GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:

Wednesday, 11th July 2007

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

Case of:

GORDON ROBERT BRUCE SKINNER MB ChB 1965 Glasg SR
Registration No: 0726922
(Day 8)

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

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MR A JENKINS, Counsel, instructed by RadcliffesLeBrasseur, Solicitors, appeared on behalf of the doctor, who was present.
MR T KARK, Counsel, instructed by Eversheds, Solicitors, appeared on behalf of the General Medical Council.

Wednesday, 11th July 2007

(9.30 am)

THE CHAIRMAN: We will now proceed with the cross-examination of the witness by Mr Kark.

DR GORDON SKINNER (continued)

Cross-examination by MR KARK

Q. Dr Skinner, do you have D7, your curriculum vitae available to you?

A. Can you tell me the file?

Q. It's in a file, I don't think. It's handed out by your counsel yesterday.

A. Yes.

Q. I'm going to turn to that in a moment, I want to ask you this: as you sat and you listened last week to the evidence of Dr Cooke, Dr Blair, Dr Summers, Dr Cundy, Dr Ince, Dr Stewart, Dr Prentice, Professor Weetman, and Mr Lynn, did you think to yourself for a moment, "I might just be wrong about this"?

A. Of course. But I've just conducted a survey which reinforced the opposite view, which I would like to present to the Panel at some point.

Q. A survey of what?

A. A survey of endocrinologists in the United Kingdom.

Q. We didn't hear about that from Mr Jenkins. What aspect of your approach do you think you might have got wrong?

A. I don't think I said I felt I had something wrong, I felt that other people's views deserved due consideration.

Q. Right. Could we have a look at your CV and look at your own medical background, please. I hope the Panel have got this. We start with your qualification back in 1965, you got your medical degree at Glasgow. Over the page, page 2, you're a house officer at the -- is it Glasgow Royal Infirmary?

A. Yes.

Q. In 1965 to 1966, and then in 1966 to 1967 you were a senior house officer in obstetrics and gynaecology, in fact that went on really up until 1968.

Then in 1969, you began your research fellowship in virology. Is that right?

A. Correct.

Q. You never became a registrar or a senior registrar, did you?

A. In obstetrics and gynaecology?

Q. At any stage in your career have you ever been a registrar? Have you been through a registrar's training?

A. No, you get honorary posts if you're in the university, I was an honorary consultant, for example.

Q. Have you ever trained under an endocrinologist?

A. Never.
Q. Your qualifications to date would not be sufficient to allow you to become a GP, would they?
A. I don't think so nowadays, no.
Q. You'd need to do another, what, four to six years' training?
A. I haven't contemplated, I can't answer you, Mr Kark. I don't know the answer to that question.
Q. It's a number of years training you would have to undergo to become a GP, wouldn't it?
A. I actually don't know, I haven't planned a career move. I really don't know the answer to that question, sorry.
Q. Since 1969 or up until the period that you've spoken about in the late 1990s, is it fair to say that you specialised in microbiology and vaccine research?
A. Yes.
Q. Would it be right to say therefore that you were based in a laboratory for much of the time?
A. Oh, quite a part of the time.
Q. If we turn to page 3 you're still a director, are you, of HIV-VAC Inc in the USA?
A. Yes.
Q. And you're Chief Executive Officer of Vaccine Research International Plc, yes?
A. No. I hope it's clear. It changed from Chief Executive

Officer to Chief Scientific Officer in the same year. I hope it's not confusing for everybody.

Q. All right. Then we can turn to your teaching, page 4. Under the heading "Medicine and Dentistry", you were in the department of medical microbiology, for 10 years you were responsible for the general administration and organisation of those courses, so was that in a teaching role effectively?

A. Yes. Part of the medical and dental courses.

Q. All right. Then you were involved under the heading Biological Sciences running an MSc course in virology. From 1965 to 1992 you were still involved in the department running the virology course to students.

A. Yes.

Q. We see over the page your MD, PhD, your MPhil, your MSc. None of those had anything to do with endocrinology or the study of the thyroid, did they?

A. No.

Q. Can we go to your research publications which are, if I may say so, impressive and lengthy, starting at page 7.

A. Thank you.

Q. Just leafing through those, starting at page 7, I think we get to page 14 before we find the first publication which was a letter to the BMJ in June of 1997, three

paragraphs up from the bottom, page 14.

Do you have that?

A. You mean the third publication up from the bottom?

Q. Yes. Page 14.

A. I think it must just be a page thing. That seems to deal with my double blind control of a vaccine against herpes genitalis in the United States.

Q. Was this -- are we on the same page?

A. I don't know.

Q. Page 14, right at the top, does it say, "GRB Skinner chemotherapeutic"?

A. Yes.

Q. So three paragraphs up from the bottom: GRB Skinner, Thomas, Taylor, is it Sellarajah, Bolt Krett --

A. Yes. I have it now, sorry.

Q. "Thyroxine should be tried in clinically hypothyroid but biochemically euthyroid patients."

It was a letter to the BMJ, and that was your first publication, was it, in this field?

A. Yes.

Q. Over the page you were obviously continuing with your virology work and your vaccine work and then, page 15, second paragraph, GRB Skinner, Holmes, Ahmad, Davies and Benitez.

"Clinical response thyroxine sodium in clinically

hypothyroid but biochemically euthyroid patients. Journal of Nutritional and Environmental Medicine 2000."

THE CHAIRMAN: That is the third paragraph down, is it not?

A. Yes, third item.

MR KARK: That was published in the Journal of Nutritional and Environmental Medicine, was that peer reviewed?

A. To my understanding it's a peer review journal.

Q. Then there is something on vaccinations, something else on herpes viruses, and then your book, which obviously isn't peer reviewed, is it?

A. No.

Q. Then below that, below 2003, we should really set aside in relation so far as your treatment of these patients are concerned because those were published this year, 2007? Yes?

A. I don't know how the Panel works. I don't know. I'm not sure --

Q. In terms of your treatment of these patients that obviously postdates the issues that the Panel are considering. Yes?

A. It says here the investigation is continuing and reported. I wouldn't tell the court how to do their work, but it seems quite relevant to me.

Q. Well, it's your paper. When did that survey start?

A. I would say about three or four years ago. It's an

ongoing -- I wouldn't call it an audit, but you're basically looking at the results of the practice.

Q. I see. Your two publications effectively are, I suggest, a letter to the BMJ and a publication in the Journal of Nutritional and Environmental Medicine.

We heard from Professor Weetman about that. Would you accept that it's not at the top of the scientific tree of publications, as it were?

A. No, I wouldn't accept that, nor do I accept the general concept that certain journals are -- let me put it another way. I don't think the value of an article relates to what journal it's in and, if I may say so, I thought it was a slightly sweeping condemnation of a journal that seems to me perfectly respectable and perfectly valid.

Q. Would that article, do you think, have been accepted in any endocrine journal?

A. I think the honest answer to this is: it would have difficulty because it would be slightly contraflow, not amazingly contraflow, to the generality of practice. But, as I say, I have conducted a survey to examine that issue.

It's always been a difficult theme throughout medical history to publish a new idea, if you like, or an idea that may be different from current practice.

I make no bones about that.

Q. Can we go back to your letter to the BMJ in 1997 which I think you accept was your very first publication.

Was this as a result of your seeing patients since 1994 and stumbling across this issue, as it were?

A. I would say about 1997 there was a significant number of patients coming, yes.

Q. But by 1997, Professor Weetman and Mr Lynn between them would have had something like over 50 years of knowledge in the management of the thyroid.

Let me ask you again: as you listened to Professor Weetman particularly and Mr Lynn particularly, did it give you cause for concern about your own practice?

A. I have listened to many endocrinologists and tried to have good debate. It didn't give me any cause for concern that I was doing anything wrong but --

Q. Did it not?

A. -- as I said, I want to discuss -- take cognisance of people's views. I don't blindly carry on ignoring them.

Q. Well, we'll see. Let us look at the papers you presented at major scientific meetings, beginning at page 15. I think we can leaf through the very many pages of that section of your CV.

You'll correct me, but I think it's not -- it goes

up to page 30 and it actually goes right up to 2007. Have you presented a single paper at any major scientific meeting in relation to the issues that this Panel are considering?

A. Yes.

Q. Which one is that?

A. I'm just looking for the actual title of it. I'm getting there.

Q. Page 30 is when you start -- is around 1996, if that helps you.

A. Yes, it has helped. I presented in March of this year.

Q. March of this year, yes?

A. 2007. Was that the question?

Q. Yes, all right. Where are we on your CV?

A. I'm on page 31.

Q. That's scientific meetings relating to hypothyroidism. I was just asking about papers that you presented. I'm working from your own CV. I think that section, perhaps I'm wrong, I thought that section of your CV ended at page 30.

A. Well, I've tried to indicate the papers presented at meetings which relate to hypothyroidism on page 31.

Q. All right. I'm going to deal, I promise you, we are going to deal with this. I'm not ignoring you for a second. But back on page 30 we're in 1996 and that

takes us actually to the bottom of the page, to 2007, we have the anti-viral properties of a cactus, vaccines against dermatophilus, a lot of publications with people called Ahmad and Davies.

Who is Mr Ahmad?

A. I'm not quite sure what you mean. Who is he?

Q. How do you know him? What's his speciality? You've published a paper with him.

A. Yes, he is a microbiologist.

Q. Mr Davies?

A. He is a microbiologist. I think these are actually ladies.

Q. I beg your pardon, thank you. I wouldn't know that from looking at --

A. No, one never can.

Q. Page 31. Let's have a look at this.

"Scientific meetings relating to hypothyroidism.

"International workshop on diagnosis of hypothyroidism in patients with 'normal thyroid chemistry'. Birmingham October 2000; Organised and Chaired by GRB Skinner."

Who did you have speaking at the meeting?

A. A Dr Peatfield.

Q. Is he an endocrinologist?

A. No.

Q. Then underneath that -- sorry, were there any other speakers?
A. Yes, there were patients. The endocrinologists who were invited wouldn't come, nary a one of them.
Q. I'm sorry to hear that.
A. Yes, a number of patients spoke and a most distinguished doctor from the United States called Dr John Lowe, who's written a magnificent book on the subject.
Q. On what subject?
A. Well, I think the title of his book is -- it concerns fibromyalgia, but it's largely to deal with hypothyroidism -- superb.
Q. "Relationship between myalgic encephalopathy and hypothyroidism."

Is that part of the same international workshop or is that something different?
A. That refers to the paragraph below it, I apologise, it may not be too clear, and that was a large number of talks I gave, including the British Thyroid Foundation, indeed, invited me to speak.
Q. I'm going to ask but the British Thyroid Foundation. That is a patient-based group, is it?
A. To be quite honest, I'm a little unclear what it is. Professor Weetman described it. It seems to be two groups. There is a British Thyroid Foundation and there

is a British Thyroid Association. One seems to be kind of patienty and one kind of doctory. That's the extent of my knowledge of this organisation.

Q. Did you speak at the meeting?

A. Yes.

Q. You did?

A. Yes.

Q. Well, who did you think you were addressing?

A. I was addressing the people who were members of, for example, the British Thyroid Foundation, the Eastbourne chapter of that Organisation.

Q. Were there any endocrinologists speaking at the meeting?

A. Speaking at the meeting?

Q. Yes.

A. No, I was, I think, was the only speaker. I was the invited speaker for the session, I suppose.

Q. Then we can see that since March of 2007 you've attended a number of meetings of the Anti-Aging Medicine World Congress. One in Nice -- sorry, two in Nice, one in Monaco. Sorry, two in Monaco. Must have been very pleasant.

Tell us about the Anti-Aging Medicine World Congress.

A. I think, in fact, this is under the auspices of Dr Hertoghe, who we will be hearing from later. It's

called Anti-Aging.

The area which I was involved in was basically to do with problems in management and diagnosis of hypothyroidism in which there was a number of excellent talks, very open-minded, excellent symposium.

Q. Did you meet Dr Hertoghe at those meetings?

A. Dr Hertoghe was more or less running them.

Q. Did you meet him?

A. I think so.

Q. Then --

A. I know so. The answer is yes, sorry.

Q. Yes, I expect you know whether you've met him or not.

A. Yes, quite.

Q. June 2007, last entry of that page, GRB Skinner. Diagnosis of hypothyroidism, Houses of Parliament. What was that all about?

A. You mean what was the meeting about, yes?

Q. It must be a very long answer if you tell us what the Houses of Parliament were about.

A. I was concerned about the question.

Q. Tell us what you were doing there.

A. "We" was a group of four or five people who were very concerned about this problem. We were talking to a group of members of parliament to try to stimulate some kind of debate on this whole issue.

Q. We can see notable lectures, fellowship awards, patented inventions, patent filings, membership of professional associations, none of those, I think, have got anything to do with hypothyroidism, is that right? Unless I've missed something.
A. No, that's absolutely correct.
Q. You yourself have never conducted, taken part in any formally recognised research that has been published in a peer review journal, have you?
A. Yes.
Q. What's that?
A. There have been two papers presented, one in the BMJ and one in the Journal of Nutritional Medicine.
I understood both of these were peer reviewed. I could be wrong on that. I didn't check it out.
Q. Was that recognised research?
A. I'm not being difficult, Mr Kark. I don't really know what you mean by that. I'm not being obtuse here.
Q. Were those based on research that you conducted with the permission of patients?
A. Yes.
Q. Which one?
A. Both.
Q. I want to examine your approach to the diagnosis and management of hypothyroidism. Can I just ask you if you

agree with this statement, that:

"The diagnosis and management of hypothyroidism requires the application of sound scientific principles and the art of medicine."

A. Yes.

Q. You would agree with that because you wrote it.

A. That's why I agreed with it.

Q. Right. Does your book accurately reflect your approach?

A. Absolutely.

Q. Does it give a true account of events that you have actually been involved in?

A. To the best of my knowledge.

Q. Do you accept that where the disease of the gland, the thyroid gland, is suspected, that one basic test that should always be performed, except perhaps in a medical emergency, would be a blood test?

A. Can I think about that question?

Q. Certainly.

A. That should always be performed ...

Q. I'll repeat it if you want?

A. No, no, I understood it. I'm not quite sure how to answer it. This is not an answer and I'm not evading the question, it is always performed either by myself or the family practitioner. If I could choose, if someone said, "You could either have a blood test or listen to

the patient", I would take listening to the patient, if it was impossible.

It may be useful to point out that once there were not any blood tests but that's not quite answering your question, I understand.

