginal. I think the difference is something like 9 per cent and 22 per cent of people as a comparison of those treated and not treated.

But many of these studies are fatally flawed, in my view, because they don't know what the patients were like who were being followed up. My gut feeling is that quite a number of them have not been adequately treated and they are still hypothyroid, certainly from my experience in 2007 in the UK.

Q. Right. Atrial fibrillation, if the patient were to experience that, how would it present itself to the patient? What would they feel?

A. Most patients would be aware of it. I haven't -- I'm not saying it doesn't happen. I have never in my many years of practice come across a patient who I happened to take the pulse rate and find they were fibrillating, but other colleagues in cardiology may well have found

that. The patient is usually aware of not feeling awfully well -- I know that sounds a bit vague -- and sometimes patients can feel their heart beating irregularly.

Q. In one of these patients you, in your notes, refer to palpitations?

A. Yes, I think that is a different thing.

Q. We will come to the specific patient, but why is that you've made any record of that, in your notes?

A. The patient said that she had, about a week ago, I wasn't there, 3 o'clock in the morning, felt her heart beating strongly.

Q. Why might it be relevant for you to make a note of it?

A. Because -- and it would be unusual to be an isolated symptom. If indeed you've been made thyrotoxic, one feature of that would be a tachycardia.

Q. Yes.

A. That's why. And an extreme dose of what you would call poisoning, not overdosage, I would say you could get atrial fibrillation, I'll accept that.

Q. On any follow-up consultation, after the first consultation, what would you be interested in, so far as the patient's signs and symptoms were concerned? My question really is: are you monitoring for that?

A. Absolutely so. Absolutely. Both in physical

examination and the patient's history.
Q. If it appeared that there may be consequences or side effects from the medication, what would you do?
A. If there seems reasonable evidence that is to do with the medication, what I do is I ask the patient to totally stop their medication for perhaps four or five days and then talk to the patient again.
Q. What's your assessment of the risk that you're perhaps exposing the patient to, if there is a possibility of atrial fibrillation? Are they going to drop dead, or what other consequences might there be for the patient?
A. I think you have to be cognisant of every risk. I think, given the practitioner is behaving in a relatively responsible fashion, I think there is virtually no risk. Nothing has no, no, no risk.

Patients can die of atrial fibrillation and do anyway, and some patients will obviously develop atrial fibrillation if they're on thyroxine treatment, which are going to include 20 million people on the earth.
Q. What do you envisage would be the long-term prospects for a patient who came to see you with signs and symptoms of hypothyroidism; you would wish to render them euthyroid?
A. (Witness nods).
Q. Does that mean biochemically as well as symptomatically?

A. No. It means that the patient has no symptoms remaining.

Q. Is there a level of TSH on a blood test that you would not be comfortable with?

A. No.

Q. What do you anticipate would be the course of your continuing dealings with the patient? Would it continue for life? We've heard the suggestion that once you place a patient on thyroid replacement therapy, that's it, they're with you for life.

A. That seems rather against the evidence of one of the patients, who apparently has stopped it. The answer to the second part of your question is: no, there is no question of it being addictive.

Patients do sometimes decide they'll stop it. Sometimes because they have been terrified by my colleagues.

The answer to the first question is: the patient should remain under the care of the family practitioner thereafter, and that's what we strive for. Long-term, if that's the question, I think a patient need only be seen once a year, but given a green light, so to speak, to contact the family practitioner, which should be the case anyway if she feels any abnormal effects related to the medication.

Q. You touched on one subject there that I would like to ask about. We've been given the suggestion that the patient may get a buzz or may get a high out of taking thyroid replacement therapy. Perhaps those are my words rather than those of the witness who referred to it, but what do you say about that, patients who are given thyroxine or other forms of replacement therapy? What's their experience of it?

A. I think there is a confusion here. Some patients may get a high or a buzz, because they have been feeling absolutely awful for 30 years and they see a chink of light that they are going to return to optimal health. Now, any person would feel that way. The suggestion that was mooted that it's addictive or patients get a euphoria or something like that is, in my view, not correct.

Q. What about the suggestion that there may be a drive for the patient to ever increase the dose they are taking? Has that been your experience?

A. Yes, I think there are some patients who would wish to do this. There are equally patients that want to reduce their dose.

I think the answer to that is, you simply tell the patient that you don't agree with that and you're not prepared to prescribe more. It seems to me something of

a non-problem that has been flagged up in these hearings, almost as if the family practitioner or doctor has somehow become impotent in the matter of -- Professor Franklyn, I don't know what that was all about, but she seemed unable to say: I deem you not to be hypothyroid, therefore, I'm going to advise the practitioner to stop your medication.

Q. The last issue I want to ask you about, before we move to the specific patients, is that cost, cost of the medication.

A. That's beyond my remit, Mr Jenkins.

Q. It is? Then I will not ask.

Let's turn to the patients, and I'm going to ask you to take up, please, the first bundle and invite you to turn, please, to tab 2.

The typed version of your notes, the transcribed version that we have on the front page, is a transcription of your handwritten notes at page 12.

A. Yes.

Q. What we've seen by way of history is at page 9 and 10 a referral letter from Dr Cooke, the GP, setting out some history, as he indicates in the letter, and he refers to the referral to Dr Smith, a physician, towards the bottom of page 9, refers to the referral to Dr Veitch over the page, page 10.

Included in these notes at tab 2, which are the notes you produced to the General Medical Council, were letters from Dr Smith and Dr Veitch. Do you have at page 3 Dr Smith and page 4, and Dr Veitch is page 5, 6, 7 and 8?

We know Dr Cooke wrote to you because we've looked at the letter. Are you able to tell us how this correspondence from Smith and Veitch came to be in your notes?

A. I don't remember how it got into my notes.

Q. Well, do you recall if you were sent this correspondence by Dr Cooke?

A. Yes. If that's what you're asking.

Q. If we turn to page 11, we have the questionnaire completed or the details, rather, completed by Patient A.

A. Yes.

Q. Would that be on the day she came to see you, on 16th January 2003?

A. Yes, that's what the patients are asked to complete.

Q. I think if we turn to page 13, we can see your statement of account for seeing her on that day and the blood tests that were ordered, and on page 14 we see the copy of a prescription that was kept in the records.

A. Yes.

Q. Perhaps I should take you to the notes. Just take us through, if you would, the complaints that this lady had.

A. Well, they are as indicated in my letter.

Q. Page 15?

A. Page 15 and in the summary -- the typed account of my notes, which I have provided --

Q. At the front of the tab.

A. Yes.

Q. The front of tab 2.

A. Yes. In brief, I thought these were reasonably typical of hypothyroidism.

Q. Again, you've given a cluster of complaints from the patient: feeling knackered, flat and lifeless. You talk about here sleep pattern. Scattered aches and pains, tightness of hands, brain in slow motion, forgets name, side vision hallucinations that we dealt with, asocial and weepy, paraesthesia of hands and feet. You deal with no libido, blurd vision, looking through smokescreens through a veil.

You have indicated she had glandular fever in the past and sees a reflexologist, and the name is given, and there is then an examination.

A. Yes.

Q. We heard Professor Weetman's criticism of your

examination, saying effectively you should have sent her to a neurologist because of the paraesthesia of hands and feet, you should have sent her to an ophthalmic practitioner because of the side vision hallucinations, and other concerns that he made.

What do you say about the extent of the examination of this patient?

A. Well, de facto, I obviously don't agree with that or I would have done it. I think to take an isolated symptom and send a patient to every specialist that might be involved in that is not even consonant with good or any medical practice. I'm astonished.

If a patient came with one complaint, for example, perhaps paraesthesia, you might think a neurological opinion, but you have to see the patient's symptomatology as a whole, and as a whole I think most practitioners would agree that it should be a strong suspicion of hypothyroidism here.

Q. You go on in the note of the examination to record her pulse as 56 a minute. Just tell us, is that normal, is it high or low?

A. It's lowish, I think. 74 would be the sort of average.

Q. You go on to talk about her voice being hoarse, has a yellowish pallor, loss of outer half of eyebrows, tongue slightly enlarged, eyes slightly bloodshot, skin

dry with cracked heels, thyroid palpable, blood pressure 105 over 60.

Tell us about the blood pressure. Where's that as against a normal scale?

A. It's a little lowish, but again, I don't think any practitioner would institute investigation of blood pressure at that level.

Q. What about "thyroid palpable"? What does that refer to? You clearly were palpating the thyroid?

A. Yes.

Q. What does it indicate in your note? What we have, if we look at page 12, is just "thyroid (+)"?

A. Yes.

Q. Is that right?

A. Yes, it's medical shorthand, which we've been discouraged from as the years go by.

The sort of view of the thyroid, as you -- some old physicians used to say that you can just not feel it or you can just nearly feel it. In fact, a palpable thyroid can mean absolutely nothing. You can have a goitre and be in perfectly good health, that was not the case, of course, with this patient.

What it means is that I could feel the thyroid gland, and as I haven't made any other comment, it means I didn't think there was any reason for alarm or

referral to someone, perhaps like Mr Lynn, who would be the next port of call in a sense.

Q. Again, the suggestion is that you carried out an inadequate examination for this patient. You're entitled to give your own response. What do you say?

A. I don't think it was inadequate.

Q. We then turn to your letter, where you thank the GP very much and talk of the patient's six-year history of utter fatigue, and you refer to:

"... occasional side vision hallucinations which I find to be quite common in hypothyroidism."

And you say on the third line of the first substantive paragraph:

"All in all it sounds rather suspicious of hypothyroidism."

You go on to deal with the other matters that you found on examination.

You say:

"Perhaps B12 deficient."

What does that mean? Does it mean that you believed that she was?

A. This is difficult, and it's something that I think Mr Lynn properly referred to. There is in all professions an element of shorthand and interprofessional understanding which -- I know

Professor Weetman gainsaid that notion.

It means that you're asking the GP -- you're saying to the general practitioner: this is something worth thinking about. You're not saying that the patient's about to perish with pernicious anaemia, which seemed to be the interpretation. You're saying: here is something we should think about.

The family practitioner, who is also -- it sounds facetious, it's not supposed to, who is also a medical practitioner and capable and well capable of critical appraisal, he may think it's not critically important. That's what perhaps B12 deficient -- I think it's almost got a meaning in the profession not quite the same as out of the profession. I hope I'm not confusing people.

Q. You then go on to refer to:

"I know she has had one or two highish TSH readings but unfortunately nobody seemed to be carried out an FT4, which would be at the laboratory end of things ... More and more laboratories are refusing to carry out this extremely helpful test. I have in fact taken a blood sample of the thyroid chemistry results, which I should have in ten days' time."

Can I take you back, please, to Dr Cooke's letter --

A. May I interrupt?

Q. Of course.

A. "Highish TSH readings" is nonsense. I don't know why I wrote that.

Q. All right.

A. There are no -- on no scale would they be considered high. I do apologise, I don't know what that's about.

Q. How do you create these letters? Do you dictate them or type them?

A. I don't know how to type. I put them on to a dictaphone.

Q. Just for the sake of completeness, can I take you back to page 9 in that same tab. We have readings for TSH, one in July 2001 and another one in May 2002, not highish.

A. Above the average, but not -- I think "highish" would be a misleading term there. I don't know why I wrote that.

Q. All right. But you say:

"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 at 25 micrograms a day in one week proceeding to 50 micrograms a day for three weeks. I have in fact given the prescription to the patient so she can get on the road, so to speak.

"I do not know if you would be willing to continue this prescription at 75 micrograms a day for three weeks

proceeding to 100 micrograms for a further four weeks and I will see the patient in two months' time."

That letter plainly typed up the day after you saw the patient?

A. Yes, that is right. I have found it. 17th January, thank you.

Q. And we then have on the following page, page 16, the results of the blood test that you instituted.

A. Yes.

Q. Tell us about the TSH and the T4 range there.

A. TSH is -- can I ... May I turn the flip chart round?

Q. Of course you may. I just moved it so that people behind could see without it being in their way.

A. TSH wise, it's of course not remarkable, as --

Q. I wonder if it could be tilted slightly more towards the Panel. Tilt it towards the Chairman.

A. Nevertheless, the average TSH, and I have measured this from a number of patients, is about 0.9 to 1.

Can I write on that, or is that Professor Weetman's evidence?

Q. You can start your own sheet or write on that one, it's not a problem either way unless anyone has any objection.

THE CHAIRMAN: Perhaps you could do yours at the bottom of that page so we can compare what you're saying and what

has been said. Is that possible, is that all right?

A. Yes.

THE CHAIRMAN: Go to another page.