Q. I'm going to try and concentrate on medical practice in the last 30 years, since when, I suggest, there have been blood tests.

Do you accept that?

A. I do. I don't accept it's been the optimal time for medicine. I do accept your ...

Q. Right. Given that it's not a choice between listening to the patient and taking a blood test, do you agree that where the disease of a gland is suspected, the basic test that should always be performed would be a blood test?

A. Yes, I do --

Q. Right.

A. -- sort of.

Q. Sort of?

A. Well, I think it's giving a funny impression to the Panel. I always do it, so -- well, that's a yes.

Q. You wouldn't dream of starting medication for a diabetic without knowing what their blood test revealed, would you?

A. If a blood test wasn't available I might, but if a blood test was available I would certainly base the results of that.

Q. Sorry, I just want to understand that. Are you saying that you would not get a blood test at the beginning of your treatment of a diabetic?

A. I didn't say that.

Q. You said if one was available. What if it isn't available?

A. If there was no blood test available, let's say prior to a blood test you would take a decision based on the clinical features.

Q. Let's look at your book to see if we can glean what your view is about the importance of blood tests and where they have a place in your scientific principles.

Can we start, I think, at page 1. You talk about the importance of clinical observation in medical practice. You say:

"The latter seems to be an outmoded concept replaced by 'evidence-based medicine' which doesn't mean evidence-based medicine but laboratory-based medicine to provide protection against possible litigation."

Is that where you place what you call laboratory-based medicine? It's really a safeguard against the lawyers?

A. Yes, I think an element of that is true. Not entirely true of course, because I don't actually say that in the sentence. I say:

"...evidence-based medicine' which does not mean evidence-based medicine but laboratory-based medicine ..."

I am drawing attention to a feeling abroad, not abroad but abounding that evidence-based medicine equals laboratory based medicine. I haven't condemned laboratory-based medicine.

Q. All right. Turn to page 7. I just want to understand how much you mean of this. The third line down:

"As soon as I hear the word professionalism and ethics I assume it's going to be a load of old cobblers relating to some kind of fraternal bonding but we all know that fraternities are refuges for the insecure."

I understand readily, Dr Skinner, that you were trying to make this book interesting and light-hearted.

A. Arresting.

Q. Sorry?

A. Arresting.

Q. Arresting?

A. Yes.

Q. Did you mean what you said there?

A. Which of my --

Q. "As soon as I hear the word professionalism and ethics I assume it's going to be a load of old cobblers"; is that your view?

A. Yes, I did really.

Q. Thank you.

Page 18, please. This is the first line:

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

Of course, when you say "clinical grounds", you mean the presentation of the patient, do you?

A. Yes.

Q. Do you believe what you wrote in your book?

A. Yes.

Q. Could we go, please, to page 92. You deal, in fact, with diabetes there:

"The most common presentation of diabetes in my practice, perhaps I shouldn't admit this, occurs in patients who have clinical hypothyroid features and even have thyroid chemistry which would traditionally support this diagnosis, but for some reason the patient doesn't improve or improves somewhat but still feels unwell."

Then at the bottom of the page there are various laboratory tests, and you deal with the fasting glucose level or a measure at different intervals after

ingestion of 75 grammes of glucose:

"... or, of course, a formal glucose tolerance test are like so much else in medicine, namely helpful if the results are abnormal but still leave a wee quandary [I can't do justice, I'm afraid, to the Scottish accent] if the results are normal. I do realise, dear colleague, that you have concluded that I have finally taken leave of my senses and am pursuing a mindless crusade to vilify and cast doubt on the evidential weight of any and every laboratory test; not quite but something like that."

Again, does that reflect your view?

A. Yes. This is within the context of saying something slightly arresting in a book to draw attention, which seems to have indeed succeeded.

Q. Page 144. I'm just concentrating on chemistry for the moment. Halfway down:

"A thorny question concerns the frequency of thyroid chemistry or which thyroid chemistry or indeed the necessity for thyroid chemistry at all. In my experience, there is little relationship between the wellbeing of a patient and Thyroid Hormone levels, particularly the TSH levels which are more or less a waste of time in a patient under treat."

Let's just split that up because there are,

of course, different considerations. But are you there intending to question the necessity for thyroid chemistry at all?

A. No.

Q. "In my experience there is little relationship between the wellbeing of a patient and thyroid hormone levels."

Then you go on to particularly where the patient is under treatment. But that first line, "little relationship between the wellbeing of the patient and thyroid hormone levels", is that what you have found?

A. Patient B illustrates that.

Q. We will look, I promise you, at Patient B in some detail.

Page 145:

"TSH readings are a bind in that any patient on substantive thyroid replacement will finish up with a TSH under 0.5 or even 0 and unless somebody knows something I don't know or there is evidence I've never seen, this is inevitable and doesn't matter a hoot."

Again, does that reflect your view?

A. Yes.

Q. Just to remind you, or remind the Panel of your evidence yesterday, "There is no level of TSH that I would not be comfortable with."

Do you stand by that?

A. Yes, we're not talking massively high levels, of course, but I'm not concerned with a TSH level of 0. I do stand by that.

Q. Page 146. This is the last reference on this issue:

"I'm convinced that if you take a decent clinical history and conduct a proper examination, one could manage thyroid replacement without a single blood test and that's more or less what we did when I was a medical student in the first half of the sixties decade."

Let's concentrate on the latter half of the last decade and this decade.

"One could manage thyroid replacement without a single blood test."

Is that your approach?

A. I don't think I say there it's my approach, I say --

Q. Is that your belief?

A. That's slightly different. I said it is my belief that you could manage it if blood tests were banned by Royal decree, I would be reasonably confident I could manage the patients properly.

Q. Well, blood tests aren't banned by Royal decree. Some might think that they're a requirement. You do not, do you?

A. I don't think I said that. I indicated yesterday that I said there are occasions when blood tests are quite

useful.

Q. Are quite useful?

A. Can be useful. You will have noted I take blood tests on my patients extensively.

Q. We'll look at that.

A. All right.

Q. Would you agree with this, that there is not a single piece of scientific research that supports the view that you can treat a potentially diseased thyroid without knowing the TSH level?

A. No-one is going to embark on such a piece of scientific research so the answer is almost axiomatically no. If I'm allowed to stray out of your caveat a little bit, this is indeed what happened when there weren't any blood tests. I'm not aware that patients were treated -- fared any worse.

Q. That's the sort of general sweeping statement that you sometimes make.

A. Your question was enormously general and sweeping.

Q. Are you saying that the treatment of thyroid disease simply hasn't improved since the 1940s?

A. I know of no evidence, to take the same kind of approach, that it has. I would personally have preferred to have been treated many years ago when cognisance was taken of my clinical state rather than my

TSH level.

Q. Do you agree with this, that once medication has started, you would normally need to find out how the thyroid has reacted to your drugs with reasonable regularity?

A. Absolutely crucial. That's why you would listen to the patient.

Q. And testing their blood?

A. Yes, I do that.

Q. Crucial or not?

A. Not crucial. Again, we're in the world where, if I could make a choice, I would listen to the patient rather than have her blood thyroid chemistry.

Q. You don't have a make a choice, Dr Skinner. You can do both. Would you do both?

A. I do do both.

Q. Is the true position, just having reviewed what you've said in your book and what you said in evidence yesterday, that your real belief is that you can treat a hypothyroid patient or apparently hypothyroid patient without bothering with the chemistry provided that the history is right and the patient looks hypothyroid?

A. The question you asked was: you could. I think you could and, indeed, has been done many a time.

Q. It's also fair, isn't it, to suggest to you that you

believe fairly passionately in the power of thyroxine?

A. Passionately?

Q. Strongly.

A. Strongly? Passionately is strange. I think it is an excellent medication and can return your patients to optimal health, which is extremely satisfying.

Q. You see, in your book you talk about the possibility of slipping thyroxine to a needy patient without their knowledge.

A. Can I have the page number?

Q. Certainly. Page 175.

Right at the top of the page. You start:

"The sad conclusion is that certain patients prefer to continue in their appalling but safe [hibernation] of ill health" --

A. Hibernian.

Q. -- "than take curative medicines."

A. Hibernian.

Q. Hibernian, thank you.

"It's very frustrating and if all forms of persuasion fail, the only choice would be to slip them the medication which will get you in grief with the General Medical Council" --

A. Too right.

Q. -- "but would work in most cases. The patient may not

know she's been slipped the medication and assume she's getting better from some other remote source which can range from the spiritual to quite commonly an obscure change in diet."

Now, first of all, do you think that is right that it would be appropriate to take that course?

A. I'm sure, Mr Kark, you know I'm not seriously suggesting that. I think there is a conditional clause: "if".

Q. Can we look at the last paragraph:

"However, I can think of four patients in my practice who continue to be unwell and I would bet my boots that they're hypothyroid but there is no way to solve the problem. It's really frustrating and I'm not absolutely convinced, notwithstanding previous comments vis-a-vis the problem of keeping your registration, that it's not worth introducing the thyroid replacement under some rather confused guise or even mixed in with one of these alternative or homoeopathic thyroid preparations like kelp or seaweed or something but it depends on the patient and her individual psychology accompanied by the fervent hope that once she improves psychologically then all be well and one can even risk confessing the wee duplicity. But it's no game for sissies. This is the true meaning of professionalism."

Have you ever considered, given your belief in the

power of thyroxine, slipping it to your patients?
A. I'm sure you know the answer is no to that question.
Q. It would have to be, wouldn't it, because it would be a criminal offence to do so?
A. I have no idea what the level of offence would be, but the answer is no. Unequivocally no. You didn't actually complete the sentence you were reading. I don't know if I'm permitted to do so?
Q. Please do.
A. "This is the true meaning of professionalism, which is doing the best for your patients."
Q. Yes, thank you.
A. Thank you.
Q. Can we turn to the issue of differential diagnosis. You accept, I expect, that it is always important to consider the differential diagnosis?
A. Part and parcel of being a doctor.
Q. You cannot do that, can you, if you have a fixed idea in your mind as to the cause of the problem before the patient walks through the door?
A. I say that in my book.
Q. Let's see what you say about it in your book. Page 21, first of all. The paragraph two thirds of the way down the page:
"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."

Page 61, this is where I think you've been dealing above with paraesthesia. The new paragraph on that page:

"Other differential diagnosis in the nature of other general neurological upset and/or megaloblastic anaemia may require exclusion."

Page 85, right at the bottom of the page, last three lines:

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

On further down that page:

"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. Other differential diagnoses have no recognised association with hypothyroidism, for example fatigue in patients with tuberculosis or haematological malignancy."

You say:

"I have always dreaded the young adult patient might have leukaemia or other malignancy but it has never occurred in my practice."

Finally, I think, page 185, in fact, we are dealing there with a patient who had or might have had ovarian carcinoma. You say five lines up:

"This patient emphasises a critically important principle that a patient who has rather non-specific single symptoms of not feeling very well or gone off food or is kind of tired all the time, requires serious attention with particular awareness of possible malignancy and so obviously that would be a possible diagnosis."

Can we then go to tab 4 of file 2. This is where you set out --

A. Page number please?

Q. Hold on, I'm going to give you a couple of references. Just to remind the Panel and yourself what the purpose of this document was, page 11 begins:

"The purpose of the portfolio is to give the assessment team a clear picture of the following: your qualifications and experience, your workload, the situation in which you work, your involvement in clinical governance, your continuing professional

development, your membership of any professional groups and committees and your assessment of your own capabilities."

Then if we turn to page 16, the second entry down:

"Medical director 1998, three/four days a week. Brief description of the work involved and motivation for undertaking the post: management and diagnosis of thyroid problems restoration of health in a seriously neglected group of patients."

Page 31, I'm just going to go through these quite quickly. The description of your work is given as thyroid disease treatment. Then can we go, please, to page 67. We can see here that you are asked to give your familiarity rating in relation to managing the problems that follow and you're asked to give a scoring, 1 being very rarely and 5 being very frequently.

There you have scored -- and I'm not going through each one of them them -- under psychological problems, neuroses you have scored 1, meaning very rarely. Depression, you scored at 3, meaning fairly often, because depression is quite often a differential diagnosis to hypothyroidism, in other words the symptoms will often be very similar, won't they?

A. You can certainly get an overlap.

Q. Over the page, page 68, please. Almost everything

there is very rarely, but can we go down to thyrotoxicosis. You've marked that as 2, meaning rarely.

Is that because you don't accept, just using this case by way of example, that a patient with a T4 level above the reference range and a TSH level which is negligible, you don't accept that that patient is thyrotoxic? Is that the basis of that?

A. The basis of that is that that's what the referral letter says from the family practitioner.

Q. Well --

A. So I took this particular document to ask --

Q. "Please indicate how frequently you find yourself managing the following problems in your work in general practice by putting a ring around the appropriate number."

So what you're being asked to do is say how often you have to manage the following problems. In relation to the thyrotoxicosis you said:

"Rarely."

A. That is correct. About five, six patients a year, I would say. It's increasing.

Q. Are we seeing three of them?

A. Sorry?

Q. Do we have three of them here?

A. No, I don't think we've seen any of these patients at all.

Q. That's what I was saying. You don't accept that any of these patients are thyrotoxic, do you?

A. Oh absolutely not, none whatsoever.

Q. Hypothyroidism you have, of course, marked 5, very frequently.

Page 74, please. Halfway down the page:

"Sometimes various factors can make it difficult for us to reach these standards, that is the standards of good medical practice. Please comment here on any factors about you or your practice that make it difficult for you to reach these standards.

"A number of colleagues in this field essentially disagree with my view that hypothyroidism should be diagnosed primarily on clinical evidence while taking due cognisance of thyroid chemistry. It is regrettable that a small proportion of colleagues inexplicably decline discussion on the issue. Indeed none of the complainants would attend a working seminar which I organised to investigate these issues."

You recognise, of course, that a number of colleagues, as you put it, disagree with your view, almost the entire body of endocrinologists disagree with your view, don't they?

A. No.
Q. Page 80:
"During the last ten years my clinical work has been virtually exclusively in hypothyroidism and during the last four years exclusively by referral from family practitioner or specialist colleagues. This is an important issue indicating a significant measure of validation consequent on continuing referral from colleagues and from patients directly or indirectly via these colleagues."
What that means is: because you have patients walking through your door, that is a measure of validation. Is that what you're saying?
A. No.
Q. What are you saying?
A. I don't quite understand, with respect, what walking through the door means. That says what it says. That, as a practice, depends exclusively, especially in the last -- but always it did, on family practitioner referrals or from patients. I'm trying to indicate to the Commission of Healthcare, who we prepared this work for, I'm trying to sort of indicate that sometimes the patients will go to the family practitioner and ask for a referral.
I'm not trying to confuse them into thinking that

necessarily the family practitioner spontaneously refers them, but there's no one coming in directly through the door. I hope that's very clear.