A. TSH values have what's called a left sided skewed distribution. If you have 0.5 there and 5 there, it's the kind of range most laboratories have. The modal value -- most values are around 1, with a tail out there. The mean is nought in the middle of the range. I'm not trying to justify or argue to the Panel that 1.49 is a high reading, but 1 is about the average. It's is unusual and more unusual to find values as you go out this way. (indicating). The 1.49 would be about there. (indicating).

Now, the FT4 is 12.2, and I think this is quite an important point. The 95 per cent interval goes from 9 to 20. Now, we've touched on this already, but the T4 value with this lady was 12.

A point I made before, which I think is very important: Professor Weetman's evidence was -- I think he said something like, and it will be in the transcript, "As far as I'm concerned, you're in or out." That I don't agree with because you could be out just there and in just there (indicating).

MR JENKINS: 8.9 is out and 9.1 is in.

A. That seemed to be the contention being advanced. Most

people, I would have thought -- I would be staggered if there was any endocrinologist, even, that would say that that is the same as that. (indicating). So if way at the top of the 95 per cent is the same, what has been said, as just at the bottom, I don't think that's commensurate with, I hate to say it, but common sense.

Now, this is a slightly broader issue, but we have seen that if you took Patient B, this patient had an FT4 value of 39. It wasn't thyrotoxic in my view. Patient C had a value of 11 and wasn't thyrotoxic. This is because hypothyroidism is not a level of a hormone, it's the effect a given level has on your body tissues and all these features, thus clinical assessment is a sine qua non.

So we all understand, and I myself see of course, that 12 is within this reference interval, but it's lowish in it. So I wouldn't have thought that was sufficient to negate or exclude the diagnosis.

Q. Well, we know this lady did start to take thyroxine that you had prescribed for her and we understand that she took some days at 25 micrograms and then went on to take some days at 50 micrograms. I think I can take you to page 26. This is your letter to the GP from 13th February 2003.

A. My second letter.

Q. Yes. You enclose within this letter the results that we've just looked at. I think what's happened in the interim is that Patient A has complained and said she doesn't want to see you again. We have seen the letter she wrote at page 20. She is saying, "I can no longer be a patient under your care."

I'm just using your letter at page 26 to see what was being said at the time about the course of her taking the medication, because in the second substantive paragraph at page 26 you say:

"Unfortunately we had some teething problems with thyroxine sodium and certainly at the 50-microgram dosage Patient A has been troubled by headaches and disturbed mood with feelings of violence, but I did talk to her about this and she agreed that these have been present in the past and I felt assured that Patient A was not a danger to herself or anyone else. We did in fact discuss the possibility of a psychiatric opinion and Patient A seemed to think this was a possible way forward but I think in the first instance we can reasonably hope that her clinical features, including mood disturbances, will reduce or disappear when the thyroid status is restored and I will take full responsibility for any consequences that may derive from proceeding down this strategy."

You talk about a complication being that Patient A's husband was telephoned to indicate he does not wish to make any further contact with his wife. Indeed I think you have been copied into a letter where Patient A expresses the same view.

Can I just go back to the complaint of headaches and a complaint that she was feeling violent. Again, we've seen her letter, but tell us: did you speak to her over the telephone, Patient A, at some point?

A. Yes.

Q. We've heard reference to her telephoning and speaking to a lady who told her to stop taking the medication.

A. That's what she says.

Q. Are you able to tell us who the lady would have been?

A. I think it's my late wife.

Q. And which phone number would have been called for your late wife to speak to the patient?

A. I assume it would be my mobile, but it's not inconceivable that it was my house because there is no sort of reluctance to give my home number out if necessary. So I don't know that.

Q. I'm looking at the notice of hearing for those who may have it in front of them, the yellow pages. We'll go through it line by line, as it were, Dr Skinner, in due course. I wonder if you could be given a copy. It's

blue, I think, a copy for the witness. (Handed).

A. Thank you.

Q. Head 7A, this at present is unadmitted.

It reads:

"Between 16th January 2003 and 6th 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."

We heard Mr Lynn's view. You agree you spoke to her about headaches and disturbed mood with feelings of violence. We see it from your letter at page 26 that that happened?

A. Yes.

Q. And you agree it was over the telephone. There is no note of such a conversation in your clinical notes.

A. That is correct.

Q. Tell us why.

A. I think, as very much Mr Lynn said, it's a shortfall, which I freely admit to, and indeed the Commission of Healthcare addressed this issue in general terms. As Mr Lynn said, you get hundreds of phone calls a day and you should write them all down, but in the hurly-burly of a medical practice you can forget. I don't know why I didn't put them down, I have no reason.

Q. You go on in the letter -- I'm sorry, let me stop. It

said you failed to assess Mrs A or arrange for her to be assessed by her general practitioner. Let's just go back to page 26 and the second paragraph, I have read it already.

You say:

"I did talk to her about this and she agreed these have been present in the past and felt assured Patient A was not a danger to herself or anyone else. We did in fact discuss the possibility of a psychiatric opinion. She seemed to think it was a possible way forward but I think in the first instance we can reasonably hope that her clinical features, including mood disturbances, will reduce or disappear when the status was restored."

It's complained of that you failed to assess her or arrange for her to be assessed by her GP. What do you say about that?

A. I think it's an unreasonable allegation that I failed to assess her. Any conversation with a patient on the telephone that doesn't lead to them -- some further action could be thus interpreted. I did assess her. And doctors have to make a clinical judgment. My judgment was that she wasn't finally, having talked to Patient A, a danger to herself or society.

Q. What was your view as to the likelihood that the headaches complained of were a side effect of the

medication?
A. She had headaches before. That doesn't of course exempt the possibility. But my view was that, given about 12 million people have headaches in the UK every day, there wasn't sufficient evidence in a transient symptom -- you don't know it's transient at the time, I understand that -- to merit a full scale investigation of a patient saying she had a headache on the phone. That was my view.
Q. I understand. We know that you prescribed Armour Thyroid for this patient and we have a copy of the prescription in the bundle. It's page 17.
A. We're back to the bundle, Mr Jenkins?
Q. Yes, tab 2. You prescribed Armour Thyroid. We heard Mrs A's evidence that her headaches resolved immediately she started to take this medication.
A. Yes, I think I recall that.
Q. But I think in fact you were not communicating with her at that point. Her husband had said he didn't want you to speak to her and you had had her letter from 6th February.
A. Yes. There were further communications, but I think having discussed this with her, yes, you're quite right, I received her sad letter. Sad to me.
Q. Your response was at page 24, I think. This is

8th February 2003:

"Dear Mrs A. I apologise for the hurried note. I want to get this to you with some time to spare before your holiday. I tried to fax you but there has been no answer. I am so sorry about how upset you are - I really believed we were enjoying some light-hearted banter at your consultation but I have obviously misread the situation. I acknowledge and of course accept that you wish no further interaction with me but I must complete the 'instructions' vis-a-vis your thyroid medication. After we hurriedly sent a prescription for the Armour Thyroid to you; it should have arrived.

"I think the best plan is to take 25 micrograms of thyroxine as of now (not 50 micrograms thyroxine) and order the Armour Thyroid by fax. It may come before your holiday. If not, we can forward some to you by some means."

You then go on to say how she should take it and then contact Dr Edward Cooke, her GP.

"If you wish, but only if you authorise, I will write to him to exactly appraise him of the situation."

You give her what appears to be a mobile phone number. Was that yours?

A. Yes.

Q. "... if this is unclear. I do not want you to lose

momentum on your medication strategy."

And you say:

"Regarding the fee, I really don't want to take your money if you feel you have not had value and I will send you £155.00 next week. Finally, and this is critical, 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 and Dr Cooke will arrange a good endocrinological opinion presumably in your locality. I hope it all goes well."

And did you send the prescription for Armour Thyroid?

A. Yes.

Q. Did you get her consent to writing to Dr Cooke the letter that we see at page 26?

A. Yes, page 25 is the permission.

Q. Yes, thank you very much.

Let's go back to the letter, if we may, at page 26 because there are two other topics I want to deal with. On page 27 you start that page by saying:

"I really do think that with some adjustment of thyroxine dosage with the introduction of Armour Thyroid, which is an excellent preparation used extensively in the United States ... then we will significantly improve Patient A's health. It is

perfectly legal to prescribe Armour Thyroid. The only downside is cost."

You then go on to say:

"... worth just putting to bed for once and for all I thought that Patient A was somewhat sallow as many hypothyroid parents become B12 deficient and I have suggested that she take 1000 micrograms B12 per day on a pragmatic basis."

Again, it's complained of you that you failed to perform any investigation on Mrs A to assess a B12 deficiency. That allegation is not admitted. What do you say about it, the allegation that you failed to perform any investigation with regard to B12 deficiency?

A. I suppose it depends how you define an investigation. I would have said that flagging up with the family practitioner -- it's not an investigation, of course, but I thought that was quite a reasonable way forward in the matter.

Q. Well, you accept, I think, that you did not perform an investigation?

A. If you mean blood tests or checking for an intrinsic gastric factor, the answer is: absolutely.

Q. Did you regard yourself as under an obligation, yourself, to perform an investigation on Mrs A to assess her B12 deficiency, if any?

A. Certainly not.
Q. So is this the position, and I hope I can lead to this extent just to make things clear: you don't regard it as a failure to perform an investigation because, in your view, you had no obligation yourself to undertake one?
A. Correct.
Q. You didn't do it but you flagged it up for the GP.
A. That's what happened.
Q. I understand. Can we deal with the second issue in that paragraph. You deal with the possibility of serious B12 deficiency or secondary hypoadrenalism, and you say:

"I do know that she had a haemoglobin level of 12.8 grams per decilitre in August last year but I think if might be worth repeating it at this juncture."

What are you doing vis-a-vis the GP? Are you suggesting you'll do it?
A. No, I think most medical practitioners would take that -- that is a mandate, of course, one practitioner can't mandate another but would take that as a suggestion. If he agrees, he is an adult, consenting professional so to speak -- it seems to have been lost a built in all this -- if he agrees then he might repeat the 12.8. 12.8 is not a dramatic level, it's a lowish level of haemoglobin. Similarly with the secondary hypoadrenalism.

As I said earlier, that is many times self sorting once the thyroid is -- because the adrenal gland then gets an adequate level of thyroxine.

Q. Just looking again at the notice of hearing, it is said in head 3i that you suspected a diagnosis of secondary hypoadrenalism. Do you have it?

A. Yes, thank you.

Q. Well, did you suspect a diagnosis of secondary hypoadrenalism?

A. I don't know how to answer that. I don't know how you -- what we think of every thought a practitioner has becomes a suspicion that somehow you suspect the most extreme possible example of it, and that was very much the cast and tone of Professor Weetman's evidence.

I don't know what to say to that. I think you're saying: family practitioner, please consider this point. I'm not being evasive in this. I think you could say you suspect, yes, in the literal sense of the word. I don't think there is a problem in that.

Q. Can I ask you about probability. Did it seem bound or obvious that she did have secondary hypoadrenalism, or that it was a remote possibility or it was certainly possible.

A. Yes, again --

Q. Where would you put it on the scale?

A. Well, probability is a tough one. I think it's a possibility, as many other things that aren't flagged up are a possibility.

I'm not trying to not answer your question, but you're almost saying, or this is almost being alleged that every BUPA screening procedure has flagged up something because a blood test was taken and wasn't followed through. I don't actually feel the spirit of this question shows -- I'm not trying to be confrontational -- an understanding of the principles and practice of medicine really, and truly between professional colleagues you will say something like this and it would be extraordinary if the colleague came back and said: oh, look what you suspected, you did not investigate it. It's just not commensurate with medical practice, in my view.

Q. We didn't draft the notice of hearing.

A. I'm aware of that.

Q. Others across the room did, and I'm just asking your evidence on the drafting as it presently stands.

A. Sorry, if I've beyond the brief of the --

Q. Don't worry. What is said is, that in the light of your suspicion, you failed to refer Mrs A to an endocrinologist or other relevant specialist for evaluation.

We heard Mr Lynn's evidence yesterday on this topic but can I ask you for yours. In the light of the possibility that there was secondary hypoadrenalism, did you regard it as necessary to refer her to an endocrinologist or another specialist, or was it sufficient to raise it with the GP, or what was your state of mind with regard to the possibility of secondary hypoadrenalism?

A. It's as I have said, I think it was perfectly sufficient to flag it up with the family practitioner at this stage.

Q. I'm going to go on with Patient A because we know from tab 1 of the same bundle how she responded and reported responding to her GP, and I'm going to ask you to turn to tab 1, please, at page 4.

We have in the middle of the page for 16th October 2002, the referral to the physician. Sorry, it's the long history of abdominal pain, and the Panel will remind themselves of what is set out there.