Q. You see, you said yesterday that none of the GPs here or any one of the GPs here didn't want their patient to come and see you. There was only one case that we've got where there was a referral: patient A, one case?

A. Yes, there was one case that was referred, one case the GP knew the patient was coming, yes.

Q. But the rest all tried to stop you, didn't they, eventually?

A. No. I think the first -- the last case, Patient D, it was perfectly clear that the family practitioner didn't want me to see the case. Neither of the other two practitioners ever, ever made any contact with me so I would have to have been telepathic to know that.

Q. You say this:

"Every patient is jointly managed within the framework of a referral letter from an appropriate colleague who then receives a return letter from each consultation with discussion by telephone if required on any particular problems which may arise with any individual patient. This ensures that one is not working in splendid or unsplendid isolation making unilateral eccentric decisions and every decision is at

least viewed by a colleague or is the subject of an interactive discussion between that colleague and myself."

Dr Skinner, again we're going to look through the individual patients and go through the detail. But you were receiving letters, weren't you, from a general practice that were asking you to stop. You were aware that you had complaints against you, for instance from Liz Jordan. You were aware that there was considerable concern about your practice but you don't actually take any note of it, do you?

A. I don't agree with your proposition which you made in the first place.

Q. What, that there was considerable concern among your colleagues about your practice?

A. We looked at -- Mr Gribble advised, we looked at four cases. I see many, many patients and it is actually staggeringly opposite. One family practitioner in my medical career has asked if I would stop seeing a patient. That's only one. And indeed I sought advice from the General Medical Council on that issue.

Q. Let's put the portfolio aside.

The thyroid, as we have begun to understand, is a gland which secretes those hormones, T4 and T3. If you take a blood test that does not support your

preliminary diagnosis of hypothyroidism and you rely instead on clinical features, what are you purporting to treat?

A. Hypothyroidism.

Q. As a result of what?

A. As a result of the effect of the thyroid hormones on the tissues of the body, which gives rise to the syndrome of hypothyroidism.

Q. Would you treat a patient for hypothyroidism if you didn't suspect that there was disease of the thyroid?

A. Of course not.

Q. So in each of these cases you have suspected, have you, that there was a disease of the thyroid?

A. Of course.

Q. What's the most common disease of the thyroid?

A. I would have thought it was hypothyroidism.

Q. Well, that's not actually a disease, is it? What's the disease of the thyroid, what's causing the hypothyroidism, normally, if it's diseased?

A. There's many, many postulated causes.

Q. One of the most common, I'm going to suggest, is Hashimotos, isn't it?

A. I have seen that suggested myself. In my own experience I have -- it may, of course, be a form of Hashimotos, but the most striking correlate, over the years I have

noticed, extremely so, is any patient who has adult chicken pox -- I do refer to that in the book -- or a history of glandular fever, that doesn't of course exclude Hashimotos aetiology inasmuch as the damage to the thyroid gland from these viruses might release antigens which could stimulate antibodies to them.

Q. How often do you conduct autoimmune tests?

A. Not very often. In fact, I don't. I haven't found them to be of much value in the treatment of the patient.

Q. How are you going to discover if the patient is suffering from Hashimotos if you don't conduct an autoimmune check?

A. I'm not going to know.

Q. Does it not matter?

A. I do not think it's central to the treatment of the patient. As I say in my book, which you read very diligently, thank you, I've seen perfectly healthy patients with no antibodies. I've seen patients with high antibody levels -- sorry, healthy patients with high antibody levels, patients with no antibodies who had severe thyroid disease. So I'm a bit concerned about the relationship to management in relation to finding Hashimotos.

Q. If you don't do those checks you don't know the cause of the hypothyroidism, do you? You don't know what's

happening in the body?
A. Yes, I think you do.
Q. Do you agree?
A. No, I don't agree with that.
Q. How do you, unless you do a blood test, know what's causing the hypothyroidism? You know you've got a hypothyroidic patient, you would say, but how do you know what's causing it?
A. We come back again and again and again to Sir William Osler's statement: listen to the patient. The patient may tell you she has had her thyroid taken out. I've seen a number of patients where no-one else seemed to discover that. That is one possibility. As I mentioned, glandular fever. If you're saying do we know the complex processes involved, I don't think we know these in most diseases actually.
Q. Is there a danger, do you think, if you don't do the appropriate blood tests, that you are treating a thyroid gland that does not, in fact, need treating because there is nothing wrong with it?
A. I wouldn't say that's a danger anyway. You're treating the effect of that hormone on the body's entire structure.
Q. The dangers, I'm going to suggest, are these: first, you may be missing the true cause of a patient's problem.

Do you accept that is a danger?

A. It's a possibility if you have the wrong diagnosis.

Q. You run the risk of making the patient hyperthyroid, causing possibly tachycardia and osteoporosis? Do you agree with that? You run the risk?

A. There is a finite risk in anything. The answer in general terms is no, unless you abandon the patient and the patient cannot tell you anything about herself. I mean, there is a risk in living in the things you're referring to. While the answer would be arithmetically yes, I feel it would slightly confuse the Panel to just say: yes, yes.

Q. Do you warn your patients when they have become what others would think of as thyrotoxic, do you warn your patients about the dangers that might be involved with that?

A. Others, you mean if their biochemistry --

Q. Yes.

A. I always -- in fact, often the patients do anyway -- draw it to their attention.

Q. What do you draw to their attention?

A. That let us say Patient B had an FT4 of 39, we would discuss that and you would crucially take the patient's history, examine the patient, and tell the patient that your thyroid chemistry is abnormal, but if there is no

other reason, there's evidence of thyrotoxicity, you would then discuss it on that basis.

Q. Do you warn the patients that some think that there is a danger that you will develop in later life osteoporosis.

A. Yes, I usually discuss that.

Q. You do?

A. Yes. Patients will almost always bring that up themselves.

Q. What do you say about it?

A. To the patient?

Q. Yes.

A. I would say to the patient, as I would say to the Panel, that the evidence first of all is very, very insecure and there is no evidence in the kind of patient that we have before us in this study -- it was emphasised to me that we're dealing with patients whose clinical features are present and their chemistry is normal. I know of no study even investigating that. So the matter is discussed; I don't put the fear of death into the patient.

Q. You see, you say that the research is very, very insecure and effectively you told us yesterday that so far as the danger of osteoporosis is concerned arising from a severely reduced TSH, quoting Professor Franklyn,

I think it was --

A. Yes, it was.

Q. -- that there was no risk.

A. Yes. That's in a different group of patients.

Q. You see, again I'm going to suggest, with respect, that that was the sort of sweeping statement you sometimes make. That report to which I think Professor Franklyn contributed, was published in the Lancet in 1992, wasn't it?

A. I can't remember. Something of that nature.

Q. And it was based on a study of just 49 patients. Do you remember that?

A. Yes.

Q. What you didn't mention when you gave evidence to the Panel yesterday was a further study, and that was in 2001. I'll show it to you, if you want, in a moment.

A. May we have the author's name, please?

Q. Douglas Bower, Bruce Essinger, Michael Nevitt, Katie Stone, for the study of Osteoporotic Fractures Research Group. And they studied 686 women older than 65 years of age from a cohort of 9,704.

Do you know about this?

A. I don't think I've seen that paper. Am I allowed to look at it while we discuss it?

Q. I afraid I don't have a copy. I will pass it to you as

soon as I have put the relevant aspect to you:

"After adjustment for age, history of previous hyperthyroidism, self-rated health, use of oestrogen and thyroid hormone, women with a low TSH level less than 0.1 had a threefold increased risk for hip fractures and a fourfold increased risk for vertebral fractures compared with women who had normal TSH levels. After adjustment for TSH level a history of hypothyroidism was associated with a twofold increase in hip fracture but use of thyroid hormone itself was not associated with increased risk of hip fracture."

In other words it's the TSH that's the problem.

"Conclusions. Women older than 65 years of age who have low serum TSH levels, indicating physiologic hyperthyroidism, are at an increased risk for new hip and vertebral fractures. Use of thyroid hormone itself does not increase risk of a fracture if TSH levels are normal."

You can certainly have a look at that. (Handed)

A. I think that really provides substance to what I've been saying. They say if the patient's been made hyperthyroid.

Q. Yes.

A. Well, that would be a wrong thing to do and the patient shouldn't be made hyperthyroid.

Q. How do you define hyperthyroidism?
A. Through the standard textbook description of someone who's thyrotoxic. Not through -- I don't know how they defined it, but ... so they're actually saying there that a group of patients who have pathological, it seems from what you say -- and I'm not quite sure what risk of fracture they said there was anyway.
Q. You have the article now.
A. The absolute risk, not a ratio. Ratios are treacherous things.
Q. When you come out with something as you did yesterday to this Panel, expecting it to be believed, did you not think it was right to say, "Well, there is much more recent research that gives a very different conclusion"?
A. I wasn't asked that question. I was asked to give an opinion on something.
Q. I see.
A. But I do emphasise again that the patients here are not the patients which we are dealing with in this hearing.
Q. No, but, Dr Skinner, you have given thyroxine to four patients, right? In relation to one patient, Patient A, she moved away from your care and she was treated with thyroxine, I entirely accept. But when she was being treated with thyroxine by other doctors they kept her TSH levels within the reference range. You understand

that, don't you?

A. I understand it. I received no communication on it. Did they?

Q. That's the evidence that we have heard.

A. From the family practitioner or what?

Q. If I'm wrong about that, the Panel will no doubt note it. But I am going to suggest that Patient A was kept within the TSH reference levels.

Now, three other patients who stayed with you, B, C and D, all ended up, I'm going to suggest, at some stage or another with a negligible TSH level.

Do you agree with that? You may not think it's important.

A. No, I understand the question very well. While they were under my care?

Q. Yes.

A. Yes, is the answer to that. I'm trying to think. B has a 0. C had ... and D, I think, had a low level. I'm prepared to accept that issue. I'm prepared to accept that.

Q. Patient B ended up with less than 0.1 and a T4 of 39. Patient C, less than 0.1 and a T4 of 25.5. Actually we don't know -- I've put it wrong because Patient D we don't know about because you didn't do a blood test. But we'll come back to that.

A. I think I did blood tests on D.
Q. If I'm wrong about that, obviously I will withdraw that comment.
Those two patients who had a TSH of less than 0.1, you don't regard them as being hypothyroid, is that right?
A. Absolutely correct.
Q. But even if you don't regard them as being hypothyroid, do you not accept, given the basis of the research, that there is a risk -- a risk -- in those patients of osteoporosis?
A. I don't know of any good evidence in the patients we are talking about or the patients in this paper that -- I mean, there is a conflict in the literature. I didn't pretend for a minute there were not some authors who have argued this. But I think the evidence is shown to be most insecure.
Q. But Dr Skinner, you've been practising in this area of medicine for, what, eight years?
A. Ten.
Q. Ten. We heard from Professor Weetman, I think he has been doing for what he does for certainly over 25 years, probably longer, and we have heard from Mr Lynn. The answer is: if you don't know, tread cautiously. Isn't that right?

A. Of course it's right, but you've also got to balance it against the appalling risk of ignoring the diagnosis.

Q. Let us look at the diagnosis and turn to Patient A. You will need file 1.

Dr Skinner, I should have said this at the beginning. If you do want a break at any time don't be embarrassed to ask.

A. I'm grateful.

Q. Patient A, in July of 2001 and May of 2002, had TSH levels of 1.49 and 1.45. If you want I can give you the references for those.

A. The page number would be very helpful.

Q. 144 for the first because, in fact, we've got them in the reference letter that you were sent.

THE CHAIRMAN: Mr Kark, just to be clear, where are we, what tab?

MR KARK: File 1, tab 1.

THE CHAIRMAN: And the page?

MR KARK: Page 44.

I hope I'm now going to stay with this file.

So we know this lady's TSH levels, if one accepts this, I don't suppose there is any reason not to. In July of 2001 she had a TSH of 1.49 and on 13th May, her TSH level was 1.45; yes?

A. Yes.

Q. You received a number of documents in fact. Let's just have a look at those to see what her complaints had been. Tab 2, page 2. This isn't dated, but I think it's in fact 13th November 2001. I'm afraid I can't tell you now why I think that, but I have checked it and I think it is 13th November 2001.

She was describing there -- this was a letter...

MR JENKINS: Page 3, tab 1, medical report received from Hughes.

MR KARK: Thank you. This lady was complaining of a pain in the left side of her face, numbness in her cheek. She had vision problems, she had loss of vision in one or other eye during her pregnancy, a clicking jaw, she had been treated with Prozac for depression. Then, page 3, this is from Dr Smith, consultant physician, and nephrologist, she feels tired all the time, she had glandular fever and he thought she had a chronic low grade viral infection.

Over the page, again reference to her feeling tired all the time. Then, page 5, fatigue, depression, abdominal pain. At the bottom:

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

Page 8, she had abdominal discomfort. Then you get your reference letter from Dr Cooke. Can we just go to

page 10, please. The very last line:

"Patient wonders if it could be e.g. autoimmune thyroiditis. Has had chronic Epstein-Barr viral infection. Ask opinion of Dr Skinner who has an interest in this."

So that was the patient's concern that the cause of her problem was autoimmune thyroiditis. We examined this earlier.

How would we discover if this lady did, in fact, have autoimmune thyroiditis? What's the basic laboratory test you would do?

A. You would take a blood test.

Q. Did you?

A. I didn't ask the laboratory to examine that, no.

Q. Why not?

A. The reasons I have given heretofore.

Q. Well, do it again, please.

A. Okay. I don't think that it's got any immediate treatment relevance. That's been my experience over the years. Let's say we did find some antibodies, (inaudible word) or something, I don't think it would alter the management at all. The argument, I suppose, would be that if believed the patient wasn't hypothyroid and you found an antibody level in that instance you might think: she might become it later on, but even then

I'm not sure that the endocrinological consensus would agree or believe that the thing is to institute treatment.

So even if you did it -- I'm always reluctant to do blood tests if there isn't actually a diagnostic or a therapeutic advantage to it. So that would be why ... I rarely do these tests. Really only if a patient asks for them sometimes. Especially if I believe the diagnosis to be secure, which I did, and was latter proved.