Family history, constipation, and there is some detail about bowel habits, "Ask opinion of Dr V", must be Dr Veitch. We see entries from Dr Veitch's review of the patient on 18th December. We then see mention of your name, "Ask opinion of Dr Skinner who has an interest in this", and then a referral to you on

20th December, which is the same date, plainly, as Dr Cooke's letter that we've looked at.

There then follows your seeing the patient in January, your prescribing for the patient in January and February, and the next entry is:

"Patient's condition improved on small dose of thyroxine, TFT [thyroid function tests] is within normal accepted range."

There is then a referral to Professor Franklyn at the Queen Elizabeth Hospital in Birmingham.

As the GP writes:

"I am concerned as to side effects of thyroxine when ... thyroid function test that fall inside supposedly normal ranges."

The next entry we have is 15th April 2003:

"Patient's condition same. Definitely felt better on small dose of thyroxine but should not take unlicensed drug."

That would appear to be a reference to the Armour Thyroid that you had prescribed in February.

A. Yes, I would think so.

Q. 27th May:

"Patient's condition improved. Finds feels physically better on increased dose to 75 micrograms a day."

You had been prescribing thyroxine at 50 micrograms at the highest level. You prescribed it at a higher level but she had not got there.

A. I prescribed it at 25 micrograms --

Q. Indeed, then 50, then she had headaches and we have seen your letter of 8th February where you said go back to 25.

A. Yes, it's not entirely clear what -- she was taking 25 or 50 when the headache developed.

Q. I think we'll see -- we have seen your letter at page 26 suggesting it was at 50 micrograms, and we're going to look at Professor Franklyn's letter at page 56 in this bundle, which I think makes the same point.

Let's look at that now. This lady really has quite a chronicity, I think it is, of symptoms, and she sets them out:

"Subsequently seen by a practitioner outside the NHS, and began treatment with thyroxine 25 micrograms and subsequently 50 micrograms daily. She did feel that her bowel symptoms improved, although on the higher dose of thyroxine she did notice some emotional at symptoms emerging. Because of this, she therefore swapped to an animal preparation of dessicated thyroid, which has not been licensed for use in the UK for a good many years."

It would appear the symptoms emerged at a time when

she was taking the higher dose, the 50 micrograms. But can I take you back to page 4. It's finds:

"Feels physically better on increased dose to 75 micrograms a day. No signs of toxicosis. Continue for a month, then check the FTs."

Over the page, although you had written out a prescription with 75 micrograms as part of what was proposed, Mrs A was never there on your prescription, was she?

A. No.

Q. This was prescribed by another doctor, her GP it would seem.

A. Yes, and I think under Professor Franklyn's instructions.

Q. Well, we have her letter.

Over the page, page 5, 30th June 2003:

"A lot better. Periods regular and bowels regular. More energy. To stay on 75 micrograms a day."

Next entry is three months later, 2nd October 2003:

"Patient feels well. Periods better. No more constipation. Due blood check next week but seems likely dosage correct."

There are then some blood tests taken.

There is then a telephone encounter, as it's described in the notes:

"In view of lowish TSH still then increase to 100 micrograms daily and check in three months."

I think blood checks are done in February 2004. There is then a gap of eight and a half months until October 2004 and then 15 months' gap until the next blood test's done in January 2006.

We know that for that period she was on 100 micrograms a day. Clearly not on your prescription.

A. No.

Q. But increased by someone else.

A. Correct.

Q. What do you say -- you're entitled to an opinion -- on why it may be that this patient's symptoms decreased, why she felt better, why her constipation was alleviated once you put her on this type of drug?

A. Well, I thought it was the correct diagnosis and would respond to the correct treatment.

Q. Let's turn to Patient B, if we may, please. I'm going to ask you to turn to tab 4, please.

THE CHAIRMAN: Mr Jenkins, would this be an appropriate time to stop?

MR JENKINS: It's an entirely suitable time, madam.

THE CHAIRMAN: We will return then at 1.45. Thank you.

(12.50 pm)

(Lunch Adjournment).

(1.45 pm)

THE CHAIRMAN: Mr Jenkins, just before we start, could we call the graph that Dr Skinner did, please, D9. Thank you.

Mr Jenkins.

MR JENKINS: Dr Skinner, I should have stayed with the notice of hearing just to finish off the outstanding allegations, so far as Patient A is concerned. I wonder if you could have it in front of you. Yours is blue, the Panel have a yellow version.

Paragraphs 1 and 2a have been admitted, plainly.

Paragraph 2b, I don't know if it's been amended on the form of the document that you have, Dr Skinner, but you will recall at the start of the hearing last Tuesday, an application was made to amend the word "normal" in 2b to "reference".

Has it been amended on your copy? 2b. The letter of referral contained the results of two previous blood tests showing Mrs A's TSH to have been within the reference range.

A. Yes.

Q. That has not been admitted so far. But I should have taken you back to Dr Cooke's letter. Again, if you want to refresh your memory, it's at page 9 of tab 2, bundle 1, tab 2, where he refers to the TSHs that we

have looked at the 1.49 and 1.45.

A. Yes.

Q. It did say "normal" originally, it now says "TSHs within the reference range".

A. Yes.

Q. Do you accept that the two previous blood tests were within the reference range?

A. Yes.

Q. Madam, it's a matter entirely for you. It remains outstanding, not formally admitted, but you've heard Dr Skinner's evidence in relation to 2b and you may want to put a mark on your notice of hearing to indicate what has just been made?

THE CHAIRMAN: Thank you. Is that correct, Mr Kark?

MR KARK: Yes, certainly. I have just marked mine "admitted in evidence".

MR JENKINS: I would encourage the Panel to do the same.

The other heads of charge, as we go down, 3a, it has been admitted that you saw Mrs A on 16th January 2003 as a private patient.

3b and 3c, the allegations that you took an inadequate history and carried out an inadequate examination. Those plainly are denied.

The other allegations that follow on that page have been admitted d, e, f, and g, including g that you

suspected a diagnosis of B12. I have asked you about 3h and the fact that you did not perform an investigation on Mrs A to assess her B12 deficiency.

A. Correct.

Q. But you regard yourself as having no obligation in those circumstances, merely to flag it up to the GP, as you did.

So far as 12i is concerned, I asked you -- 3i, I am sorry, I asked you about suspicion and levels of possibility, and you dealt with that, and we prepared your response to 3j that in the circumstances there wasn't an obligation on you to refer her to an endocrinologist or other specialist for evaluation.

4a, again should have been amended on the copy that you have, Dr Skinner. The word "normal" now changed to the word "reference".

A. It is.

Q. We've seen the biochemical results in respect of Mrs A that you had ordered, if we need to remind ourselves of the page, and you will recall that the results were TSH of 1.4, and that is page 16 of tab 2, and a T4 of 12.2, and those, according to the documents, were within the reference range.

A. Yes, indeed.

Q. Do you accept that the biochemical results of Mrs A's

blood test were received on or about 24th January 2003 and that the results were within the reference range?

A. Yes.

Q. I am grateful. Again, the Panel may want to put "admitted in evidence" for 4a.

As to 5 in its entirely, the allegation is that your prescribing for Mrs A was inappropriate, unnecessary, irresponsible, not in her best interests, to place your patient at risk of harm. Plainly those remain denied.

A. Denied.

Q. And for 6, your conduct as set out above was -- and the same phrases are used, inappropriate, unprofessional, irresponsible, not in the best interests of your patient, and to place her at risk of harm, and plainly those too are denied.

A. Yes.

Q. As to 7a, we've heard your evidence that you did speak to Mrs A on the telephone after your first consultation on 16th January and before 6th February when you wrote out a prescription for her.

A. 7a?

Q. 7a, yes. We have heard that she talked of a headache.

A. Yes.

Q. Again, should that allegation be admitted, that you did speak to Mrs A on the telephone, who complained of

symptoms that could have been an adverse effect to your prescription?

A. There are three facts contained therein. One, explained of new symptoms is denied.

Q. Yes.

A. "Could have been" is not possible to answer, it's a subjunctive clause:

"You spoke to [her] on the telephone."

That is accepted.

Q. Thank you, but you've indicated you didn't make a record in the notes of such conversations.

A. Correct.

Q. And you dealt with whether it was incumbent upon you to assess her or arrange for her to be assessed. Your indication is you did speak to her on the telephone, you elicited that she had had those issues before.

A. Yes, I assessed her through the conversation.

Q. I understand, thank you.

Let's turn to Patient B and the Panel may want to turn over to the next page of the notice of hearing and turn, please, to tab 4 of bundle 1.

We have your notes again transcribed, but I don't think anything particular -- and the Panel will want to took at the notes themselves on page 4, repeated on page 9, but I think it's exactly the same document, and

page 12 for a later consultation in March 2004.

We start at page 1 of the bundle of this tab, where the patient has put in her date of birth, her name. Do you have it? It's the big bundle.

A. I'm sorry, we're on file 2?

Q. The big bundle. File 1, tab 4.

I am looking after the transcribed notes, the first numbered page, page 1.

This is the medication -- sorry, this is the form that the patient filled in, indicating her GP's details. We then have two blood results from 2002 and January 2003. Then we have your note of seeing Mrs B on 20th March 2003.

A. Yes.

Q. We know that you were subsequently to write to the GP. It's page 6 of the bundle. It's what Mr Kark has called the "doghouse letter", saying:

"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 to see me."

Just tell us, if a patient does come but without a referral letter, what's your practice, so far as agreeing to see the patient is concerned?

A. There hasn't been a practice because it hasn't happened in the last --

Q. It happened here.

A. Yes, but in the last three years it hasn't. I think in these circumstances there is some genuine confusion. I would not send the patient back to Aberdeen. I would see the patient and contact the family practitioner then, and prior to seeing the patient.

Q. In the letter you go on to rehearse a number of the features that you've recorded in the notes that we have seen at page 4, and which have been transcribed.

Have you left your glasses somewhere?

A. Sorry, I've two glasses. I'm just getting the other ones out. I have got them, you can carry on if you want.

Q. You describe her in the second paragraph of your letter to Dr Blair as being almost classically hypothyroid. Can you tell us what that means, "classically hypothyroid"?

A. It means it's -- it's not available to clear definition, it means to most practitioners the clinical features would accord with or be typical with hypothyroidism.

Q. You go on to say that notwithstanding the thyroid chemistry, she is hypothyroid, which is, of course, a matter of some controversy these days, and you thought

there was a very good case for thyroid replacement. You've given her a prescription, but suggested she doesn't begin the medication until for perhaps 10 to 14 days:

"... lest you didn't wish her to come and see me and it would discourteous to institute this without your knowledge."

Professor Weetman was critical of that. His opinion was that if it was appropriate for the patient to be taking the medication or to be prescribed it, they should go on and take it.

Can you just explain why it is that you wanted Dr Blair to have an opportunity to deal with any concerns he may have?

A. Well, firstly, that is our usual practice now on advice from the General Medical Council, basically, but if the patient wasn't referred, I think that is common courtesy. I think family practitioner, of course, knew she was coming but that's a different issue. I think that's the professional way to behave.

Q. I understand. You prescribed for her; are you able to tell us what the level of prescribing was from your note?

A. If a patient's having thyroxine, it's always the same prescription, which is what we discussed this morning.

25 for a week, increasing in 25 microgram integers to 100 micrograms per day, and then an assessment at two months.

Q. I think there is no mention of that in your note itself.

A. In my written note, that is correct, and that is a shortfall. I think because I know what I'm doing I don't always keep writing it.

Q. I understand.

Well, did you get a response from Dr Blair?

A. No.

Q. We've seen your letter to him.

A. 6?

Q. Yes. Can I take you to page 7. This is a document from your records because this tab, tab 4, are the records that you provided to the General Medical Council.

Do you have page 7 of tab 4?

A. Yes, indeed.

Q. This I think is not completed by the patient or it's certainly different handwriting from the one that we've seen much earlier in the bundle. We see reference to the same general practice in Gourock, and we see the patient's medication and dose.

A. Yes. I see that.

Q. 100 micrograms until 17th June 2003, and 125, presumably micrograms, for three months from then. We see the date

of the last blood test is 13th January 2003, and "date of last checkup with us or GP", which I think explains whose document this is. It's a document from your clinic.

A. Yes, it is a document from our clinic and filled in by Patient B.

Q. Right. Are you able to tell us what arrangements for review were made with this patient when you first saw her again in March 2003?

A. Yes. The patient was essentially returned to the care of Dr Blair, which, as I say, is what we tried to do.

Q. Coming back to your letter at page 6, in the third paragraph of the letter having said to Dr Blair:

"I have suggested she should wait and not begin the medication for 10 to 14 days lest you didn't wish her to come, and it would be discourteous to institute this without your knowledge ..."