Q. It was proved, was it?

A. Yes, it was.

Q. I see. During your consultation you also made a note that you thought she might have B12 deficiency.

A. I can't find that in my notes.

Q. It might be in the letter.

MR JENKINS: Page 15, the letter.

MR KARK: Yes. Dr Cooke, 17th January, your last few lines of the first paragraph:

"I think it is really quite likely that she is hypothyroid and perhaps B12 deficient."

Now, if a patient is, in fact, suffering from autoimmune thyroiditis, what should that signal to you? Might she have other autoimmune problems?

A. I'm not quite sure what you're getting at, sorry. How

do you mean, what should it signal?

Q. If you had discovered that she did have raised antibodies in relation to her thyroid, would that have caused you any concerns about any other part of her body?

A. I think what you are saying -- I'm not trying to second guess you -- is: would this have meant she might have other diseases, which the presence of thyroid antibodies were flagging up?

Q. Might you have wanted to check her cortisol level?

A. If we had found thyroid antibodies?

Q. Yes?

A. I think that would not be the usual practice at all from finding thyroid antibodies, unless again and again there is evidence from other matters.

Q. Such as?

A. Unless there was clinical evidence that the patient might have some other disease of some other system, in which case you would flag it up to the family practitioner.

Q. Your concerns about B12 deficiency, those would have been easily resolved, would they not, by a blood test?

A. Yes, that would be the first port of call, measure the full blood count for size of the red blood cells and a B12 estimation.

Q. But you didn't do that. Why not, if that's your first port of call?
A. Because you don't -- if you raise a question with the family practitioner you don't investigate every matter you raise with the family practitioner. The Commission of Healthcare have advised us in that direction.
Q. Are you saying that there would, with this patient who came in with these symptoms and in a patient with whom you suspect B12 deficiency, there was no point in doing a blood test?
A. No, I'm not saying that.
Q. What would have been the point of doing a blood test if you decided to do one?
A. The point would have been if I had unilaterally decided to investigate this through the private sector to establish if there was B12 deficiency.
Q. Her TSH levels, the ones you actually had dating back to May 2002, were very well within the reference range, weren't they? 1.45~--
A. Absolutely, both.
Q. I mean, really almost bang in the middle.
A. Just about the middle, given the normal distribution. Yes, I would agree with that. They're within the reference interval, yes.
Q. It's within the reference interval, not only the

accepted reference interval in the UK but also in the USA?

A. Absolutely.

Q. Even a narrower version?

A. Yes, that point's gone, right.

Q. Do you agree that really no endocrinologist in this country would have treated that woman with thyroxine?

A. Well, it's a tough question because I don't know what every endocrinologist would have done. But my honest answer would be in these circumstances, and in the survey which I might present to you, only 22 per cent of endocrinologists --

Q. Well --

A. I'm trying to answer your question numerically, Mr Kark. 22 per cent of endocrinologists agreed that they had treated patients in these circumstances.

Q. Are you going to call one? Are you going to call an endocrinologist, Dr Skinner? Anybody from the UK?

A. I am not conducting the case. I don't believe we are. I don't know though. I'm sure that Mr Jenkins could provide the relevant information.

Q. I'm sure he will. Have a look at page 16, please.

Now, this blood test -- did you take it? Did you take the blood?

A. Did I physically conduct the venesection?

Q. Yes.
A. Yes.
Q. This blood test, which doesn't check for antibodies, does it, you didn't ask for that test?
A. That has been established.
Q. You received five days after your consultation. This demonstrated that her T4 was 12.2 and her TSH was 1.4, so really her TSH had hardly moved from the level in 2001 and 2002?
A. Yes.
Q. You started this woman on thyroxine, did you?
A. Yes.
Q. At what level?
A. The dose level?
Q. Yes.
A. 25 micrograms per day.
Q. Well, can we just go back to your note.
A. My written notes?
Q. We can use your typewritten note, if you want, right at the beginning of tab 2. All we see there at the bottom, though I might be missing it, is simply treatment, oral B12.

The note, if you want to have reference to your own note, it's at page 12, of course. Where do we see the note of your decided treatment? I don't think you've

written it down, have you?

A. We see it in tab 2, page 15. The penultimate paragraph.

Q. All I was asking you about originally was in your note.

A. Do you see it in my written note?

Q. Yes.

A. About the prescription?

Q. Yes.

A. No, you don't.

Q. All right. Then we know what your prescription was because we have it, I think, at page 14.

A. 15.

Q. Well, no, if you look at 14 it shows the prescription.

A. Sorry.

Q. Then page 15. Then we know that the patient complained to yourself and she wrote to you a lengthy letter. Then if we go to page 17 you prescribed her Grain Armour.

I understand that you think it is beneficial, but can you just explain, first of all, did you supply that as a result of the telephone conversation that you had?

A. Yes.

Q. You haven't got, back at page 16, a T3 level, have you?

A. No.

Q. So your basis of switching to Grain Armour was what?

A. Essentially, after a conversation with the patient, she said thyroxine was not agreeing with her, it was giving

her a headache. She wanted to take Armour Thyroid. I indicated yesterday that I don't know de facto a reason why a patient can't take Armour Thyroid if, indeed, the patient says she would like to. There is no medical reason against it.

Q. Can we go to page 26, which is your letter to Dr Cooke.

"The clinical features of the lowish T4 reading do, I think, suggest that the lady may be suffering from hypothyroidism and while her T4 is within the reference, 95 per cent reference range, it is significantly below the average for healthy patients."

Now, just examining that for a moment, the reference range is a reference range of healthy patients, isn't it?

A. It should be. There has been much discussion about the inclusions of patients in that. That is correct in principle.

Q. Even if one can be right at the bottom of the scale of those healthy patients or right at the top of the scale of those healthy patients, you will still be within the reference range?

A. That's an arithmetic truism.

Q. Thank you.

This woman had a T4 of 12.2 so she's not got a T4 down at 9 or 9.1 or 10 or 11; she is, I suggest, well

within the reference range, isn't she?

A. She's within the reference range.

Q. Right.

A. But in the lower part of it, which I demonstrated, I hope, yesterday to the Panel.

Q. Her TSH, do you agree, is a more important and accepted to be a more important established test of what's actually happening with her thyroid? Do you agree with that premise or not?

A. I agree with the premise that since it was developed, most colleagues would put more emphasis on it. It depends, of course, on the level of each. I would agree that they would. And indeed some colleagues would swear without caveat or consideration that it's an absolute gold standard, if a patient's TSH is normal, the patient feels well. I agree with you entirely, regrettably.

Q. You don't agree with them, does that mean?

A. I certainly don't agree with it; we have seen it in four cases already.

Q. That I think was the last communication there was on your notes in relation to this patient. You say at page 27 that there was a possibility of a serious -- let's just read it properly. The middle paragraph on page 27:

"Finally, and it may be tangential but worth just

putting to bed for once and for all, I thought [Patient A] was somewhat sallow as many hypothyroid patients become B12 deficient. I have suggested 1,000 micrograms of B12 per day on a pragmatic basis. And, secondly, as her blood pressure is lowish, it would be worth perhaps taking a blood sample for full blood count and serum cortisol, just to put the possibility of serious B12 deficiency or secondary hypoadrenalism to bed once and for all.

"So I think this is the best way forward for this patient. The outcome of the professional relationship with her is, of course, very upsetting but I've never to date had a complaint in 35 years of practice."

Can we see how this patient's care, in fact, continued. If we go back to page 56, tab 1, I entirely accept that whatever she thought about it, Professor Franklyn continued this lady on a dose of thyroxine but she says in that letter on page 57:

"I did explain that, given this extremely normal TSH, one can be confident about ruling out a diagnosis of hypothyroidism. Since she did experience some improvement in her bowel symptoms after taking thyroxine treatment, it is quite understandable she would wish to pursue it. I explained that there is no specific indication as driven by her thyroid function test for

this to be continued or, indeed, expected to be helpful. Nonetheless should she choose to continue with the thyroid treatment my advice would be that she should revert back to thyroxine, stop dessicated thyroid, and that steps should be put in place to ensure that she is not overtreated. The latter recommendation is based on extensive evidence that overtreatment with thyroid hormones as indicated by suppression of TSH is associated with long-term adverse effects, specifically the development of atrial fibrillation and increased risk of osteoporosis."

So you asked earlier whether there was evidence that she was kept within the TSH reference range. That certainly appears to have been the goal, doesn't it, from what Professor Franklyn wrote?

A. That's on line something, I can't remember it. I'm looking. 6.

Q. Steps should be taken to ensure she's not overtreated and then the reason for not overtreating?

A. Yes, that is Professor Franklyn's view. She works in Birmingham beside me.

Q. Yes, I was going to ask you about that. Birmingham has a very large endocrine practice, doesn't it, at the hospital?

A. Yes.

Q. It's very well-known?
A. I think it's equally as known as any other unit in the United Kingdom. I wasn't aware it was particularly famous.
Q. Is it not a world class unit, regarded internationally as a world class unit, Birmingham?
A. I don't know. I have never heard anyone say that. I can't comment on that.
Q. Page 58, we can see that the patient's thyroid test in April of 2003 -- I'm going concentrate on the TSH -- is then at 0.4, right at the bottom end of the range and I think that is the last relevant matter, except if you go back to page 5 we can just run through her TSH tests thereafter.

Remembering that this woman is on thyroxine, in October 2003 her TSH level has in fact gone down to 0.37. In February of 2004 it's 0.31. In fact there, unfortunately, we don't have the reference ranges. In February 2004 it is, yes, February 2004, it is 0.31. That is at time when she's on thyroxine and her T4 levels are raised.

I think we have got one further entry, actually, in January of last year, 2006. I think her TSH was 0.48. Yes. It's about a third of the way down the page. So she's back then within the reference range.

When you decided to give this woman thyroxine, as you did, did you consider disease of the pituitary?

A. Yes.

Q. Did you take any steps to establish by blood test whether that was so or not?

A. No.

Q. Just give me a moment. I think you accept that you did not perform any investigation of her B12 but really say that you pointed it out to the GP and it was up to him?

A. Yes, that's true.

Q. Right.

A. "Up to him" has a slightly unusual connotation. Normally a family practitioner might telephone you or write to you and discuss the matter.

Q. You accept that you spoke to Mrs A over the telephone and she complained of new symptoms. Did you think that those new symptoms could have been an adverse effect of your prescription or not?

A. I wasn't sure. Many, many patients have headaches. She had had headaches before and my judgment from talking on the telephone was that she wasn't -- she hadn't had an acute cerebral event.

Q. But the effect of that conversation was you changed her prescription effectively to Armour Thyroid.

A. Yes.

Q. So, presumably, you thought that some of her symptoms might be related to the prescription that she was receiving?

A. There is a finite possibility, but to judge the extent of it and decide what you're going to do.

MR KARK: I'm going to move on to Patient B and that might be a convenient moment.

THE CHAIRMAN: Thank you. We will reconvene at 11.35.

(11.10 am)

(A short break)

(11.35 am)

MR KARK: Dr Skinner, we were going to move on to Patient B. She came to see you on 20th March 2003. She had had a number of problems in the past. We know that she had had problems with her eyes back in 1995 and there is a reference to that at tab 3, page 78, the same file that we've been in, file 1.

We see at page 79 that she had a deep hoarse voice, that's a reaction, apparently to the use of spray polish and there are a number of references to that. Pledge and carpet cleaner triggered that.

In August of 2002 she had a TSH of 2.3 and T4 of 16.7. If you go to your notes, tab 4, page 2, you will see the reference to that blood test result, 21st August 2002.

You wouldn't suggest, would you, that her T4 was anything but normal and her TSH was anything but normal, they were both well within the reference range?

A. I would, if I may, take issue with that statement.

Q. Oh. Which one do you say was outside the reference range?

A. I think you said well within the reference range, not outside, Mr Kark. That would be the TSH. I discussed with the Panel yesterday that -- I understand there is controversy, but if we took the US suggested top of the reference interval at 2.5, let's say 0.5 to 2.5, I tried to argue that 0.6 could hardly be considered the same as 2.4. This at 2.3 is not well within that reference interval.

Q. It's within even the US reference range, isn't it?

A. I'm accepting it's within, but I'm pointing out it's not well within.

Q. Do you take any account of these?

A. Yes.

Q. What account do you take? What note do you take of the TSH levels?

A. Most importantly, if it is abnormal, as I've argued for many years, it will usually be associated with disease, TSH of 9, let us say. This is not your question, but the reciprocal I don't believe to be true. FT4

readings, I find extremely helpful in -- they are not very common, but the patients who are referred to me with a history or who have thyrotoxicosis I find that a very helpful measurement to try and judge where we are with suppression therapy.

Q. I thought you told -- sorry, go on.

A. I was only going to give another example, if I may. I did indicate it can happen, actually I don't know if it has happened. Yes, it has happened in one patient, that if a patient starts a prescription, say, while you're waiting for the FT4 and it comes back hugely raised, you would think again. One doesn't cavalierly ignore thyroid chemistry. So yes is the answer to your question, I do take note.

Q. This lady, we know, had had problems with depression and, going back to page 109, we can see that she had a Becks score -- page 109, tab 3 -- a Becks score of 22 out of 30 and she was -- I don't know if that's moderate or severe, somewhere between the two I expect, she was moderately to severely depressed in February 2003, wasn't she? Page 109 is the questionnaire.

I see the reference range, as it were, for the Becks depression test. 16 plus is severe. So she was on the basis of the Becks depression index, she was severely depressed. That questionnaire was just a month, six

weeks, before she came to see you.

A. The date is 5th February, so that's correct.

Q. If we look at your note, which we have the typed version of, did you pick up on the depression?

A. May I have the page number?

Q. The typed note at the beginning of tab 4.

A. Now, when you say "pick up", may I ask you to be more specific on that?

Q. Yes. Did you appreciate this woman was severely depressed?

A. I didn't feel she was severely depressed talking to her. I'm not casting aspersions on the Becks score. You would be, of course, slightly strange if you felt so awful and were as happy as Larry. You could be depressed because you're hypothyroid. I would be.

Q. You can indeed. But did you ask her any questions to ascertain whether she was depressed? Did you ask her if she had completed a Becks depression inventory recently?

A. I knew she had.

Q. Did you have that?

A. I believe so. I can't absolutely remember.

Q. I'm just looking through your notes. What you had at the time of your first consultation, I think, was, page 1, you seem to have had the blood test from August 2002 and then there are your notes.

A. I can't actually remember if I had the Becks in front of me at that stage or not.
Q. But wouldn't it be in your note if you had it? You wouldn't have got rid of anything, would you?
A. I would hope not.
Q. No, and you would have made a note in your notes about depression, wouldn't you?
A. Not necessarily. You talk to the patient and form a new impression. You don't write down everything that you have discussed.
Q. But you told us earlier, just this morning, that there was, I think you put it, an overlap between depression and hypothyroidism?
A. Absolutely.
Q. If you're looking for a differential diagnosis, depression is high up the scale, isn't it?
A. Only depending on the patient's clinical features. It's what the patient says. It may not be. Not every patient is going to be depressed. Most patients will be fed up with their state of being, and when I talked to this patient I didn't think depression -- she was fed up. I didn't think it was the predominant feature, notwithstanding Beck's depression score.
Q. Six weeks earlier she filled in the following remarks: "I'm blue or sad all the time and can't snap out of

it. I feel discouraged about the future. As I look back on my life I can see a lot of failures. I am dissatisfied with everything. I feel bad or unworthy a good part of the time. I'm disgusted with myself."

I will not read on.

A. It just sounds like Patient B, exactly what she said and she was unequivocally hypothyroid.

Q. In any event, if you did consider it, do you accept that you did not write down depression as a differential diagnosis?

A. I didn't write down any differential diagnosis.

Q. Did you have a differential diagnosis?

A. Sorry, in general or with this patient?

Q. For this patient.

A. Yes, I would consider many differential diagnoses.

Q. Help us: what was your differential diagnosis for this patient if it wasn't hypothyroid?

A. I would have said if someone came along and said, "What else do you think might be wrong with this patient?", and we are in a confidential situation, of course. I realise there are patients here. Her general difficulty in coping with life, I wouldn't ... she was a lady who was constantly in dispute with decorators and so on, and this kind of thing.

She was very overweight. I think she was -- my

second diagnosis would be that she was just finding life a bit of a struggle. I was very convinced and remain convinced, I saw her quite recently, that she is hypothyroid. So you can consider differential diagnoses, but if you have reasonable surety I don't think you need to write down a load of stuff about it.

Q. You accept that the TSH does not support that diagnosis, or don't you?

A. I don't accept that at all.

Q. What did you actually prescribe to her?

A. Thyroxine.

Q. How much?

A. I always start patients on the regime I've heretofore described, which is 25 micrograms for a week, 50 for three weeks, 75 for three weeks and then 100 for perhaps three, perhaps more. It depends really when the patient's coming back to see me.

Q. Again, I don't think we see a note of that in your consultation record. I don't think in this case we have a prescription.

A. A copy of the prescription?

Q. A copy of the prescription.

A. No, I see that and I don't quite understand. I make no bones about that.

Q. We can go to the letter you wrote to her GP and this is

one of the doghouse --

A. The doghouse --

Q. -- letters.

THE CHAIRMAN: Can you give us the page number, please?

MR KARK: Page 6 of tab 4.

How often have you found you're having to write the doghouse letter? Is it just these we're looking at?

A. In my clinical practice?

Q. Yes.

A. Never, since clear guidance from this body that I should never see a patient without referral. Prior to that, I would say about eight times.

Q. Eight times in total?

A. Yes.

Q. Out of how many patients that you saw in 2002, 2003?

A. I haven't counted that up, but usually it would be about a thousand consultations in a year. So new patients maybe about a hundred, something like.

Q. It's pretty unlucky, isn't it, that we've got I think two doghouse letters in this case out of four patients?

A. No, I don't think it's unlucky, I think we're turning the cause and effect round. In the regrettable situation which arose with two of the patients, the family practitioner is understandably cross that this has happened, so I don't think it's -- I think there are

other factors apart from random chance here.

Q. Well, I don't understand that because you've written the doghouse letter before you know that the practitioner is cross. The fact that there is ultimately a complaint in relation to that patient is neither here nor there.

We have two cases here. I think it's just two, where you've written the doghouse letter out of the four patients that we're considering. Those would be two out of the eight patients, would it, in the whole two years?

A. Yes.

Q. I see. Let's have a look at the letter that you wrote. Page 6. You write this:

"Patient B is one of those difficult situations where she seems almost classically hypothyroid."

Now, could you just help us please: which classic test were you basing that remark upon?

A. The next sentence describes the plural. It says: number of typical features. As you have and as Professor Weetman have emphasised, one feature, for example fatigue, could be a myriad of -- could describe a myriad of illnesses. It's the combination of these features which would give rise to the classicism of the matter.

Q. She had choking fits during the night.

A. Excuse me, I'm not correcting, I think it's choking

fits.
Q. That's what I just said.
A. I thought you said shaking fits.
Q. No, it's my accent -- choking fits during the night. Did you know that this woman had apparently an allergy to certain cleaners that had caused her voice problems in the past?
A. I can't remember if I knew that at the time.
Q. "Side vision hallucinations which I find to be quite common in hypothyroidism".

Let me just ask you about that. First of all, what other diagnosis might there be for side vision hallucinations other than hypothyroidism?
A. Hallucinations in general terms -- of course, there's again a myriad of diagnoses and ocular phenomena, but what I'm describing there and which I describe in my book, which you have kindly read, is a particular -- you have to listen to the patient again. It's a particular phenomenon where the patient will say that he or she notes something passing like a shadow or thinks somebody's there. It's a very characteristic account of a patient -- there's a gardener who thought there were robins eating the seeds he had just planted.
Q. Very characteristic of hypothyroidism?
A. Very characteristic, in my view.

Q. Are we going to find that in any book you can lay your hands on?
A. You can find evidence, I'm sure Dr Hertoghe will provide. The particular description I've given may be an observation which I'm presenting to the medical world for future consideration.
Q. Let's just take the last 30 years or so of medical research. Any book you could lay your hands on which supports that observation of yours?
A. The precise observation I have made, I say you will not find it in a book.
Q. Do you know this book, (indicating), "The Thyroid, a Fundamental and Clinical Text"?
A. I've read bits, yes.
Q. This book has been contributed to by practically every well-known endocrinologist in the country, including Franklyn, Weetman, I think, Lazarus, Toft, the lot. You know that book, don't you?
A. I have said I read it, yes.
Q. Are we going to see any reference to side vision hallucinations, do you think, in that test?
A. I don't think so, no. Nor was it vaccination prior to its inception.
Q. Sorry, can you say that again?
A. Nor was it vaccination of people prior to its inception.

Q. So this is the cutting edge of thyroid disease, is it?
A. I think it's an important observation, I would like colleagues to ask their patients about. I suspect they don't, probably, so they haven't actually uncovered this. And patients tend not to raise this feature in case somebody thinks they're kind of a little bit, you know ...
Q. Hold on, Dr Skinner. Are you saying that for the last 20 years endocrinologists up and down the country have not heard, apparently, about these hallucinations because of patients are concerned about telling them?
A. Yes.
Q. But they tell you?
A. Yes.
Q. I see. You say that you have given her to Dr Blair. You say:

"Notwithstanding the thyroid chemistry she is hypothyroid."

I will not go into that again.

"I really thought there was a very good case for thyroid replacement and I've given her a prescription for thyroxine sodium. But I suggest that she doesn't begin it for 10 to 14 days."

You don't actually say how much, for what it's worth, do you?

A. No.
Q. We know that following that consultation and following that letter, on 8th April Dr Blair advised his patient against taking thyroxine. I can give you the note if you want to check it, but it's --
A. I have the note and I have seen that note.
Q. All right.
A. I accepted that.
Q. And you started this lady off on a course of thyroxine, didn't you?
A. I think that has been established.
Q. Right. When did you next check her bloods? Can you turn to page 8.
A. Do you mean personally or when did Dr Blair do it?
Q. I was going to ask you personally. I was just going to say, I don't want you to be misled. You know this is not your blood test, is it? Dr Blair asked for this. We can see that at the top of the page.
A. He intimated to me or it was intimated to me that he had taken a blood test in December of that year.
Q. Your original prescription would have lasted for how long?
A. Three months.
Q. You saw this patient in March of 2003?
A. Could you give me a page, please.

Q. It's page 4.
A. Yes, I have that.
Q. That's when you saw --
A. The first follow-up was in January 2004.
Q. Right.
A. Dr Blair had been dealing with it before.
Q. Yes. You saw her first on 20th March 2003, yes?
A. Yes.
Q. You started her on thyroxine and your prescription would have lasted three months?
A. Yes.
Q. We don't have the other prescriptions. There must have been other prescriptions?
A. Yes, I don't understand that and I do -- that would be a serious shortfall. I don't know why I haven't got copies of these prescriptions in the notes.
Q. But we could take it that she was on thyroxine, she wasn't on Armour at any stage, was she, this patient?
A. Not according to Dr Blair's notes. I didn't see the patient, you see.
Q. So how was she getting these further prescriptions?
A. Well, this sounds awful, but I suppose I must have been writing them for her.
Q. Yes.
A. In conjunction with Dr Blair.

Q. Well, Dr Blair wasn't giving her prescriptions.
A. I said in conjunction. He was monitoring the patient regularly.
Q. He was monitoring her, telling her to try and stop the thyroxine.
A. I had no information about that at all. The patient was returned to the monitoring of the family practitioner.
Q. Sorry, look back at 3/28 then. We heard from Dr Blair. Go back to page 28 of tab 3.

8th April 2003. It's quite difficult to read his writing:

"See letter, advised against thyroxine", I think it is.

"26th September [in capital letters] clearly advised against taking thyroxine."

There is no doubt, is there, Dr Blair didn't like these prescriptions that you were providing for thyroxine?

A. I have no way of knowing that.
Q. Well --
A. I have had no communication ever from Dr Blair.
Q. Tell us how it worked. You have seen the patient first of all when she's got an apparently normal TSH -- I'm sorry, a TSH within the reference range but you say only just, and T4 of 16.8. You start her off on thyroxine.

Three months later you must have given her another prescription, yes?

A. I assume so, but I didn't keep copies at that time.

Q. No, and three months after that you must have given her another prescription?

A. Yes.

Q. You didn't take any blood; you didn't see her?

A. Dr Blair was looking after her.

Q. No, you are the one giving her the prescriptions.

A. I accept that, but I don't accept it's necessary to take a blood sample in that circumstance.

Q. Well, how did you think your thyroxine was working?

A. I trusted my colleague who was monitoring it.

Q. Your colleague was trying to stop it. You're the one, forgive the term, knocking out prescriptions for thyroxine. What were you doing to ensure that that was the right thing to do?

A. I repeat what I was saying, I was entrusting my colleague who had made no intimation that he was concerned in any way. Is that not reasonable practice?

Q. Dr Skinner, the answer is: you did nothing, isn't it?

A. No, it's not. I think it puts the thing in a very unfortunate light, which I don't think is the case.

Q. Perhaps things are in an unfortunate light. You were giving repeat prescriptions for thyroxine. You did no

blood test and you didn't see your patient. That's the reality, isn't it?

A. I think it's the reality. I don't understand the prescription point, I have to say, in all honesty.

Q. By the time we get to December of 2003, this patient has a T4 level of 39, way beyond the reference range, and a TSH level of less than 0.1; putting her into the danger category, as it were.

If she stays at that level for long there is a danger, depending on which research you read, of osteoporosis? That is right, is it not?

A. We discussed that and I think I indicated that that was not the patients who were under this case, and that patient did not fall into the category of the patients that were thus investigated.

Q. Because she wasn't over 65?

A. She wasn't hypothyroid. Even Dr Blair agreed with that.

Q. Hang on. She's got a TSH of 0.1 and a T4 of 39 and biochemically she was hypothyroid, wasn't she?

A. No.

Q. What's your definition of biochemically hypothyroid? Help us.

A. I'm trying to help you. It's a term that has no meaning whatsoever. Incidentally, the laboratory didn't confirm this view, but it's a high level. Now, you cannot be

biochemically hypothyroid. What you can only say -- well, this reading is above a reference interval. It depends if you imply in the term "hypothyroid" that the patient's thyrotoxic, which the patient wasn't. Dr Blair saw her, didn't think so, and reduced her --

Q. Hold on, Dr Skinner. How did you know this patient wasn't thyrotoxic?

A. From Dr Blair's notes and from my examination of the patient about a week or so later.

Q. Sorry, you didn't have Dr Blair's notes.

A. I have them now.

Q. I know you have them now.

A. I don't understand the question.

Q. I'll repeat it until you do. How did you know, when you were giving her prescriptions for thyroxine, she wasn't thyrotoxic?

A. Because I entrusted my colleague.

Q. You put your trust in your colleague who profoundly disagrees with your prescriptions. You're trusting him to ensure that she does not become thyrotoxic while you continue knocking out prescriptions. Is that how it works?

A. His profound disagreement doesn't imply that Dr Blair, who seemed a very sensible family practitioner, is not capable of seeing if the patient is thyrotoxic. I think

these are two issues here that are being slightly muddled into one. If Dr Blair had thought the patient was at any stage thyrotoxic, he presumably would have contacted me and told me.

Q. Let's see what happens nine months later when she does come back to see you again and we have a second consultation with you. Page 9 at the very bottom, tab 4 or, of course, your notes, the typewritten version.

I am just working off your typewritten version at the moment, behind tab 4:

"Taking reduced dose of 200 micrograms thyroxine per day."

Let us stop there for a moment. Presumably that means that previously she had been on a higher dose than 200 micrograms? Yes?

A. Yes.

Q. Right. How did she get her --

A. I don't know how she got to 225. That does surprise me a little bit, but it's not an excessively high dose anyway. Patients used to take 200 to 400 micrograms in the 60s and 70s.

Q. It depends if there is anything wrong with her thyroid in the first place, doesn't it, Dr Skinner?

A. Absolutely. Do you mean if the original diagnosis was correct or not correct, is that what you're saying?

Q. 200 micrograms of thyroxine into a patient who has a normal thyroid would be an enormous amount, wouldn't it?
A. It wouldn't be a enormous amount, no.
Q. A large amount?
A. Well, it's a ... It's a question which -- do you mean if a normal patient who is not hypothyroid takes 200 micrograms?
Q. Yes.
A. Yes, that would be a thing you would not wish to do. I don't think the patient would perish in the next few weeks or something.
Q. That's a relief, no doubt.
A. I should also add the patient is quite heavy. That is a matter which merits consideration.
Q. Let us have a look again at your second consultation:

"Taking a reduced dose of 200 micrograms thyroxine on account of palpitations for one month."

I accept that may not mean that throughout the month she's got palpitations, but that's your note.
A. May I speak? I think it was clarified yesterday that that's free of palpitations for one month.
Q. Oh, I'm sorry, I'm reading -- you're quite right, that is what you said yesterday, but I did want to come back to that.