You go on to say:

"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."

Had that been the plan that you would see her again after a couple of months after instituting her --

A. That's the offered plan in this case to the family practitioner. The family practitioner clearly felt he

could proceed to follow the patient up. It's a perfectly satisfactory outcome.

Q. The next document that we have in time, I think, is the laboratory result in December 2003 at page 8, which was laboratory result ordered by Dr Blair in Scotland, and shows the patient's T4 level as 39 and the TSH as less than 0.1. The comment of the pathologist making the report is that this suggests she was slightly overreplaced with thyroxine.

What do you say about that comment, "slightly overreplaced with thyroxine"?

A. It's a strange comment because most times laboratories are very -- clearly they do the test, so they're very hung up on the sort of extent of the blood test. If you are asking me what would be my interpretation, is that what you're asking?

Q. Yes.

A. Yes, it's perfectly obvious it's above the 95 per cent reference interval. The crunch of the matter is, and as Dr Blair affirmed, the patient had no features of being thyrotoxic at all.

Q. Well, we're going to come and look at Dr Blair's records very soon but just staying with these documents, I think you saw the patient in January 2004.

A. Yes.

Q. And we have your notes in respect of that. We have your letter to Dr Blair at page 11.
A. Yes.
Q. Your notes are transcribed on the front page from 20th January 2004. It's the typed version.
MR KARK: Sorry, I think it should be the 21st, the manuscript at page 4.
MR JENKINS: I'm just about to ask that.
If we look at the handwritten version, it's page 4, it has been put in again at page 9. I wonder if you're able to help us with the date. Presumably the handwritten version is the one to rely on.
A. Sorry, I was not actually following this controversy. 21st January I thought was --
Q. Yes, we should change the typed transcript version on the initial page of the bundle. Can you just tell us what you were told and what you've recorded on page 4 as to any palpitations?
A. I'm actually working from page 9, I think it's the same thing.
Q. It is the same thing. I think both of them are not very good photocopies, they have both chopped something off at the bottom.
A. The essence of the matter is that I could find no evidence of the patient being thyrotoxic at all. Her

pulse was 56 per minute, she still had an enlarged tongue, which she still could have if she was at that moment thyrotoxic, one understands that, and I thought she was clearly hypothyroid, notwithstanding --

Q. I wonder if I could ask you to read us what your note says. The Panel will plainly look at the transcript typed version, but just read us the note.

A. Can you give me the page for the typed version?

Q. It should be at the front of the tab, tab 4.

A. Right. So we're on 20th January or 21st?

Q. I want you to just read from the handwritten version. Put the typed version to one side.

A. Back to page 9, yes, right.

Q. Or 4, yes.

A. My 4 is typed. Sorry, right. I'm now on a handwritten version, 21st January.

Q. Can you tell us the first part of your entry for that day?

A. It says:

"200 micrograms of thyroxine. Free of palpitations for one month. Her memory is still bad, her hair is less dry, nails are better, weight is the same. She mentioned some difficulty about incapacity benefit. No palpitations since. Feet swelling better."

Then we go on to the examination where she weighed

18 stone:

"Pulse was 56 per minute, blood pressure 135 over 80."

Tongue I've given two pluses to and said "indented". That's indented round its edges.

Q. Is that a usual medical scale of up to three pluses?

A. It is. It's a very loose scale but I think it's one most doctors will use. There isn't a tonguometer, so to speak.

Q. No, no.

A. Thyroid was palpable -- thyroid gland, sorry, was palpable:

"To receive 150 micrograms thyroxine and 20 micrograms of Tertroxin [which is T3]."

Q. Again, I don't know it says thyroxine or Tertroxin --

A. No.

Q. -- but the inference that we have from Professor Weetman is that's all it could be. Can you confirm that --

A. Yes.

Q. -- that's what it was?

A. Yes.

Q. Can I take you back to the previous page, page 4. If we look above where it says, "free of palpitations for one month", can you read us those entries. Is it energy, weight, libido, eyes better? On the right-hand

side of the page.

A. Yes, I see, up there, yes. Sorry, I missed that when I was reading it out.

Q. It's all right, I'm just wondering whether those fall within this entry for January 2004 or whether they relate to the March 03 entry.

A. These relate to the January entry.

Q. Right. "Eyes better" implies this is a second occasion that you have spoken to her.

A. Yes, I saw her on 20th March.

Q. Yes.

A. Of 2003.

Q. Well, just tell us, if the TSH range or the TSH reading from the biochemical result in December was less than 0.1 and the T4 was high at 39, outside the reference range, are there signs or indications that this lady's clinically thyrotoxic?

A. No, none.

Q. What would you have expected to see if she was thyrotoxic?

A. I would say over the years the most common feature is a kind of inefficient energy, a kind of restlessness patients get. They feel out of sorts and a bit, I think, "driven" would be the word.

Then they can have tachycardia, they can be a bit

hot and sweaty, they have diarrhoea, and slightly further down the line, not in the early stages of being thyrotoxic, in my experience, they can have a tremor, a fine sort of tremor, and over a longer period of time you can get weight loss.

Q. You saw this lady again, I think, in March of 2004. Before we get to that stage, we should look at page 18 of tab 4. You had prescribed T3, Tertroxin, 20 micrograms on 21st January 04 and 150 micrograms of thyroxine. Prescribing it for 150 days, I think.

A. I think it's 150 micrograms.

Q. Yes, I'm sorry, I corrected myself. For 150 days?

A. Yes.

Q. This was the prescription that was not dispensed. We see the Tesco Stores Limited instore pharmacy stamp on the bottom right-hand corner, and an indication that only thyroxine had been dispensed.

A. Correct.

Q. And not Tertroxin.

A. That is correct.

Q. We have not heard from the pharmacist, but you saw her again in March 2003, we have your notes.

A. I wonder if it's 2004, Mr Jenkins.

Q. I'm grateful, thank you. What we have are notes on page 5 in relation to that Tesco prescription that we've

just looked at of a failure to dispense against it. Yes?

A. Yes.

Q. Is that your writing on page 5?

A. I think it is.

Q. Are you able to tell us now when you learned that the prescription hadn't been dispensed against by the pharmacy at Tesco?

A. I can't remember when I learned of that. I think the patient telephoned the next day to say she hadn't had her medication -- she hadn't had the thyroxine.

Q. But your notes for the March 04 consultation are at page 12.

A. Yes.

Q. And again I'm going to ask you to look at the handwritten document rather than the typed transcript.

A. Right.

Q. Because I think some explanation has been added in in the transcript, and we need to look at the original notes on page 12.

Can you tell us what you've written? Is it "Three-quarters of an hour heart beating"?

A. Yes. Mrs B said her heart had beaten -- well, that's badly written -- for about three-quarters of an hour in the middle of the night. A question of perhaps

excessive alcohol ingestion arose. Then there is 75 of thyroxine and 20 micrograms, she had been taking since then, that is what that note means.

She hadn't been taking her -- she wasn't taking antidepressive medication now, she had taken these previously.

Q. So that's what you've written, "No antidepressant now, but taken previously".

Can you help us with what is in the left-hand margin?

A. "No palpitations since the Saturday that this episode occurred."

Q. Right.

A. "She now feels better. Hassle from the Job Centre".

Q. Right.

A. "Pulse was 52 per minute, regular. Tongue reduced in size. Thyroid [nothing against it]."

That would -- that's me writing thyroid, about to write that it's still there, but it isn't there.

Then blood pressure 130 over 80, note an aide memoire to write to Dr Blair, and that 11 of 100 alternating with 75 micrograms thyroxine for 20 micrograms, should take -- or 20 micrograms of Tertroxin for three weeks prior to returning to Dr Blair whom she was seeing very regularly.

Q. Can we go to Dr Blair's letter to the GMC at page 19, please. You were later to be given a copy of this.

He says in February 2004:

"I was consulted by my Patient, A, on 28th January 2003."

He sets out a history as he would put it.

He said in the first paragraph:

"During the course of the conversation she also asked regarding a Dr Skinner of 158 Queens Drive in Glasgow, whom she was considering seeing privately. I did not at any stage refer A to Dr Skinner."

He mentions a Beck Depression and Inventory Scale and says that he:

"... discussed with A her normal thyroid function test. Suggested she was suffering from depressive symptoms as well as being perimenopausal."

He goes on to say:

"On 8th April I received a letter from Dr Skinner, a copy of which is enclosed."

And this would be the first letter that you sent, saying to Dr Blair:

"I have asked her not to take them" --

A. Yes, that is my first communication to Dr Blair.

Q. Indeed. He says he strongly advised A against taking thyroxine, he felt there was no clinical indications.

He talks of some trials which have been carried out in the States, further studies in Stobhill had shown there was no scientific basis for such a prescription.

Can we break off there. Stobhill was the Pollock paper that we've seen?

A. Yes, that's what he's referring to.

Q. I asked Professor Weetman a number of questions about the soundness of that study and the conclusions that one can draw from it.

Breaking off from Patient B for a moment, would you regard it as sound evidence the Stobhill Pollock paper, that treating biochemically reference range patients who had symptoms was unwise or inappropriate or unnecessary?

A. I don't agree that it's helpful. I think the drive of Professor Weetman's point was that even though the study was flawed you would have seen a difference, but that point is not applicable if the dose of stuff the patient's got, which was only 100 micrograms, which is what was used, if you give them 1 microgram -- so all these considerations fall down, and I think probably the essential point is that the patients didn't get enough treatment and not for long enough. So I think that makes that study a little insecure as a signpost for the future of management of hypothyroid patients.

Q. Let's come back to this letter, we're now on page 20.

He says:

"A is by no means unintelligent. She is perfectly able to understand all the discussions in relation to the studies ... and despite this, when she consulted me on 15th May [he must mean 2003] she had started on the thyroxine tablets, having stopped her antidepressant, and at that stage said she was feeling better.

"On 26th September she was taking 175 micrograms of thyroxine and was also wanting to start her antidepressants. At that stage she was given very clear advice, which on 4th December [again it must be 2003] the dose had been increased to 225 micrograms per day. Pulse and BP were surprisingly normal. Thyroid function tests on 9th December were unsurprising, copy enclosed."

That's the document we looked at from 9th December --

A. Yes.

Q. -- showing a T4 of 39.

What do you say about the pulse and BP being normal when Dr Blair measured them?

A. I don't share his surprise, as I have emphasised to the Panel that -- it's how the body reacts to a given dosage, and earlier on I said that you have a situation with someone with a free thyroxine level of 39 who's not thyrotoxic, and Dr Blair points that out very fairly.

I have seen patients, not under my care, with thyroxine levels over 100, they felt fine. It's how the patient is.

Q. You saw the patient again on 22nd March; page 24 if you would. I'm looking at the letter to the GP.

A. Yes.

Q. This deals with the consultation where we've looked at the records. Did you know at this stage that Dr Blair was complaining to the GMC about you?

A. I have had no contact from Dr Blair throughout the entire case.

Q. I think if we look at the next page, page 25, you had seen a letter from Liz Jordan from the PCT in which she wrote to the GMC and said that the blood test result from December 2003 suggested that the patient was slightly overreplaced with thyroxine, and you were writing to the GMC to deal with that concern.

A. Yes. I'm sorry, Mr Jenkins, we're on page 25?

Q. For the moment, yes.

A. I didn't think that was one of her complaints, but I may not be finding it again. Dr Jordan's complaint seemed to relate to a Tesco pharmacy that prescription that fired the whole complaint process off. I wonder if we're on a different document.

Q. No, well, let's go to 17. It's my fault for jumping

about.

A. It's very confusing with all this paperwork.

THE CHAIRMAN: Where are you now, Mr Jenkins?

MR JENKINS: I'm in three places, I'm sorry. I'm going to 17 and I'll stay there for a while. Tab 4, at page 17.

A. May I speak? I apologise, I have found what you're looking for --

Q. Don't worry.

A. -- which does say that in the middle of paragraph 3, "slightly elevation above normal levels", is what she says.

Q. I understand. Let's just deal with it.

Paragraph 1, Dr Jordan is saying:

"I'm writing to raise a concern."

And she's writing in her capacity of medical director of the PCT.

She goes on in the second paragraph to talk about the Tesco prescription:

"When it was presented to a local community pharmacist, the pharmacist questioned the drugs ..."

Paragraph 3 deals with Dr Blair, and says in the middle of the paragraph:

"The patient's most recent thyroid function, I believe, showed some slight elevation above normal

levels."