Can you just help us with the note? It's very, very difficult, perhaps I'm just bad at reading your writing, but page 9, there is a squiggle and then "200 micrograms per day" and then something, "palpitations for one month".

A. Yes.

Q. You think that squiggle is "free", do you?

A. Yes.

Q. But you translated it originally when you typed up your notes as "on account of". Which one are you going to stick with?

A. Let me find the typewritten --

Q. Right at the beginning of tab 4.

A. May I have a page number?

Q. It should be inserted right at the beginning of the tab.

A. Here we are. Now, where are we here now?

Q. It should be 21st January 2004. Second consultation:

"Taking reduced dose of 200 micrograms thyroxine per day on account of palpitations for one month."

Did you dictate this to your secretary or something?

A. Yes, but it depends where you put the adverbial clause, does it not? A better way would have been to have said taking reduced 200 micrograms for one month on account of palpitations.

Q. I don't want to spend too long on it, but this is your

document, Dr Skinner, you dictated this to your secretary, you passed it to your lawyers, they kindly passed it to the GMC, so presumably you checked it?

A. But I'm standing by it. I'm saying the adverbial phrase has been transposed.

Q. Don't worry about the adverbial phrase.

A. Well, it's crucial to your contentions.

Q. You're now saying that it should read "free of", and I just want to know which the true interpretation is.

A. The interpretation is that she has, at this point in time -- she had been taking 200 micrograms per day for one month and it was on account of palpitations.
I don't really know why it was on account of palpitations because I don't think she had any since that episode -- in fact, it hasn't even started yet.
I don't quite understand that, but she certainly hadn't had palpitations for a month.

Q. What do you think the palpitations might have been caused by? I don't think you have seen palpitations elsewhere in her medical records prior to this date, although Mr Jenkins will correct me if I'm wrong.

A. I don't remember her having palpitations. She had one episode of thudding or beating heart in the night.

Q. Right. What do you think might have caused that?

A. Alcohol.

Q. She was also on, apparently, 225 micrograms of thyroxine. Do you think that might have had anything to do with it?
A. When are you alleging she had the palpitations?
Q. I'm simply working from your note which says, "No palpitations since ..."
Perhaps I'm being rather slow about this, but if you write in your note "reduce thyroxine", either on account of palpitations or free of palpitations, it might indicate to the uneducated observer that she had had palpitations. Can you help us?
A. Yes, I'm trying my best. These notes, of course, are from me and you write them down with the patient in front of you. Now, let me see my note to Dr Blair. Can we maybe look at that?
Q. You mean your letter to Dr Blair?
A. The letter following on this.
Q. Page 11.
A. Now, I don't mention the palpitations there.
Q. I was going to ask you about that as well. Here's your patient complaining about palpitations, she has reduced her dose of thyroxine as a result. Did you not think that that was relevant to mention to her GP?
A. It was the GP who reduced the dose to 200.
Q. Did you not think it relevant to mention to the GP that

the patient had complained of palpitations?
A. She just had seen the GP about a week before.
Q. Dr Skinner, when you spoke to her, she is sitting there in front of you, did she use the word "palpitations"?
A. I don't think.
Q. I'm sorry, I'm being slow. How else does it get into your note?
A. I don't know. I don't remember her saying she had had any problem with palpitations.
Q. I don't suppose you do remember now, but can we take it that the note you made as the patient, presumably, was sitting opposite you was an accurate reflection of something she said to you?
A. You would hope so.
Q. Right, so there is a patient sitting in front of you telling you she has had palpitations. Why did you not mention that to the GP?
A. Well, I've answered that. If indeed she said that. She had just come from the GP. You wouldn't reiterate everything back to the GP, would you? He had reduced the dose because of, I think, the FT4 level. He didn't direct me to palpitations.
Q. You didn't know what the GP was doing, did you?
A. He certainly never contacted me. I had to glean that from the patient.

Q. I'll move on. In any event, you did not mention in your letter to the GP that the patient had mentioned palpitations, you say because he must have already known.

Let's see what you do say. Now, this is 28th January. Did you know by this stage -- I think you may have done -- that there had been a letter of complaint from Dr Jordan?

A. I don't think there had been at that stage.

Q. You might not have been. I think it was written only two days earlier. But in any event, you then write on 28th January this:

"A note on Patient B who has noticed some improvements on thyroid replacement and is clearly still hypothyroid notwithstanding highish T4 reading."

Well, your highish T4 reading was the T4 produced by Dr Blair back in December, which was the T4 of 39 which you described as highish.

"I think the obvious hypothesis is that she isn't converting T4 to T3 thus back stacking T4."

How did you get to that?

A. Because we have a patient here, which I think is germane to the whole issue in these proceedings. We have a patient with an FT4 of 39 --

Q. Which is very high, isn't it?

A. Yes, it's high, of course. This an arithmetical truism again -- and was, to my mind, when I saw her, she was hypothyroid.
Q. What do you mean, "to my mind, when I saw her"? What was it that made you think she was still hypothyroid?
A. May we go to the relevant part?
Q. Yes.
A. First of all, Dr Blair -- no, that would be retrospective. I didn't know this at the time, except I did know, in fairness, that he had only slightly reduced her dose level. He clearly didn't think there was a crisis here. Anyway, to answer your question --
Q. The notes are at page 9.
A. Yes. She had improved and she gave no clinical features whatsoever of thyrotoxicosis. This is the crucial point.
Q. Sorry, what features did she have of hypothyroidism when you saw her? Can you just read them out to us?
A. Yes. Do you mean what I say in my notes?
Q. Yes, on 21st January when you saw her you said she was still hypothyroid and I just wanted to know, you haven't done any blood tests?
A. We have just had a blood test.
Q. The blood test doesn't show she's hypothyroid, does it?
A. It can't. We've been through that many, many times,

sir. I haven't written down why I thought she was still hypothyroid. There would be an element of such tedious reiteration if a doctor did that every time, however, I did write down her pulse was 56 per minute, which would be unusual -- it's not impossible, everything is possible in medicine -- to be thyrotoxic with a pulse, regular pulse rate of 56 per minute.

Her tongue was still enlarged and still indented but it could still be still enlarged if she had become toxic, I accept that, and I could feel her thyroid gland. The whole impression of the patient was such that she seemed to me and indeed to this day seems to be hypothyroid.

Q. You say she's still clearly hypothyroid and that's based on the features you just described, is that right?

A. Absolutely right.

Q. And so you then come to the conclusion that she is therefore not converting her T4 because otherwise she wouldn't look like that? Is that right, she wouldn't have those features?

A. It is an explanation of this, yes.

Q. And so you decide that she's back stacking, as you put it, her T4, and so you're going to reduce the T4 and give her some T3, yes?

A. Yes.

Q. And that's all on the basis of her, as you put it, clinical signs. If you wanted to know if she wasn't converting her T3, which I suggest is an extremely rare occasion, event, but if you wanted to know if she wasn't converting to T3, why not do a blood test?

A. I don't think blood tests help in this matter. It wouldn't be how I would normally come to this conclusion. One of the ways I would come to -- one of the possible ... and I use the word "hypothesis here is that a patient, hypothyroid, high FT4, why is this high FT4 in conventional thinking not making her thyrotoxic? And a hypothesis is that she's not converting it to T3.

Q. Right. Are there others?

A. Yes.

Q. That's one possible --

A. Yes, that is one possibility.

Q. What are the others?

A. Another possibility relates to the whole question that Professor Weetman drew attention to and has been investigated extensively by Professor Chatterjee in Cambridge, which is called end organ non-receptivity. In other words, in spite of high dosage, the cells in the body are not responding adequately and not doing the job, if you like, in spite of quite high levels.

Q. Why would that be?
A. It would be because the processing of the hormones in the cells is deficient.
Q. For what reason might they be deficient?
A. Well, there's a lot of work that's now examining the receptors. There's a genetic problem in that the receptors to receive these hormones are lacking and not doing the job. So the way round it actually, that has been proposed, is pretty well to increase the dose and overcome it.
Q. So what test did you do to find out if your first hypothesis was right?
A. I think I've said I didn't do a test to --
Q. No. And then you start her off on T3 with no idea, frankly, what was happening to her blood in terms of T3. You just didn't have any idea, did you?
A. I think we've been through that, Mr Kark.
Q. All right. Let us go to the next meeting that you have with her. You know by the next meeting, I think, that there has been a complaint, because if we look at page 13 a complaint has come in to your desk on 9th March 2004 and you know by now, you've read the letter from Dr Jordan -- did you know of Dr Jordan?
A. No, I've never spoken to Dr Jordan, or she to me, in my life.

Q. But she was the medical director of -- is that your local trust, Renfrewshire and Inverclyde?
A. I'm sort of based in Birmingham.
Q. Sorry. Anyway, you didn't know Dr Jordan. You did know a complaint had been made. This is slightly out of turn actually. If we go to page 18. Sorry, I should have dealt with this first. After your second consultation back on 21st January, of course, you changed the prescription and have given this patient T3. It took Tescos pharmacists to effectively say: hold on, I'm not prepared to dispense this. Did you find out quite quickly that a Tesco pharmacist had refused to dispense one of your prescriptions?
A. I was asked this yesterday and I think it was the next day the patient phoned ... I don't actually know how we resolved it, and when the Tesco pharmacist, who I also imagine hasn't seen the patient, decided to release the appropriate prescription, so ... I've forgotten the question, I'm sorry. Please ask it again.
Q. I asked you if you can remember when you first heard effectively that the Tesco pharmacy decided they were not going to release this prescription. Was it quite soon?
A. Yes, I think it was quite soon.
Q. Is that quite an uncomfortable position for a doctor to

be in? Is it quite surprising when, having issued a prescription, a pharmacist turns round and says: hold on, I'm not happy with this?

A. It's beyond comprehension that a pharmacist would do that, yes.

Q. It's very rare, isn't it? It's not beyond comprehension?

A. It's beyond my comprehension.

Q. Pharmacists have a duty, don't they, only to dispense drugs if appropriate, prescription or not. This Tesco pharmacist was saying, "I'm unhappy with this"?

A. The Tesco pharmacist was sufficiently unhappy to not execute her proper duty. I think reference to even a medical textbook would indicate there was nothing abnormal about this prescription. I'm frankly staggered by the pharmacist, but ...

Q. You knew the Tesco pharmacist had refused your prescription. You knew you'd had a complaint in to the GMC, you had letters from Dr Jordan and Dr Blair.

A. Excuse me, this is a point of detail. I had one letter transferred to me from the GMC. I had no letter from Dr Blair. I have never been written to from Dr Blair. This is a factual point. Sorry to interrupt you.

Q. Fine. I just want to test that. Would you go to page 19. Do you see that's a letter from Dr Blair?

He hadn't written it to you, he had written it to the GMC?

A. Yes.

Q. The GMC had sent it to you, hadn't they?

A. It was sent to me some time obviously.

Q. Let me help you. Go back, would you please, to page 13.

A. I could accept I received it at some point. I was only emphasising he himself had never consulted me on the patient. So it might save you time to say I accept it.

Q. Can you suggest that you received it shortly after 9th March?

A. I don't know, but I'm quite prepared to accept that.

Q. I'll tell you why I say that. Page 13 is the letter from the GMC, dated 9th March, and their enclosures include a copy of the letter from Dr Jordan and a letter from Dr Blair.

A. Okay.

Q. Right. So what I was trying to establish is: by the time you come to the third consultation on 18th March, you've had the Tesco pharmacist refusing part of your prescription. You have had a letter, you have seen a letter from Dr Blair and a letter from Dr Jordan. Let's go to your notes of what happened on 18th March and we will find them at page 12 of tab 4.

The typewritten version, of course, is right at the

beginning of the bundle. This woman was then on Tertroxin or not?

A. I'm struggling.

Q. Let me help you. Page 12 is your manuscript note?

A. That's my notes on that consultation in March, yes.

Q. Can you tell from your note when the lady was then on Tertroxin? You will see 75 micrograms and 20 micrograms.

A. Yes, she should have been, yes.

Q. Right, and is there a reference there again to three-quarters of an hour beating heart?

A. Yes.

Q. What is that a reference to?

A. The patient reported that, about a week ago, she had wakened in the night and could hear her heart beating. It then stopped beating and then she came to see me about a week later, I think concerned about this.

Q. I hope it didn't stop beating, it stopped thudding?

A. Thank you, that's helpful.

Q. She told you about that. It was three-quarters of an hour, I think, beating heart, and you say excessive alcohol during the evening. Here you have a patient who has had palpitations previously. She has then had a period of three-quarters of an hour of a beating heart one night. Again, did you think to yourself: well, I'd

better be cautious here with my thyroxine and Tertroxin because that could be causing this lady's heart problems?

A. Yes.

Q. You did?

A. Yes, I thought it was possible.

Q. What did you do about it?

A. The dose was reduced.

Q. So you did think that your thyroxine and your Tertroxin might be the cause?

A. It was a possibility one considers. It's hard to discriminate at the time.

Q. Let's go to page 24, which is your letter following that consultation. You saw your patient on a courtesy basis and you say this:

"As you know, she is now taking 75 micrograms thyroxine per day with 20 micrograms Tertroxin. Seems to be in reasonable shape although I still think she is hypothyroid."

Now, again, was this based purely on the clinical presentation, as it were?

A. Yes, especially her pulse rate of 52, it was getting lower.

Q. That could be all sorts of things, couldn't it?

A. She could be an athlete, but I think that was unlikely

in the circumstances.

Q. Well, apart from being an athlete, do other people sometimes have a slow pulse?

A. Oh yes, you can have a slow pulse, but we have records of her pulse before so we have some temporal information on the matter.

Q. You say:

"I think it would be possible in a canny way, as they say, to increase her input of thyroxine replacement as I personally doubt the strange episode in the early hours of one morning was related to excessive thyroxine replacement."

You may or may not have been right about that. How did you think she was still hypothyroid? What were the clinical signs specifically, apart from the pulse? Anything else?

A. I'll go to my note if I may.

Q. Yes. Page 12 again.

A. One of the running features here, which of course one doesn't record every time you see a patient, is the appearance of a patient. Regretfully she hasn't been called by the prosecution.

Q. What was it about her appearance?

A. Patients who are hypothyroid have a puffy, sort of dull, brooding visage; her eyes are dull; her hair's in poor

shape. I hesitate to mention the art of medicine, but clinicians of some experience get a feel for a patient as well. My feel for this lady was that she was hypothyroid and indeed still is, as I've said.