And gives the details of Dr Blair:

"... who could be contacted by the GMC and would be happy to provide further details."

And she provides a copy of the prescription, that's the Tesco prescription, and invites the GMC to investigate, effectively.

You will then have been written to by the GMC and your response is at page 25.

A. Yes.

Q. You have said in the third paragraph that you've issued a prescription, you've changed -- you said when it seemed she was not converting thyroxine to Tri-iodothyronine, T4 to T3, her prescription was issued and the rationale of this prescription was explained in your second letter to Dr Blair, and we have looked that the elsewhere in the bundle.

You say:

"I think it is important to note that neither the parent nor Dr Blair have at any time intimated dissatisfaction on my administrations. Indeed I was consulted by the patient only five days ago in my rooms in Glasgow and she is doing quite well."

We've looked at your notes from March, 18th March. Let's go back to your letter, if we may, the previous

page, because it's written the day before the letter to the GMC.

You mention that Patient B was someone you saw on a courtesy basis. She apparently was in dire financial straits. Does that mean you took no fee?

A. Correct.

Q. I don't mean to say that with a lot of patients behind you, but that is a fact.

A. I made a very rare exception.

Q. I understand. You made mention of a strange episode of racing heart at the weekend, that's the Saturday that you've referred to in your record, and you relate it perhaps to excessive intake of alcohol on the previous evening, and you talk about dose. Yes?

A. Sorry, yes.

Q. You talk about alternating the dose, perhaps the right approach would be to alternate 75 micrograms and 100 micrograms thyroxine per day but continuing with 20 micrograms of Tertroxin.

You say:

"I thought it would be possible to increase her input of thyroxine replacement."

As you personally doubt that the strange episode in the early hours of one morning was related to excessive thyroxine replacement.

You talk about Patient B has a bit of a problem in confrontation vis-a-vis disability and income support but you say:

"In general I think she has notably improved since the institution of thyroid replacement."

Have you seen any records elsewhere to suggest that there was any clinical deterioration or clinical cause for concern about this patient?

A. No.

Q. Again, perhaps I don't need to take you to Dr Blair's records, we looked at them with Dr Blair, but over the course of the year he didn't record any increase in heart beat, or heart rate, or concerns of that type?

A. Not from the given evidence.

Q. Can I turn to the notice of hearing with regard to Patient B, please.

8a has been admitted saying that on 20th March 2003 you saw Miss B as a private patient without a referral from her GP.

8b is presently not admitted, and you should have a version which includes the amendment so that it now reads:

"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."

A. That's admitted.
Q. That's admitted, thank you.
It is said that you took an inadequate history and carried out an inadequate examination on that occasion, 20th March 2003. Plainly, that's denied.
A. Yes.
Q. As to e, it is said that, presently unadmitted, that:
"You provided Miss B with a prescription of Sodium Thyroxine, 100 micrograms per day until [18th] June 2003 to be followed by 125 micrograms per day for the three months thereafter."
Again, we looked at page 7 of tab 4.
A. Yes, that's not admitted. That's wrong as it reads.
Q. I just want you to look at page 7.
A. Yes.
Q. The patient herself has written medications and dose 100 micrograms until 17th June and then 125 more three months from then.
A. Correct.
Q. That is what she has written. Is she right?
A. She is right and I am right, because the word "until" doesn't have a starting point in time. She undoubtedly would be -- by the time you got to May, she would then naturally proceed to the 100 micrograms.
Q. I understand. So I'm just looking again at 8e,

the suggestion that on 20th March 2003 you provided her with a prescription for Sodium Thyroxine, 100 micrograms a day until 17th June.

A. I don't know how to answer that. It's true for the last three weeks prior or perhaps four weeks prior to 17th June, but it's not true prior to that date.

Q. I understand.

A. I'm not sure how to answer this.

Q. I hope that's clear, I'm sure it will become clear later if it's not clear now.

A. It was the end point of the prescription.

Q. I understand, we know that you go up in stages, if you start to prescribe and go up, yes.

A. Yes.

Q. At 9a to e are allegations we've seen before in respect of Patient A. It is said that with Patient B your prescribing was inappropriate, unnecessary, and what have you, those are plainly denied.

10b, it is said that between the first time you saw her on 20th March 2003 and 21st January 2004 you failed to monitor Miss B adequately or at all. That's not admitted at present.

A. No.

Q. We then have 10c which is admitted, and you are aware of the results of a blood test set out in a report dated

9th December 2003.

10d:

"The results of that report show that Miss B had become biochemically thyrotoxic."

What do you say about that? The reference range for T4 is 10 to 24 and the reading is 39. Reference range for TSH is not given. The reading is given as less than 0.1.

A. I categorically deny that.

Q. It's said this overreplacement was as a result of your prescribing thyroxine. Do you accept that there was an overreplacement?

A. I don't accept that.

Q. And 11, it's said that your prescribing was inappropriate, et cetera. Again it is denied.

A. Denied.

Q. Head 12a, it has been admitted that you saw Miss B again.

A. Yes.

Q. On 18th March. 12b, it's said that:

"You provided Miss B with a prescription of Sodium Thyroxine 75 micrograms or 100 micrograms on alternate days and Tertroxin 20 micrograms for an unknown period of time."

Forgive me, let me find the page again.

MR KARK: The notice is at page 12.

MR JENKINS: Thank you, I'm also looking for the letter to Dr Blair.

Page 5. Notes at page 12, I am grateful, and the letter is page 5.

Thank you, it is page 6, I am grateful.

Again, going back to the notice of hearing. It's said that on that occasion, 18th March 04, when you saw Miss B again --

MR KARK: I'm so sorry to interrupt, but can I just point out the letter to Dr Blair is back in 03 and the note is 04.

MR JENKINS: Thank you. Yes, the letter should be page 24, shouldn't it?

So the allegation that:

"You provided Miss B with a prescription of Sodium Thyroxine on 18th March 2004 of 75 micrograms or 100 micrograms on alternate days and Tertroxin 20 micrograms a day for an unknown period of time."

What do you say about that, looking at your notes and the letter at page 24?

A. Facts 1 and 2 are admitted. The fact number -- suggestion number 3 is denied.

Q. Well, can I ask this: if we deleted the words "for an unknown period of time".

A. Then it's perfectly admitted.
Q. You agree plainly that you did prescribe Tertroxin, it's not clear for what period of time you prescribed it.
A. I said it was for three weeks in the notes, and remember, it's shared care with the practitioner.
Q. I understand. Going back to the notes, page 12, does the three weeks refer to both the thyroxine --
A. Yes.
Q. -- and the Tertroxin, the 20 micrograms?
A. Yes.
Q. Thank you. Can I say immediately if there was an application to amend I wouldn't resist it.

It's said that your prescribing in that fashion for Miss B was inappropriate, unnecessary, irresponsible and not in the best interests of the patient. What do you say about that? You deny it plainly.
A. I do.
Q. And there is then an allegation that in July 2004 you provided Miss B with a prescription for Sodium Thyroxine at 150 micrograms a day for three months, and that's already been admitted on your behalf.
A. Yes.
Q. As to the allegation that that prescribing was inappropriate, unnecessary, and the rest, that is denied.

A. Yes.
Q. Let's move to the next patient, if we may.
This is a patient who was first seen when she was a patient of Dr Summers. You will recall his evidence that he did prescribe but that he hadn't seen any blood results. The patient was subsequently to become a patient at the practice in Wimbledon and the Panel will recall seeing Dr Cundy over the videolink and Dr Ince in person.
A. Yes. I recall that too.
Q. If we turn to tab 6, we've got the transcribed notes in respect of Patient C, and the notes for your first consultation on 6th March 2004, starting at the page numbered 1, which immediately follows the transcription.
A. Yes.
Q. We have your letter to Dr Summers, dated 10th March 2004, at page 2. We see that Patient C came to your rooms, was meant to be bringing a referral with her, but you say:
"I think she was perhaps too timid to ask you, Dr Summers, for a referral."
You set out a summary of her history and you talk again about catching grey objects on the floor out of the side of her eye, you talk of her pulse rate and say skin and hair -- You say:

"I thought it was quite likely she was hypothyroid, although not seriously hypothyroid."

You say you had taken a blood sample for thyroid chemistry:

"Should have this result in ten days. Will let you know what goes forward at that point in time. As an aside, C has a notable family history of diabetes and you say you've asked her to re-test her blood and urine while fasting and after taking a glucose load to put this possible problem to bed once and for all.

"My apologies for seeing this patient without referral from your practice, which is really our invariable practice these days."

Can I take you back to the notes on page 1. I wonder if we could just go through what it is you have written, so for those who have a typed version as well, they can compare the two. Can you just tell us word for word what you've written. Is it "CO, 18 months ago" --

A. Yes, that is shorthand for "patient complains of".

Q. I understand. Over to the right-hand side you have GP?

A. Is in Pimlico.

Q. That is where Dr Summers was then working?

A. Yes.

Q. Thank you.

You've got an arrow down from "18 months ago".

A. Yes, that indicates previous history when she consulted a general practitioner in Glasgow.
Q. What does it say, "dizzy and strange"?
A. She felt a bit dizzy and strange, and she was a little vague but she said her blood pressure at the time was 80 over 50, so a slightly low white cell count, and she thought it might still be lowish.
Q. Still lowish? Right.
A. Yes. She said she was now very tired, really tired, gets up -- come 11.30 she still can't get up, she did have grey side vision, hallucinations of grey things.
Q. Can you go up from that, we see "GP Glasgow", and that relates to at an earlier time.
A. Yes.
Q. Is it then "memory and concentration"?
A. Yes.
Q. "Jumping about"?
A. No, no. That means her memory and concentration were poor, and attention or -- perhaps concentration, she was jumping about from one subject to another.

Now, over to the left, where I tend to write the previous history, her menarche, that's when her period started was 14. It stopped at 15 for 18 months. In 1996, again she was again a little vague, she sums up hormone investigation.

She had very poor libido. Her periods were irregularish, I recall, and she had an interuterine device in place for one month.

The pill caused bleeding. She felt coldish, twitchy and weepy. For five months she had had an RSP, which is a regular partner.

Over on the left the family history, there is a mum who's an insulin dependent diabetic, and her gran and her uncle had diabetes.

On examination her pulse was 60, her tongue was indented, blood pressure 105 over 60. There was nothing unusual in her thyroid gland.

Her hair was dry, and her skin was dry, and her heels were dry, and my sign of the foot, which is a sort of what we might do for an aide memoire was to check her thyroid chemistry, and I asked her if she would check her fasting urine -- sorry, that's for me, I'm going try and get her fasting blood checked and she herself could check her urine.

Q. Are you able to tell us whether you prescribed for her from that note?

A. From that note?

Q. Yes.

A. No, it doesn't say in that note.

Q. Can we go to page 2, your letter to the GP, we have

looked at it, Dr Summers. That does not indicate whether you've prescribed or not.

A. No, it doesn't, no.

Q. If we go to page 3, that's the blood test that you ordered.

A. Yes.

Q. Would you make any comment about what the chemistry results were.

A. It's kind of similar to Patient A. In my view, the free thyroxine level is low. I understand it's within a reference interval. It's quite lowish on average in patients I see in fact.

TSH of 2.2 is certainly above the average, which runs about 1, as I indicated, and because of the skewed distribution on the graph I think it's eyebrow raising in conjunction with the other features.

Q. You saw this patient again in May.

A. Yes.

Q. We've got your entry on page 4. Is that right?

A. Yes.

Q. I think we can confirm the date from page 5, looking at the date of the consultation. Is that right?

A. Yes, some time in May.

Q. 8th May, what is recorded on this statement of account as the date of the consultation.

A. Yes.
Q. I think the date has been chopped off your clinical note, we don't see it on the top left-hand corner of page 4.

If we go to page 6, this is a second letter to Dr Summers in SW1:

"Dear Dr Summers, 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 of thyroxine, with curiously no thyrotoxicity, which made me wonder if perhaps there is some conversion problem here. I thought we needed to rationalise and stabilise the situation and perhaps add in some T3 if there is a conversion problem, and I have set her dosage of 150 micrograms thyroxine a day with 20 micrograms Tertroxin per day, and I pleaded that she stayed at this dose for four weeks, at which point I'll speak to her on the telephone to decide the way forward."

Are you able to tell us whether you had prescribed for her in March, looking at that letter?
A. I don't understand this too well. I must have done because she was certainly taking that three months later. I don't know why I haven't got a copy of that in my notes. I know in August Dr Summers did the

prescription.