Q. But this consultation, Dr Skinner, was after a year when you had been treating her with thyroxine?

A. Exactly.

Q. And then you had your worries about back stacking, so you gave her some T3, but you still thought she was hypothyroid. Did you pause for a moment and think to yourself: hang on, she's been on this stuff for a year, she's now full of T3 as well; this isn't working, it must be something else? Did you think that for a second?

A. I think that with every patient.

Q. Right. Well, what do you did about that?

A. I'm not quite sure what point's being made here.

Q. The point is that you continued her on thyroxine, didn't you?

A. Yes, and indeed would resume(?) it. As you see, I have written to the family practitioner to ask him to rethink this a little bit.

Q. Have a look at page 28, which is your next prescription. Sorry to jump about. This is July of 2004. It looks like you've taken her off T3 now, is that right?

A. Yes.
Q. Why do you do that?
A. I think probably to see if she needed it or not because she was in poor financial circumstances. T3 is quite expensive, and long-term I thought it was worth asking the question: could it be that this will do the job and could the -- I was vaguely wondering, could the T3 be involved, as you've rightly pointed out, in this curious episode in the middle of the night.
Q. Can we go back to page 24. At that stage, March 2004, she is on thyroxine and 20 micrograms of Tertroxin, yes?
A. Yes.
Q. And you say in the middle of the page you're going to continue with the 20 micrograms of Tertroxin because it's a canny way to increase her input. Then we go to July of that year and you have taken her off the T3 and she's now on thyroxine at 150 micrograms. How did you come to that prescription? You haven't seen the patient again, have you?
A. I'm looking to see the last time I saw her.
Q. It was 18th March. We just looked at it, page 12.
A. Yes, I did see the patient at intervals, as I've indicated. I'm not saying it was a formal -- she was a friend of the practice manager and I think she told me that she was finding this a bit expensive.

Q. Hold on.
A. So I rethought the thing.
Q. Are you saying you saw -- we haven't heard this before, I don't think. Are you saying you saw this patient and there's no note?
A. Yes, she was a friend of the practice manager. She would often be in the premises when I went to my rooms in Glasgow.
Q. Dr Skinner, are you saying you saw this patient, and it's the first time I think you have said this, in between March of 2004 and July of 2004 and that caused you to change this prescription?
A. Yes.
Q. When did you come to that realisation?
A. I can't remember the point in time.
Q. Why did you not mention it yesterday?
A. I don't think I was asked. It was not a secret.
Q. Well, Dr Skinner, you do understand the issues involved in this case, don't you? You know that it would be important if you had seen this patient to tell the Panel about it. And I just ask: was it as you were sitting there yesterday that you realised you must have seen the patient or today?
A. I don't recall asserting that I had never seen the patient during that time. Doesn't one come across many

patients in the course of one's professional life?
Q. We're asking about you and your patients. If you hadn't seen the patient, would it be fairly unjustifiable to change the prescription or do you think that would be reasonable?
A. In many circumstances it would be quite reasonable following a telephone conversation. That happens day in and day out in medical practice.
Q. When was your last blood test for this patient? I think it's back in December of 2003, isn't it? So seven months before this changed prescription. How did you know --
A. Which was a reduction.
Q. It may have been a reduction, but how did you know what was going on in her body?
A. I would re-emphasise that Dr Blair was ...
Q. It's down to Dr Blair to do that, is it?
A. It's not down to him. I think that's an unfortunate implication but the patient was seeing Dr Blair extremely regularly, he's a competent practitioner.
Q. Yes. Page 25 was, in fact, before this prescription and it was in answer to the letters from the GMC. You say at the bottom of that page, just to give you an opportunity of dealing with this, because I commented on it in my opening:

"It is disappointing that after 40 years of practice, when I have had no complaint or litigious procedure that my professional practice is being sullied by an uninformed and strangely adversarial communication to the GMC."

Had you simply forgotten the problems with Patient A or did you not regard that as a complaint?

A. Did I have that complaint by then?

Q. Well, yes.

A. Did I?

Q. Patient A had written to you asking not to see you again on 6th February 2003. I just ask: had you forgotten that you had had that previous complaint?

A. If that is the case then that contention is out by a figure of 1 and that would seem to be a wrong statement to Miss Floyd, if that indeed is the correct chronology, which -- I'm all mixed up now.

Q. Are you mixed up? Do you mean that?

A. I'm a wee bit mixed up. I wouldn't deliberately say that because it would be manifestly obvious to Miss Floyd that it was wrong --

Q. She wouldn't know.

A. Why would he she not know?

Q. Because the patient hadn't expand to the GMC. The patient had only complained to you. So when you

write to Ceri Floyd saying, "I've never had a complaint in 40 years", she wouldn't know about Miss A, would she?

MR JENKINS: Can we look at tab 1, page 51?

MR KARK: Thank you.

MR JENKINS: It's the last sentence of the letter.

MR KARK: Yes. I'm grateful to Mr Jenkins for pointing that out. Page 51 says, this is the bottom of Patient A's letter:

"I also feel that your mistreatment of me requires the involvement of the GMC to which I make complaint."

Did you actually hear anything from the GMC about that?

A. Lots, but I'm not quite sure when the first intimation was. There was a morass of papers coming from the GMC.

Q. I'm going to move on because there are bigger issues perhaps.

We know, coming back to Patient B, that on 5th August, following your prescription in July, the patient decided to try to reduce and stop her thyroxine. I hope we have that at page 28 of tab 3. Yes, the entry on 5th August:

"Has decided to [then down arrow, which I think means reduced] and stop thyroxine."

Yes?

A. Are you asking?

Q. You can confirm, I think, that that seems to be what the patient decided to do.
A. This is Dr Blair's note.
Q. Yes, I understand that.
THE CHAIRMAN: Mr Kark, a slight confusion, can we just catch up here. I think you're at the bottom of page 28, tab 3; is that correct?
MR KARK: Yes. It's difficult to read.
THE CHAIRMAN: It's hard to read that date at the very bottom. 5/8/04, isn't it?
MR KARK: 5th August 04, and I'll just read my interpretation:

"Has decided to ..."

Then down arrow, which normally means "reduce" in medical terms, doesn't it?
A. I would say that's very fair.
Q. And then "stop", and I think it must be thyroxine. Then, "advised", I think it's, "50 micrograms, every two weeks."

So he's obviously saying to the patient, "Don't just stop it immediately but try and bring it down".

If we look at page 29 we will see an entry against 14th October 2004, I think that is:

"Off thyroxine."

So she's brought it down. This is really just to

finish off this section because you see it was said a number of times by Mr Jenkins that the patients felt better on thyroxine. That is your comment as well, isn't it?

A. Yes.

Q. If we go to page 122 of tab 3, she writes and we heard in evidence this was around the beginning of 2006, she writes:

"I have not noticed any difference since the pills finished and feel that I am well on the road to recovery", and then thanking the doctor for being understanding.

Then, finally, just to finish this section, file 2, tab 1, page 3. You wrote to Dr Blair again, didn't you, in October of 2006?

A. Yes.

Q. You can turn it up, but I'll read it to you and if I get it wrong I'm sure people opposite will jump up.

25th October 2006, you say:

"Dear Dr Blair, a note on Patient B who did not specifically come in for a consultation, but came to see her friend. As you know, she stopped her thyroxine, but it seems to me that she is still hypothyroid because she was tired and has scattered aches and pains and difficulty in cognition. Her pulse rate was 62 per

minute and blood pressure 150 over 80. Notably overweight with dull, puffy eyes. It is interesting that indeed her pulse rate was 62. When you kindly saw her she was taking 200 micrograms thyroxine a day. I took a blood sample which is enclosed and, as so often happens in my view, the thyroid chemistry was fairly normal, but I know it is a controversial area. I really do think that Patient B is hypothyroid. Perhaps you might give some consideration to the possibility of reinstituting thyroid replacement."

Her T4 was 14.1 , and her TSH was 1.92. Even in these circumstances you were keen to restart the thyroid therapy, weren't you?

A. Yes, I thought that was the correct way forward, which is why I flagged it up for consideration by Dr Blair.

Q. Let me move on to Patient C.

Could we take up the heads of charge. Do you still have the blue pieces of paper?

A. I do, here it is.

THE CHAIRMAN: We are still with Patient B, are we, then?

MR KARK: Yes, we are.

Could you go to 8e. You criticise this charge and I don't take any umbrage with that. But I just want to see if you can help us. You provided Miss B with a prescription of Sodium Thyroxine, 100 micrograms per

day, until 17th June 2003, to be followed by 125 per day for three months thereafter.

What you did at your first prescription on 20th March was you gave her 25 micrograms for a week; is that right?

A. Yes.

Q. Increasing to 100 micrograms?

A. No.

Q. Sorry, to 50 micrograms.

A. Yes.

Q. For, is it three weeks?

A. Yes, it would usually be. I think it would be.

Q. To be followed by 100 micrograms?

A. Usually 75 -- I apologise, I can't find a copy -- and then 100.

MR KARK: All right. Thank you.

Charge 17 -- no, we're moving on to Patient C so let's leave that aside until we start Patient C.

Madam, are you content for me to continue until 1.00 or would you like to take an early break?

THE CHAIRMAN: It's up to you really, where you feel a good break would come. It could be appropriate if you would like to start afresh with Patient C.

MR KARK: I think that would probably be good for both Dr Skinner and myself.

THE CHAIRMAN: Right. Until 1.45 then.

(12.45 pm)

(Lunch Adjournment)

(1.45 pm)

MR JENKINS: Before Mr Kark resumes, could I indicate that I did have a word with the learned legal assessor before the luncheon adjournment and I have raised a concern that there might be some expressions from the members of the public at the back of the room which might be distract for the Panel, and I have asked people as best they can to show a neutral visage when they hear the evidence.

THE CHAIRMAN: Thank you.

MR KARK: Dr Skinner, we were going to turn to Patient C and, as you know, you will find the notes in relation to Patient C in the back of tab 6.

Your first consultation with her took place on 6th March 2004. It is tab 6.

Her symptoms were that she was tired, she couldn't get up --

THE CHAIRMAN: Sorry, are you looking for your spectacles? Are you happy to go ahead?

A. I have two, you see. Thank you, ma'am. I have a pair on. I think I can cope with this one pair. Also, apologies for being a little late. Normally someone

comes and escorts me, but I don't know what happened.

THE CHAIRMAN: All right. Thank you.

MR KARK: Obviously if you need your other pair of glasses we will sort it. Tab 6, we have your typewritten note. The first consultation took place on 6th March and your notes are that she was now really tired, can't get up in the morning, poor memory, concentration jumping about, weight had increased by a stone up to 9 stone, periods irregular, she felt cold, twitching legs, weepy, side vision hallucinations of grey things and poor libido.

There's no note there, I don't think, of what you decided to do. Right at the bottom we can see treatment further tests, fasting blood glucose, urine glucose and T4 and TSH. So is that a reference to taking blood tests?

A. The FT4 and TSHs and the other is an aide memoire.

Q. What test did you do? Your notes are at page 1.

A. Yes, measured the free thyroxine, the thyroid stimulating hormone, and drew to the practitioner's attention the question of possible diabetes.

Q. Right. So you say in your note to the practitioner, Dr Summers, that we have at page 2:

"I may be in the doghouse, not having a referral. Her pulse rate was 60 a minute, with rather dry skin and

hair and I thought it quite likely she was hypothyroid, although not seriously hypothyroid, and I have taken a blood sample and I will let you know what goes forward at that point of time."

She has a family history of diabetes."

What did you do with this patient after 10th March? Did you give her a prescription?

A. Yes.

Q. Did you give it to her at her first consultation?

A. Yes.

Q. Do you know where it is?

A. The prescription I gave her, no. Do you mean is there a copy in the notes?

Q. Yes.

A. No. I don't know why there isn't, again.

Q. And there's no note in your note of not only what the prescription was, you haven't noted the fact that you have given a prescription, have you? You haven't even noted thyroxine, unless it doesn't appear in your typed note and it does appear in your original?

A. I haven't noted down my intention at all here, I accept that.

Q. Did you not think it was relevant for Dr Summers to know that you had started her on thyroxine?

A. Yes, I do. I think what happened is I was waiting for

the thyroid chemistry and perhaps going to write to him again, but I don't think I have written to him again in ten days' time.

Q. But given that your patient had -- not your patient, Dr Summers' patient had just been to see you when you write this letter on 10th March, was there any reason why you didn't mention to her GP that you have placed her on presumably an increasing dose of thyroxine?

A. None whatsoever.

Q. You see, the impression that you might be thought to be giving in the third paragraph is that you're going to wait for the blood sample; you are going to get that in 10 days' time and then you are going to take it forward from there. But that wouldn't be quite accurate, would it, because you started this patient on thyroxine before you even got the blood sample back?

A. I don't know if I did that or not. It's simply not recorded. The third paragraph, I think I've said, "I'll let you know what goes forward". I don't think I specifically said what you're saying I said, that I wasn't going to start her treatment before then.

Q. What did you mean by "what goes forward"?

A. Well, essentially, here is the blood test, as you see I have done with other patients, and it seems a reasonable way forward. But I simply can't remember

in March 2004 my thinking at the time. I don't understand why there's not a copy of the prescription. The same applies to Patient B.

Q. Then you get the blood test back and when you got this blood test, which showed another patient to be within the reference range and having, even by your own standard, thought that she was -- let me just get the expression right -- "quite likely to be hypothyroid but not seriously so", when you got that blood test which we have at page 3, did you think for a moment, "Ah, hold on, that doesn't bear out what I originally thought"? Or do you think it does bear out what you originally thought?

A. I think it bears it out.

Q. On what basis; on what standard?

A. I don't want to be tedious, although I have. May I use the board?

Q. I wouldn't mark that board, no. If you need to use a board, yes.

Do you want a clean sheet of paper?

A. Whatever is deemed to be correct.

This is the 95 per cent reference interval, which, it seems a bit pedantic to remind you, but that is 95 per cent of whichever population was sampled.

Now, 11 is here (indicating). So a point

I addressed before was that I would be surprised if it was alleged, which in fact Professor Weetman alleged, that you're in or you're out. It seems to me that there is a difference and likely to be a difference in a patient who is there (indicating) or a patient that's there (indicating).

So given the patient's clinical features, I myself would be happy that that is consonant with it, and similar consideration to the TSH of 2.2. That is on the new US reference range which goes up to 2.5.

Q. Do you see the US reference range is, first of all, not the standard applied in this country. It's based on a different population, presumably, with a different diet, et cetera. The UK reference range is 0.4, for this laboratory, to 5.5.