Q. No.

A. I'm not sure in retrospect if he did it in May or not.

Q. What you told us is your practice would normally be to keep a copy of any prescription in the notes.

A. Yes, I agree that.

Q. But it does not appear as if there is a copy in these notes.

A. I can't find a copy. I don't know why.

Q. But you're clearly adjusting the dose --

A. Yes.

Q. -- to 150 micrograms and T3 as well.

A. Exactly.

Q. Can I take you back to your note, page 4. Can you just tell us what you have written?

A. "Married May 2005".

Q. That was a year hence.

A. That was a projected event.

Q. And that was clearly planned. She was planning to marry.

A. Yes, exactly.

Q. What's the next line say?

A. "Weepiness better. Appetite good. Bowel better. Concentration improved. Sleeping better."

Q. So it's concentration with an arrow going upwards.

A. Yes.
Q. And the fact that you say sleeping?
A. That she was sleeping better.
Q. I understand.
A. Libido had improved, which is the arrow going across the way rather than down the way, and the hot and cold situation was improved. Pulse 64 per minute, regular. Tongue smaller but still indented. Blood pressure maintaining 105 over 60.
Q. Is this a picture of a patient who's being overtreated or who is still hypothyroid? Tell us what that's a picture of on the clinical signs?
A. I would say it's probably still hypothyroid. That was my impression at the time.
Q. Back to your letter, page 6. You said you:

"... pleaded with her to stay on this dose nor four weeks at which point I will speak to her on the telephone to decide the way forward."

You told us that the patients had access to you over the telephone.
A. Yes.
Q. Would you initiate telephone calls to patients on occasion?
A. I certainly could, but I would also leave it sometimes to the patient just to let me know what's happening.

Usually in about a month or something like that.

Q. I think the next note we have of you with this patient is page 7. The date on the copy that I've got, someone's written it in, "Query: 20th May 04". I don't know if you're able to help us with that. What we should go to perhaps is the next page, which has this patient's name at the top right-hand corner.

A. That is 7/8/04.

Q. Yes.

A. On page 8.

Q. That is right.

A. Yes. It says at the top, "Notes, Helen Rule".

Q. We're not using names, but it's Patient C.

A. Oh, I do apologise, I'm terribly sorry.

Q. And is this what your note says:

"Periods regular, IUD [interuterine device] fitted."

A. Yes.

Q. Periods heavy?

A. Yes, periods heavy. Shall I read it?

Q. Do, please.

A. "Lacking energy. Restless legs especially in the afternoon if concentrating. Can't get to sleep, memory and concentration still poor."

Over on the right is my shorthand with a D for what the patient's actually taking, which was 150 micrograms

thyroxine, 20 micrograms Tertroxin, and vitamin B12.

Q. Right.

A. I've made a note here:

"Thyroid replacement March to May."

I don't know why I've written that down there.

Over on the left "she got promoted recently".

Q. Yes.

A. "Weight's the same and she was still a little constipated. Pulse rate was 64 per minute. Tongue still enlarged and indented. Thyroid is not palpable. Blood pressure was 80 over 60."

Which over on the right you can see I rechecked it and it was 105 over 80.

Q. We know that you ordered a blood test for this patient and we have the result on page 10 of tab 6. What do we need to know about that blood test, Dr Skinner?

A. The thyroid chemistry is, I think, quite satisfactory. I realise there is controversy on this issue, given the patient's not thyrotoxic. I took a -- I commissioned a cortisol reading, which is -- Cortisol readings in isolation are to be taken with some caution but given that the lady was working and was being promoted and was generally getting into fair fettle, perhaps, I didn't think that would really require further investigation for any potential adrenal problem.

Q. We will come back to that when we look at the notice of hearing.

You wrote to her, I think, on page 9.

A. Page 9.

Q. Where you said to Patient C:

"Here are your thyroid chemistry and cortisol, which indicate the level's a little on the high side but if you're not feeling any adverse effects, I think you should stay at the same dose until I see you next or if you were planning any of your increasing strategies, perhaps you would let me.

"The cortisol level is satisfactory but we shouldn't entirely rule out the possibility of adrenal supplementation if we don't return you to optimal health.

"I look forward to seeing you soon and hopefully we will have you sorted out by Christmas time."

Again, why did you invite the patient to let you know if she was "planning any of her increasing strategies"?

A. There is always a concern if patients are changing their dose in any substantial way without you knowing; that's why. This particular patient was prone to initiating and changing things.

Q. Now, can I just ask, when you had dealt with Dr Summers,

we've seen you sent two letters to him. One is at page 2 --

A. Yes.

Q. -- in which you say:

"I have taken a blood sample. Should have this result in ten days, and will let you know what goes forward."

You then have a blood sample from March 04 and you write to Dr Summers again on 10th May 2004.

Are you able to tell us whether you would have wished the blood result to be sent to Dr Summers?

A. We send all the thyroid chemistry to the practitioner.

Q. Perhaps I can ask you to turn to the previous tab, please, and turn, if you will, please, to page 2.

A. Tab 5?

Q. Yes. You have to be aware that there is a page 1A as well.

A. Yes.

Q. This is, I think, Dr Ince making this note in late 2004 in which she says:

"Had a chart to patient. Original blood test results showed patient to be euthyroid and explains why no response to treatment."

She says:

"To stop all medication and repeat thyroid function

tests in two months."

She makes a comment that the patient feels a lot better off medication.

The original blood test results are those that we were looking at in tab 6 that you had ordered at tab 3.

A. Yes.

Q. And you told us those would have been sent to Dr Summers.

A. Oh, absolutely.

Q. Well, we know that Dr Summers did prescribe thyroxine for this patient because he told us so, and when we looked at the documentation it appeared to suggest he was prescribing on 2nd August 2004. It's tab 5, page 8.

We've got a problem right towards the top of the page, hypothyroidism started on 2nd August 2004. That's when it appears to be entered onto the computer.

We then with "repeat masters" a third of the way down the page, Liothyronine, that's the T3 drug, and then Levothyroxine, 50 micrograms and 100 micrograms, but we don't have any dates when they were issued. But Dr Summers told us that he prescribed for this patient when she was at the SW1 practice.

What he told us is that if he had had the blood test

results, he wouldn't have prescribed for this woman at all.

Again, would you have sent the blood test results for Dr Summers in your two letters at tab 6?

A. Yes, certainly, I always do.

Q. There is then, I think, coming back to tab 6, a letter from Dr Ince to you at page 16, because enquiries were being made by the practice to find out the circumstances in which you started prescribing for her. I think you agree that there were problems, if you look at page 19, in finding the notes for the patient.

A. Yes.

Q. She had changed her address but hadn't changed her name, and you say in the middle paragraph on page 19:

"She had a number of features. I thought her thyroid chemistry was suggestive of hypothyroidism."

You say:

"As the years go by I become less and less reliant on thyroid chemistry as an index of diagnosis of treatment level in hypothyroid patients."

You say you have not in fact seen her for some time.

Well, can I ask: we know that a complaint was made to the General Medical Council and as part of the complaint we have dealt with before, a letter was written to Dr Prentice, tab 5, page 12, in the middle

paragraph, third sentence:

"Dr Skinner started this lady on 150 micrograms of thyroxine."

Did you?

A. No.

Q. And this is subsequently, I think, repeated by Dr Prentice, as we've seen, in his letter back. We have looked that the before.

Dr Prentice again complained that you had not written to the GP when you treated the patient. Again, you had, so far as Dr Summers was concerned.

A. Twice.

Q. You had kept the practice informed.

A. Two letters.

Q. Can I turn to the notice of hearing so far as this patient is concerned, please. It's accepted, plainly, that you saw her on 6th March 2004 as a private patient without a referral from her GP. That has been admitted, yes?

A. Yes.

Q. Head 16a, 16b and c, the allegations that:

"You took an inadequate history and carried out an inadequate examination."

Plainly you deny it.

A. Denied.

Q. It's been admitted, 16d, that:

"You took a blood sample for thyroid chemistry results."

16e has been amended now to read:

"On or about 16th March you received the results of a blood test which showed [her] TSH and T4 to be within the reference range."

At the moment that's not admitted. Do you have it, 16e?

A. Yes. I think that is admitted, Mr Jenkins.

Q. Perhaps it should be, but at the moment it isn't.

A. Oh. It just says I received the results of a blood test, which showed it was in a reference range. That's true.

Q. It is true, I'm grateful. Again the Panel may want to write in "admitted in evidence" for 16e, after it was amended.

It's then said that:

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

Again, we've looked at the documents, one of them is tab 6, page 8, in which you've written in the right-hand margin "thyroid replacement therapy". Do you have it? Bundle 1, tab 6, page 8.

A. This is in August.
Q. It is, but you've written "thyroid replacement", March to May.
A. Yes.
Q. If you go back to page 6, your letter to Dr Summers, you had just seen this patient on 8th May, and your letter two days later is a note on C:
"... who I think is already improving on thyroid replacement, but she's put her dose up off her own bat."
Are you able to help us, just looking at head 17, that before 8th May you prescribed Miss C with Sodium Thyroxine. Let's just deal with the core of it. Is that right or not?
A. That's correct.
Q. Right.
A. The first fact.
Q. So if the head of charge were to read:
"On a day before 8th May 2004 you prescribed Miss C with Sodium Thyroxine."
That would be correct?
A. That would be correct.
Q. Again, madam, plainly I leave it to Mr Kark to decide how he wants to take it forward, but he may choose to leave it or choose to amend, but I'm hoping to clarify matters for you and the Panel.

It's said that your prescribing to Miss C in those circumstances was inappropriate, unnecessary, and what have you. Those allegations plainly are denied?

A. Yes.

Q. 19a deals with that date, 8th May 2004, and it's said that you saw her. That is admitted.

Secondly, 19b:

"You provided her with a prescription for Sodium Thyroxine 150 micrograms a day and Tertroxin 20 micrograms a day."

Again, I think if we look at page 6 that's what you did.

A. Yes. Not from -- I think an "unknown period of time" is a little harsh.

Q. It may be because it wasn't known by the individual who drafted this what the period of time was, but if those words are left out of the count, you agree that you provided Miss C on that day, 8th May, with Sodium Thyroxine 150 micrograms and Tertroxin 20 micrograms?

A. Yes.

Q. I'm grateful.

Head 20, you don't accept, clearly, that your prescribing was in any way inappropriate or irresponsible.

A. No.
Q. And as at 7th August, I'm looking at head 21b, it's said:
"7th August 2004 you saw Miss C again."
That is admitted, and it's said that your prescribing for her was 150 micrograms a day and Tertroxin 20 micrograms a day.
Well, looking at page 8 --
A. That's not admitted.
Q. Page 8 is your note from that day, 7th August 2004, and you've told us in the top right-hand corner where it says "d", and then various levels of dose of medication, you have told us that's what she was on.
A. Yes, that's what I usually do.
Q. I understand. Does your note there suggest whether you continued her prescription or not?
A. No, I'm quite clear on that. The patient was going to get and indeed then got Dr Summers to prescribe it for her, and in fact she asked me not to contact the practitioner as she was changing practitioners, and she would let me know who the new chap was, or lady.
Q. Well, again, we've looked at the prescribing documentation in tab 5. We don't have dates for the repeat masters on page 8 of tab 5, but we know that hypothyroidism was put in there certainly in August 04.

A. I think Dr Summers' written evidence is -- he has written quite clearly that he did this prescription.

Q. He has told us that he wrote the prescription. I have no problem with that.

It's said that your prescribing to Miss C, head 22, was inappropriate and the rest. You don't accept that?

A. No.

Q. Head 23a, it has been admitted that you suspected a diagnosis of B12 deficiency and we know that she was on B12 from the last note we saw.

Back again, I'm sorry to flick from tab to tab, but it's back to tab 6, page 8. She was on B12 or you have recorded her as being on vitamin B12.

A. I haven't said I put her on it.

Q. It has been admitted that you suspected a diagnosis of B12 deficiency.

A. May I ask where that is? I'm not saying it's impossible, I just ...

Q. It may or may not be in the notes but it has been admitted on your behalf.

A. Has it? I remember Patient C was the lady who started things.

Q. Sure.

A. Yes.

Q. The suggestion is that if you suspected B12 deficiency,

you should have gone on yourself to investigate it. That's the same allegation that was made in respect of Patient A.

A. Yes. I have heard that allegation, which I attempted to refute in the generality of the matter. But in the particularity of the matter I don't think I have made that assertion.

Q. No, no, but again if there was a suspicion that the patient had B12 deficiency, was there an obligation upon you to investigate it?

A. I'm not trying to be obtuse, but it would depend on the level of your suspicion in a medical practice, entirely.

I suppose an example might be, there is quite a large number of vegetarians in Birmingham and they have a chronic tendency to B12 deficiency, but something, for example, an obvious dietary possibility, I don't think you go charging round investigating it. I think there is a level of judgment due to the extent of the malaise or illness.

Q. I think if you want to look at the B12 issue, if you go to tab 6, page 14, that may help you.

A. I'm just giving an account of what the patient was taking there.

Q. All right.

A. The "and" doesn't refer to the previous gerundive, if

you see what I mean, it means she's also taking oral B12. So I would deny that.

Q. I'm going to ask for a break in a minute but I'm going to ask for help from Mr Kark before I do.

Head 24a, there is reference to a blood test for Miss C and I'm not able immediately to find the page where that blood test result may be. It may be Mr Kark has a slightly better grip --

MR KARK: Page 10, tab 6, I think.

MR JENKINS: Thank you.

24a has been admitted that:

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

That is admitted.

A. Yes.

Q. It is said that:

"The blood test results demonstrated that Miss C had become biochemically thyrotoxic."

A. That's denied.

Q. It's said that:

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

At the moment that is not admitted.

A. It's not admitted. I don't know if this is applicable

or not, with the word "failed" in it, which has a sense of, I don't know, bad practice or something.

Q. Well --

A. I did not, I would accept.

Q. If you go to page 9 in tab 6 what you had said to her was:

"I think you should stay at the same dose."

A. That's correct, I did not reduce her or stop it.

Q. No, I understand.

It's said that you:

"Suspected she might be suffering adrenal failure.

"You failed to refer her to an endocrinologist to assess your suspicion."

What do you say about those?

A. If suspected means that it comes to your attention in any way, I accept that, albeit I conducted a test of adrenal hormones.

Q. Right. Let's look at the adequacy or otherwise of the steps that you did take.

There is no commentary on heads 24b, c, d and e, it is not suggested that your conduct in failing to reduce or stop her thyroid medication was wrong or inappropriate, but I think for these purposes one could infer it.

What do you say about what you say in the letter at

page 9 to Miss C:

"The levels are a little on the high side but if you're not feeling any adverse effects I think you should stay at the same dose."

Is that appropriate or not as management of this patient?

A. It is absolutely appropriate.

Q. Thank you. You do ask her to let you know if she's thinking of changing the dose, particularly increasing it.

A. Yes.

Q. And so far as the cortisol level is concerned, you say that is satisfactory.

A. Correct.

Q. "You shouldn't entirely rule out the possibility of adrenal supplementation."

Again, is that appropriate or adequate, what would you say?

A. I think it's appropriate. Particularly you must take account of the -- perhaps the occupation of the patient, who will understand a sentence with a caveat, I would suggest.

Q. It's said:

"You failed to refer [her] to an endocrinologist to assess your suspicion."

Again, would it have been appropriate or necessary for you to do so in all the circumstances?

A. I don't think so.

Q. Thank you.

A. Particularly as I had my blood test result.

MR JENKINS: Madam, it may be obvious that I'm flagging a bit. I wonder if I could ask for a short break.

THE CHAIRMAN: Yes. We will reconvene at 3.45.

(3.23 pm)

(A short break)

(3.45 pm)

MR JENKINS: Patient D, Dr Skinner, please. It's tab 8 of bundle 1.

Can we go again through the chronology. The first consultation was 24th August 2004. I think we have a typed version of your notes, we'll come to them very soon.

We have at page 1 of the paginated section of tab 8 a part of the questionnaire completed by Patient D. We see her date of birth and she gives the GP's details as Dr Blanchard of at the Forest Glade Surgery, Bromsgrove Street in Kidderminster. She sets down the various medications she's on.

We know that she was to seek a consultation with you and before she saw you in August 2004 she had some

communication with her GP, Dr Stewart, who wrote a letter to her that we have, and was forwarded to you.

It is page 3 where he says:

"I am pleased to tell you that your thyroid function tests are completely normal in indicating a very good thyroid function at the present time."

It is not clear who has written in the word "very":

"In addition, your tests for Hashimoto's thyroiditis are also negative, showing that you haven't had this condition up to now. It would neither be safe nor wise for us, Dr Skinner, or anyone else to start you on thyroxine."

He says:

"Undoubtedly, this will give you more energy and make you feel better, but it would cause your thyroid gland to switch off and could cause you to have overactive thyroid disease, which is known as Graves' Disease, and can lead to serious physical and mental consequences such as heart failure and mental illness.

"I know I won't be happy with this, but it's actually in your best interests for us not to give you thyroxine at the present time. Because of your strong family history I am prepared to send you a form for a repeat thyroid function tests in 12 months' time and hope you will agree this is fair and appropriate.

"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."

And someone has written in:

"You just have."

Is that you?

A. Yes.

Q. We then have at page 4 a letter to you from Patient D. It's not clear precisely what date this was prepared, but it would appear to be before you saw her on 24th August and after there had been a telephone conversation with her on 21st July 2004, where she sets out her TSH results.

Are you able to tell us if you had spoken to the patient, as she suggests, on 21st July, would you have asked for any blood chemistry results? She's put in TSH results, antibodies test, and she's mentioned Dr Stewart had requested the T3 and T4 but they weren't completed.

Are you able to tell us why that might have been included in the letter? The information about her blood chemistry results.

A. I thought she was trying to be as helpful as possible.

Q. Would you have asked or not?

A. On the telephone?
Q. Yes.
A. Very probably, yes.
Q. We then have a patient questionnaire at page 6. I think we probably need to see the original document to see with complete clarity which items have been ticked and highlighted.

Over the page, page 7, this is your letter to Dr Stewart, saying -- and before you've seen Patient D, that:

"She's passed me a letter from you to her."

You say:

"I am sure you know that I've never met this patient..."

Because you haven't seen her yet.

"... and thus the predication that I would be prescribing thyroxine to her would be presumptuous to say the least."

You go on to take issue with Dr Stewart about various matters.

The final paragraph, the Panel can read for themselves, but you are concerned about what is being said about you; can I put it in those terms?
A. Yes, indeed.
Q. There is then on page 8 another questionnaire and

the suggestion was, I think, that this may have come from the Internet.

A. I think so, yes. I think there are a number of such on the Internet, quite useful.

Q. But again, Patient D has completed this document and put in a number of entries, and if we go on to page 10, again it's clearly the same patient and we've got the date of the consultation, 24th August 2004 on the top right-hand corner, she sets out again the blood test results.

Three-quarters of the way down the page she says:

"I have not felt completely well since the last pregnancy six years ago which is a Caesarean section."

And mentions taking Prozac for nearly two years. She says, "Constantly slept, felt like a zombie!"

We then have your notes of consultation of 24th August 2004.

The notice of inquiry, perhaps we can look at this at this point, dealing with heads 25 and 26. 25a has been admitted, namely that you saw her without a referral from her GP on 24th August 2004.

Heads b and c, the allegation is that:

"You took an inadequate history."

And:

"Carried out an inadequate examination."

Those you will deny.

A. Yes.

Q. We will come on to what took place at the consultation in a moment. It's said that:

"She informed you that her recent blood tests had shown her TSH ... to be within the reference range."

That was not admitted at an earlier point. Do you agree that her recent blood tests have her TSH level within the reference range?

A. Yes.

Q. So the Panel again may want to write in "admitted in evidence" for that amended head of charge.

It's said that:

"You took a blood sample for thyroid chemistry ..."

And that's been admitted, and it's said:

"You provided Mrs D with a prescription for thyroxine [I think, we have amended in] 25 micrograms for seven days, followed by 50 micrograms for 21 days. 75 for 21 days ... 100 micrograms for 60 days."

That's been admitted?

A. Yes.

Q. It's said that your prescribing for Mrs D was inappropriate, unnecessary, irresponsible, and that same cluster of allegations, and those are denied.

A. Denied.

Q. Let's just go through your note, if we may, because the photocopying's not best on this one and the Panel may want to compare it with the transcript that's been provided.

I am just going to ask you to read us precisely what you've written. "PCO"?

A. That's "patient complains of".

"Ill for five and a half years since her last baby. Rises at lunchtime or between 11.00 and 12.00. Prefers being in bed. Is tired but poor sleeping. Appetite is good. IBS [that is irritable bowel syndrome]. Weight has increased by five stone."

THE CHAIRMAN: Excuse me, sorry to interrupt. Just for everyone's knowledge here, we're on tab 8, page 11? Is everyone happy with that?

MR JENKINS: It's my fault, I'm sorry. I hope no one's been misled.

THE CHAIRMAN: Thank you.

A. "Weight had increased five stone. Won't weigh herself. Aches and pains. Aches all over. Particular lower back. Poor concentration and memory. Asocial."

MR JENKINS: On the right-hand side now?

A. I'm sorry, I have gone over to the right. I'm trying to do the same sort of group of things together:

"Asocial weepy plus plus. Irritable."

Q. What's the "PM"?
A. I don't know, sorry. I just don't know what that is:
"Pill makes aggressive. Periods regular."
Then before the examination, if we go up --
Q. Can we do the left-hand side.
A. Yes, that's what I was going to do, top of the left now Patient D, three children, 12, a boy, 9 years -- sorry, 12, a girl, 9 years a boy, and I haven't made a note of what the last child was:
"Caesarean section. Query 11 grams per 100 mills of haemoglobin. Under 11.4 ... "
I don't know if I ought to provide an explanation but that's what Patient D said her haemoglobin had always been.
"Fags, five per day. Single parent, coming and going."
Q. Do you know what that means?
A. Actually I think it may be caring, sorry.
Q. Don't worry.
A. I'm not particularly sure what that means.
Q. It may be we can get the original and the copy will be better, but we can perhaps look at that later.
A. Not very good writing:
"On examination, side visions of wiggly lines, somebody there at her side. Never on the floor.

Hawking plus. Breasts [tick]."

If I may, that means she checks her breasts regularly.

Then:

"Has taken 12.5 micrograms of thyroxine for one week and then 250 micrograms of thyroxine for three weeks, some years ago.

"Her tongue was chunky and feels too big. Hair thin and rough. Greyness. Thyroid plus plus, smooth, not sinister. Blood pressure 120 over 80, pulse 66 per minute, regular."

Q. Just remind us, the blood pressure and pulse, where do those fall on a scale of normality?

A. That, I think, would be considered perfectly normal, the pulse perhaps a little slower, but many people's pulse runs at that level.

Q. Right. What does it say, "[Something] okay"? Is that "diabetes okay"?

A. That is "diabetes okay", that is asking her if this has been checked out in sort of general terms.

Then my copy's sort of executed at the bottom, it says "FT4 TSH", that is a blood test. Then I think -- it is cut off, I think it would say thyroxine, that is my intention at that stage.

Q. Well, if you turn over the page, 12, the next page,

I think is a prescription.

A. Yes.

Q. Dated the same day as the consultation with the patient.

A. Yes.

Q. And on the following day, page 13, if you would, this is your letter to Dr Blanchard, who, as we will recall, was the name of the doctor that Miss D had put on the questionnaire.

A. Yes.

Q. You say:

"Miss D has requested that I write to you as she recently came to see me at my rooms."

You say:

"The difficulty here is that I thought that such a note was perhaps coming from Dr Stewart but in the interim he has written to D, including remarks, statements of my practice. Again, my apologies as I've seen this patient without referral from your practice which is, of course, quite legal but we do try very hard to work in a collegiate fashion with our family practitioner colleagues."

You then go on to set out I think what you found with the patient, and it includes the comment:

"TSH levels are good servants but bad masters."

You go on over the page to say:

"On balance and if the blood tests don't show anything au contraire, I think there is a good case for a thyroid replacement in this patient whose quality of life at the moment seems low."

You refer to the fact that she's a single parent with three young children. You say:

"I will let you know what goes forward with her thyroid chemistry and look forward to working with you on this patient."

Was there then a blood test, the result of which we have at page 16? Yes?

A. Sorry, yes.

Q. I'm going to ask you to turn back to the notice of hearing if you would. We've dealt with 25, we've looked at the prescribing, and I think you've told us you deny any allegation that your prescribing was inappropriate or irresponsible.

We now have head 27a, which deals with this blood test.

A. Yes.

Q. And it's said:

"On or about 3rd September you received the result of this blood test that showed her T4 and TSH levels to be within the reference range."

A. Yes.

Q. I think you accept that.
A. Yes.
Q. The Panel will then see head 27b and c, which are admitted, namely that there was a letter to the GP on 3rd September.

Can I take you to that, please, it's page 17.

Sorry, that is a letter to the patient. I beg your pardon. The letter on the practice is on a different page, it's page 15, I'm sorry.

You said you enclose Miss D's thyroid chemistry, "although we still await her FT3 reading.

You say:

"While her FT4 is a little low, albeit within the 95 per cent reference interval, I would be quite prepared to institute a four-month trial of thyroid replacement but will not proceed thus far for ten days to allow you the opportunity to comment."

They responded on 7th September, and we have that letter on page 19.

Again, we've looked at it before but it has been admitted on your behalf that included within the body of that letter, Dr Stewart and two of his colleagues say that they feel it's not safe or appropriate for Miss D to have thyroxine at that point.

You did see her again on 18th November 2004, that

has been admitted, 28a and 28b. You prescribed for her Sodium Thyroxine at 125 micrograms a day for three weeks, followed by 150 micrograms a day for three weeks, followed by 175 micrograms a day for three weeks.

Can I just take you to the documents that deal with that. Your notes for 18th November 2004 are on page 24. We'll come back to those in a moment, but can I invite you to turn to page 25 to see the letter you wrote to the GP:

"A note on Mrs D who came to see me today. I am delighted to say she is much improved with a reduction of a number of here hypothyroid features. I think she still has some way to go. I have laid out a treatment programme and we will review her again in three months' time."

Well, let's turn to your notes, the previous page, if we will, please. Can you just tell us what you've written. Does it start "Looking better"?

A. "Crying problem".

Q. "Crying problem", thank you.

A. Yes:

"Memory, concentration better. Aches, pains better weight same. Less S/Vs."

That is side vision, that is my shorthand for myself for side vision hallucinations. "Hawking less", hawking

is kind of coughing and --

Q. I understand.

A. "Chocolate digestives, bowel aches."

That is chocolate digestives give the lady bowel aches.

Q. Just explain that to us again.

A. Patient D said chocolate digestives gave her bowel aches.

Q. All right.

A. Then over on the left:

"Fags were now 10 to 15 per day."

Up at the top there is a (d) in the top, that is my understand for 100 micrograms per day, present dose of thyroxine:

"Tongue and thyroid were" --

Sorry, I'm not reading it out exactly as I should:

"Tongue plus, thyroid plus, both bracketed, both smaller."

Q. Which means what?

A. They are still bigger than they should be but they're both, I thought, less:

"Pulse 70 per minute. Nails ..."

I don't put anything beside "nails", that would normally mean nails are improving but obviously that's speculation:

"BP 120 over 60.

"Treatment plan, proceed to 125 micrograms a day three weeks, 150 micrograms a day three weeks, then 175 micrograms six weeks, and take 1,000 micrograms, [which is one milligram] of B12 per day."

I think what I've perhaps rather absent mindedly then written down is, she said, "Where can I came get them?", and I've said "Holland and Barrett".

Q. Like these?

A. I think so, I'm not sure.

Q. Right. Again, it's said of that prescribing it was inappropriate, unnecessary, irresponsible, and matters of that nature. You deny those allegations.

A. Yes, I do.

Q. It's said you suspected a diagnosis of B12 deficiency. Plainly you suggested she should take some vitamin B12.

A. Yes.

Q. And we have the same allegation that we have seen twice before in patients A and C, but:

"In the light of your suspicion you failed to perform any investigation on Mrs D to assess her B12 deficiency."

A. That is correct on this occasion.

Q. What, that you failed?

A. Yes, I never prescribed it in either of the two previous

occasions.

Q. Let's move on to the next time. Head 31a deals with January 2005 and refers to a blood test. It must be page 26.

This is a blood test from August 2004 and it is said:

"On or about 6th January 2005 you received [that test]."

A. That doesn't seem quite right. I wonder if something's somehow gone a bit astray here.

Q. Page 26, right at the bottom, the --

THE CHAIRMAN: Could I just suggest, is this the T3 following on -- you want the measurement of the T3, so this followed on?

A. Yes, ma'am, that is correct.

MR JENKINS: I think it is. But the date of 6th January does appear right at the bottom by the number, right in the bottom right-hand corner, underneath the name of the technician.

A. If I could help, Mr Jenkins, the T4 and TSH are, of course, the same.

Q. It's from the same blood sample.

A. Yes, that's right, and then this is a later report of the T3.

Q. We have looked at page 16 where it says "Free T3 results

to follow" and it took some time clearly for them to come through.

A. I think it may have taken time for us to put them in the notes to the laboratory. I'm not sure.

Q. That may or may not matter, but what's said is:

"On or about 6th January [in other words shortly after this report was published] you received a further result from the blood sample taken by you on 24th August showing that [is how it's been amended] the level of Tri-iodothyronine was within the reference range."

A. Yes.

Q. And I think we accept that that's right.

A. Absolutely.

Q. So that having been not admitted, you now accept after the amendment.

31b is the admitted allegation that:

"On 23rd February 2005 you provided Mrs D with a prescription for Sodium Thyroxine, 125 micrograms a day for three months."

Can we look at the prescription, please, it's page 28.

If we go two pages earlier I think we see your -- one page earlier, 27, again there are two copies of this page in the bundle, but this deals with 13th February 2005 when you saw Mrs D again.

A. Yes.
Q. I wonder if I can ask you just to read out what your note says. You have put "D" which is your shorthand for what the patient is presently on.
A. Exactly. It means dose basically. Dosage.
She had been taking -- that one month is shorthand again. That's the length of time she has been taking that:
"Shortfall in energy. Weight, will not disclose."
Q. She wouldn't tell you?
A. No:
"No side vision hallucinations. Memory and concentration had improved."
Over on the left, "Is definitely better", that is just a general statement of how -- the patient's first response, how are you, kind of thing:
"Pulse 70 per minute, regular. Tongue still bulky. Thyroid just palpable. BP 120 over 70."
Q. Forgive me, the plus over minus, that's less marked than the plus --
A. Yes, it's a commonly used shorthand term for just meaning a bit in one direction.
Q. Right.
A. It's not very specific.
Then the treatment plan I laid out was in fact 125

a day for -- that she was in fact presently taking, so that was not for any length of time.

Then 125 alternating with 150 for three, four weeks and then 150 for four weeks, and then see the patient in three months' time.

Q. I think if we then go on to your letter to Dr Blanchard at page 29 following that consultation and the prescription that we've just looked at, you say:

"A note on Mrs D who seems to be on a reasonable track. She's certainly noticed a significant reduction in her hypothyroid features, although she does seem somewhat nervous of this perfectly safe medication and rather fiddles about with the dose. I'm not too concerned about this within reasonable limits.

"I've laid out a very slowly incremental programme for Mrs D wherein she should be taking 150 micrograms thyroxine alternating with 175 micrograms of thyroxine per day in two months' time when I will review her and keep you abreast of developments with this lady."

We then go on to the next page. The Panel will want to look at head 31c.

It has been admitted that on 13th May 2005 you prescribed 150 micrograms a day of thyroxine for Mrs D.

There are then your notes for August 05 and November 05.

Did you see her in August 05?

A. Yes.

Q. Can you just take us through the note, does it say "well"?

A. Yes, "Well, feels good."

Q. "Weight increased two stone"?

A. Yes, that's what Mrs D said, but she said she had been eating a lot of chocolates, cakes, bread, and potatoes. "Knees/ankle" means that's improved. Memory concentration better, and libido was better:

"Pulse 70 per minute, temperature 37 degrees Centigrade. Thyroid had moved from plus minus to plus..."

Basically the thyroid gland is kind of feelable just, "Tongue still biggish".

Q. Biggish?

A. Biggish. That's what it says.

The plan was then to take 175 micrograms for six weeks followed by 200 micrograms for six weeks and I would see her in three months and do a blood test.

Q. I think that's in fact what you prescribed and the Panel will see the prescription at the following page, page 32.

That allegation that on 16th August 05 you did provide her with a prescription at those levels.

A. Yes.
Q. That is admitted 31d, and I think it's accepted -- I'm sorry, I should complete the August matters.

Page 33 you write again to Dr Blanchard in Kidderminster, saying:

"Mrs D continues to improve on thyroid replacement, but with a caveat."

You plan that she increase to 125 micrograms a day but in fact she's still taking the 150 micrograms?
A. If I may interrupt, I think that is actually a typing error. That should be 175. My apologies for that, I have only just noticed that now. It doesn't make any sense otherwise. Also, grammatically it should "I had", not "I has".
Q. I am sure we understand that. You didn't type it?
A. I didn't, I don't know how to.
Q. You say:

"I hope this is a reasonable way forward and I'll keep you abreast of further developments at my end of things."

Then if we turn to page 34, this is head 31e in the notice of hearing, it has been admitted that you did receive this letter in which the GP, Dr Stewart, says the doctors at the practice didn't agree that Mrs D should be taking thyroxine and requested that you

discharge her from your care.

I think at the next page, 35, we have a letter from you to the General Medical Council asking their advice.

A. Yes.

Q. You say:

"I saw a lady [and you give the date in August 04] who indicated she was bringing a letter of referral from her family practitioner but didn't do so."

And you mention the Interim Orders Panel.

You say:

"The patient's family practitioner has asked that I discharge the patient from my care as this colleague does not believe that the patient was hypothyroid. This is a perfectly proper difference of opinion, although in fairness the patient has improved notably on thyroid replacement, thus the patient does not wish to be discharged from my care and I am prepared to continue to see her. I don't know what to do."

I don't know if the GMC were in a position to give a response on a specific case?

A. I don't know either. They declined to do so.

Q. Did you write back to Dr Stewart at page 36?

A. Yes.

Q. Saying that you were honestly not sure what to do, you sought advice from the GMC.

A. Yes.
Q. Did you see the patient again, and I'm looking at page 37, in November 2005?
A. November?
Q. November, I'm sorry. I did not --
A. No, you said that.
Q. Page 37.
A. Yes.
Q. This is --
A. Yes, I did.
Q. -- Mrs D filling out another questionnaire.
A. Yes.
Q. It's headed "Hypothyroid questionnaire. Follow-up patient."
A. Yes.
Q. And she gives her details.
A. Yes.
Q. We then have two pages on, at page 39, a clinical note apparently for 18th November 2005.
A. Yes.
Q. And a prescription in the intervening page for 16th November 2005.
A. Yes.
Q. Can you tell us how the prescription might be dated two days, apparently, before you saw the patient?

A. Yes. I think it's probably me -- did not -- it's a dreadful confession but I often write the wrong date down. I'm never really sure what date it is. I don't think I would write it before I saw the patient. That would be highly eccentric.
Q. I understand. A mistake has been made in the date. Is that the answer?
A. That is the answer, yes.
Q. By someone or other?
A. It would be me.
Q. Probably you.
A. Right.
Q. The prescription then is dated 16th November for Sodium Thyroxine, 200 micrograms per day for three months?
A. Yes.
Q. And it's been admitted that you provided -- sorry, head 31f: you provided Mrs D with a prescription dated 16th November 2005 --
A. Yes.
Q. -- 200 micrograms per day for three months.
A. I suppose it wasn't the 18th, I suppose it was the 16th. I think it would be the 18th but I have written 16th, so I don't know where that goes.
Q. It may not be the most important --

A. Fine, thank you.
Q. And clearly you accept in November, mid-November, you saw the patient --
A. Yes, absolutely so.
Q. It's then alleged -- and this has not been admitted -- at 31g that:

"Between 17th November 2004 and 16th November 2005 you failed to monitor Mrs D adequately or at all."

Well, you've seen her in February 05, May 05, and August 05. What do you say about the allegation that you failed to monitor adequately or at all?
A. I would deny that. I don't actually understand it.
Q. Well, I think what's being suggested is that you weren't undertaking an adequate review of the treatment that was being provided to her.

It's then alleged at 31h that on or about 24th November 2005 you received the results of a blood test sample, which showed that she had become biochemically thyrotoxic.
A. That's denied.
Q. And the blood result is page 44 where the FT4 result is 27.2, and the TSH result is less than 0.1 milliunits per litre.
A. Yes, that's denied.
Q. It's said that that was an overreplacement as a result

of your prescribing thyroxine.

A. I don't accept that.

Q. Again, the same allegations that we've seen many times before, it's said that your prescribing in relation to that period for Mrs D in 2005 was inappropriate, unnecessary, and irresponsible and not in the best interests of the patient.

A. I don't agree.

Q. Head 33, I think, is accepted in relation to the invitation by the GMC to undergo an assessment. Your initial acceptance and subsequent change of mind for the reasons that you've set out in the letter that we've looked at once before.

A. Yes.

MR JENKINS: Thank you very much, Dr Skinner. Would you wait there because you will be asked questions at some point by others.

THE CHAIRMAN: As it's 4.30 I think this will be an appropriate time to adjourn and we will start again at 9.30. Thank you.

(4.30 pm)

(The hearing adjourned until 9.30 am,
on Wednesday, 11th July 2007)

INDEX