Even applying the US reference range, this lady was within it, wasn't she?

A. That's beyond dispute.

Q. Yes.

A. I have agreed with that.

THE CHAIRMAN: Can we make that exhibit D10, please. Thanks.

A. Indeed, the UK reference range, some advocates have said it should be 10 before you decide a patient is hypothyroid.

MR KARK: Because the evidence that we have heard is that most patients, certainly that Professor Weetman had come across, didn't actually show any signs of hypothyroidism.

A. No signs of hypothyroidism?

Q. Under about 10.

A. I think you're saying that -- Professor Weetman said that no patient under 10 --

Q. No, he didn't say no patient under 10. I don't have an immediate note, but my recollection is he said he had rarely seen clinical signs. You don't agree with that?

A. I'm astonished at that assertion, to be honest, but that's Professor Weetman's assertion.

Q. Let's see how this moves on. You start your patient on 6th March on thyroxine. You get the blood tests and you don't accept that that should dissuade you. You write to Dr Summers but you don't mention to him that you put her on thyroxine.

Then we turn to page 4 when you see the patient again. So she has been on thyroxine for two months or thereabouts and, at that stage, she was taking, is it 200 ... I can't see where you've got a note of it, actually.

A. You have seen my letter to the practitioner.

Q. Yes, but is there a note in this second consultation,

first of all, of what she's taking? Can you look at page 4?

A. It says: 200 micrograms for three weeks.

Q. I'm sorry, where is that?

A. I'm on page 7.

Q. I think -- I'm not sure the date of that. Anyway, you say that's 8th May 2004?

A. That is what it says on the top left.

Q. Well, I think somebody's written in "20th May query", but in any event if these are your notes of the second consultation, the patient is taking 200 micrograms -- no, 150 --

A. No, no, that was my proposed treatment. The top says what she was taking, yes.

Q. Sorry. She was on 200, your prescription was to bring her down from that to 150, but you are adding in Tertroxin?

A. Yes.

Q. What was the reason for adding in Tertroxin?

A. Very much as I have said before, that Mrs C, when she herself put her dose up to 200, did not allege much improvement. I think I've said previously that if a patient plateaus on thyroxine, that is a possible explanation of it.

Q. Right. So this was another conversion problem?

A. Yes, it could be.
Q. Let's have a look at what you say at page 6. This is to Dr Summers following that second consultation:
"Already improving on thyroid replacement although she had recently put up her dose to 200 micrograms with, curiously, no thyrotoxicity."
Your basis for that comment was what?
A. Could I ask you to --
Q. Sorry, page 6?
A. Yes. Which part of the comment, the brackets or the generality?
Q. I'm sorry.
A. There are one or two sentiments expressed.
Q. You're quite right, "Curiously, no thyrotoxicity".
A. "Curiously", is that what you're surprised about?
Q. What's your basis for saying there's no thyrotoxicity?
A. Oh, no thyrotoxicity. Because I couldn't find any when I talked to the patient and examined her.
Q. But you didn't do a blood test, did you? Are you seriously saying --
A. Yes, I didn't do a blood test.
Q. -- you can tell from looking at the patient whether she is thyrotoxic?
A. Yes, I am saying that.
Q. All right. But in any event, you reduced her dosage,

you added in T3. Again, if you were concerned about this idea of non-conversion, an easy way to find out would have been to do a T3 check, wouldn't it?

A. I've already said I don't think that really helps very much.

Q. Well, if you find that there is plenty of T3 in the system, is that not going to tell you that the problem lies not in the conversion, but that you got the wrong diagnosis in the first place?

A. I don't agree. I've looked at the ratios of FT4 to FT3 in a number of patients and it's fairly chaotic. The second thing in response to your question, which hasn't really arisen so far in these discussions -- or there are two points. There is a degree of fluctuation, in fact, I'm sure Dr Hertoghe will discuss this, when you take these measurements in relation to various other factors. It's a large subject.

But the other point I think which is very important: this test doesn't measure activity; it measures presence. It's an immunological test. What you measure could be dead or alive. The analogy I would give is that a graveyard or a dance hall could have the same number of people but considerable difference in the activity. That is another explanation for the bizarreness, if you like, of Patient B having FT4 of 39

and hypothyroid.

Q. You see, your dosage of T3 was in order to deal with that, as you saw it, failure to convert. How do you suggest the patient takes her T3?

A. By mouth.

Q. How often a day?

A. It depends entirely the dosage. The 20 micrograms is the size of the tablet so, in this instance, once a day.

Q. Do you agree with the evidence that we have heard that the problem with Tertroxin is it has a very short half-life and giving a patient one tablet a day simply isn't going to sort the problem out? Do you accept that?

A. No, I don't accept that. In fact, I don't really understand it.

Q. Why not?

A. Why don't I understand it?

Q. Yes.

A. That assertion? Because there isn't a correlation between blood level of thyroid hormones, it's what it does to the tissues. In answer to your question, if you stop a patient's thyroid hormones abruptly it takes about 3/4 weeks for the patient to decline back with hypothyroid features. So first of all, the half-life does not directly relate to the clinical status.

Q. Have you done any research about this, about patients being on T3 and the effect it has on them over the course of a period?
A. Yes.
Q. That's based on what? What sort of research did you undertake?
A. Careful observation over 10 years of practice.
Q. Right. I thought -- yes, I'd better not comment.
A. Sorry, I can't hear you.
Q. I was going to comment and I realised I had better not.

Let's turn to page 10, which is the next blood test that was obtained following that consultation. Now, this is a blood test taken, I think, on 7th August. I'm sorry, can we go to the page before, first of all, my apologies, page 8.

The consultation, the next consultation, is on 7th August. Yes? I know the date's been knocked off but I think we've established by now that it was 7th August.

MR JENKINS: Page 8, the date is on.
A. Yes, it is 7th August.
MR KARK: On my copy it has certainly been knocked off the top.

On this occasion you prescribed the patient 150 micrograms and 20 micrograms of Tertroxin plus B12?

A. The first part -- this is in August. No, I didn't prescribe that. The patient was going to ask Dr Summers if he would prescribe it. And the B12 she had been taking, she did take things off her own bat, as I said.

Q. Right. And you get the blood test results, if we look at page 10, and her blood tests reveal by this stage that her T4 is at 25.5 so beyond the reference range, her TSH has disappeared so that it's negligible or unrecordable, and her T3 is 8.9 so beyond the reference range.

Your comment about this was that the reading is quite acceptable, given that she was not thyrotoxic. Again, I'm sorry it's tedious, but by what standards did you form the opinion that she was not thyrotoxic?

A. Through the history and clinical examination.

Q. At page 9 you write to your patient:

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

Did you send that test to Dr Summers?

A. Yes.

Q. Is there a letter, covering letter, for that?

A. Patient C indicated that she didn't want a letter sent as she was planning on changing her family practitioner,

the wherefores of which I don't know, and would let me know the name of her new family practitioner. It was Dr Cundy. She doesn't, in the event, let me know that and I must confess I didn't pursue the matter at that point in time.

Q. When Dr Summers gave evidence he said that if he had seen the blood test, and this is going back to the original blood test, he would not have prescribed her thyroxine. Do you remember that?

A. I recall it very well.

Q. And that he was simply relying on your letters as a diagnosis of hypothyroidism. Do you say that you did write to him and you did include the blood test?

A. I think it's clear I wrote to him and I always send the blood test to the family practitioner and, if it is different, the referring practitioner.

Q. Yes. You see, again you have claimed on a number of occasions this patient was, I think, getting better from the thyroxine. But I just want to look at what the patient notes record. If we go back to tab 5, page 1 --

A. These are the family practitioner's notes?

Q. Yes. What the patient is revealing on 7th September when she sits down with Dr Ince was that she wasn't sure if she was happy with her prescription. Now, it's true to say that she also reveals that she's on

150 micrograms thyroxine, which you accept, I think you had given her? Yes?

A. I think Dr Summers had.

Q. I beg your pardon, all right yes, Dr Summers had been giving her, but purely as a result of what you had said?

A. Yes, under my suggestion.

Q. And two others to potentiate. One of those, presumably, was Tertroxin. Do you know what the third one was?

A. I haven't been advised of this curious thing. I don't know what it's about.

MR JENKINS: It's tab 2, page 2, of the other bundle.

MR KARK: Okay. Is it Armour?

MR JENKINS: It's what it says.

MR KARK: It looks as if it was probably Armour.

A. I wonder if it might be the B12 she puts herself on, but that's complete speculation.

Q. Could we just look at what happened to her TSH level, because Dr Ince thought it was sensible to check that. Same page, 24th September, her T4 level's gone up to 21.7, her TSH level is 0.01 and that's the sort of TSH level that wouldn't bother you; is that fair?

A. Sorry, TSH level, I wouldn't be concerned if the patient, again sorry to be tedious, shows no signs of thyrotoxicity.

Q. Can we see what you wrote on 3rd October to this lady's

insurers. We'll go to tab 6, please, page 11 first of all, where you're asked what are the current signs and symptoms the patient is suffering from.

Can I just ask: are you on the list for any major insurers?

A. You mean the likes of BUPA and PPP?

Q. Yes.

A. No, following my first Interim Orders Panel, the General Medical Council wrote to them and, because of that, they took me off their list about two years ago, so --

Q. At this time were you then on the list of BUPA?

A. I have to work out, first of all, this date. I'm not good at dates.

Q. September 2004.

A. I wouldn't have had my first IOP then so I would be, yes.

Q. Can we go to your letter to the insurers, page 14.

A. What tab, please?

Q. Let's stop and slow down. It's tab 6.

A. Sorry.

Q. That's all right. And page 14. Are you with us?

A. Yes, thank you very much.

Q. Okay. You write this:

"She is showing residual clinical features of hypothyroidism with ongoing fatigue, poor memory,

concentration and insomnia. There has been an improvement in both symptoms and signs since the treatment has been instituted. The treatment is thyroid replacement using thyroxine and Tertroxin and/or B12. Readjustment of dosage until the patient is returned to optimal health. Thyroid replacement will remove the symptoms but will not of course cure a fundamental thyroid deficiency."

What is that a reference to? What thyroid deficiency?

A. Well, what was intended, and I think it's quite reasonable, is that if the patient stops treatment she will return to having symptoms and signs. We may not know the fundamental thyroid deficiency. It could be traumatic, infectious.

Q. But you've done no test to find out, have you? You have done no autoimmune antibody test?

A. I have not tried to identify the aetiology of the thyroid deficiency. I think it suffices at this point to say that I thought I had identified such.

Q. Then you say:

"The prognosis is excellent and, while the patient needs regular follow-up, it is not a chronic condition in the sense that the patient will continue to suffer."

What do you mean by that?

A. Which part of the sentence?
Q. Well, first of all, "The prognosis is excellent". The prognosis was excellent, was it, if she carried on with the T4?
A. That would be my view at the time.
Q. But it's not a chronic condition. What does "a chronic condition" mean?
A. Well, chronic arises from the Greek chronos: time. It means that it goes on a long time and it will go on for the rest of the patient's life.
Q. Right. Well --
A. Given she is not treated, but there would be no reason for her not to be treated.
Q. But you say:

"It's not a chronic condition."

What you mean surely is: it is a chronic condition, but she can be treated as long as she keeps taking the tablets?
A. Yes, but the sentence says, "Needs regular follow-up" and if the patient's having regular follow-up one fervently hopes it's not a chronic condition or your treatment's been a failure. I'm not very sure what you're driving at here.
Q. I'm trying to establish with you whether 5 and 6 are compatible with each other.

A. Okay.
Q. And you say they are?
A. I do.
Q. I see. We move on from 3rd October. We know that what else was happening with this patient back at her surgery is that Dr Ince was concerned about your prescription and the patient notes reflect that the patient felt no better, she said, on thyroxine. That's page 1 of tab 5.

Your take on this, for want of a better word, but your observation of the patient, and this isn't the first time that it's happened, seems to be different to what the GP is seeing. Would you accept that?

A. Yes.
Q. On a number of occasions you seem to see the patient getting better but when we look at the GP notes, we see comments such as this at page 1, 5th October:

"Has been seeing specialist but feels no better on thyroxine."

Do you have any explanation for that or not?

A. Yes.
Q. What's that?
A. You have to return to the time factor. I didn't see the patient in October. It's perfectly conceivable she wasn't feel better then for reasons I don't know. My statement was made when I saw the patient and she

certainly said she was feeling better.

Q. Right.

A. And got promoted in her job.

Q. Let's have a look at Dr Ince's letter to you, which is at page 9 of that same tab. Let's stay with tab 5 for a moment, page 9 where she writes:

"I would be grateful if you could provide with me more information about the diagnosis of hypothyroidism in this lady. Please confirm the symptoms she was suffering from at the time and also any blood test results that you have, which confirm the diagnosis. Please clarify the dose."

Yes?

A. Yes.

Q. You write back to that on page 11:

"I was consulted by Patient C in March following another spot of confusion."

In other words no referral.

Then this:

"As you say, Patient C had a number of features and I thought her thyroid chemistry was suggestive of hypothyroidism."

Let's stop there for a moment. Where had Dr Ince said that the patient had a number of features?

A. She didn't, and it's manifestly a typing error referring

to the paragraph above. I have enclosed a correspondence, and it should say: "as you see". So I apologise for that. I think that's reasonably obvious. I'm not going to say Dr Ince said something she didn't say.

Q. So it should be:

"As you see from the correspondence to your practice to date, she had a number of features and I thought her thyroid chemistry was suggestive of hypothyroidism."

I will not go through that again. I think we disagree on that?

A. Yes, we disagree on that.

Q. "As the years go by I become less and less reliant on thyroid chemistry as an index of diagnosis of treatment level [treatment level] in hypothyroid patients."

That I suppose is consistent with your evidence to this Panel that there is no TSH level with which you would be uncomfortable. Is that fair?

A. It's fair on the low end. I would be uncomfortable if a patient came and they'd a TSH level of 84 but, within the context of this discussion, it is fair.

Q. I won't turn up the letter but you know that Dr Ince took advice from Dr Prentice. Do you remember that?

A. I do remember that letter, thank you.

Q. Dr Prentice's -- it's in the other file, I'm not going

to turn to it -- view was that this patient was hyperthyroid. Do you remember that?

A. Hyperthyroid?

Q. Hyperthyroid. Yes?

A. I think he said that. We can look it up but I'll accept he said that.

Q. If anyone wants to check, file 2, tab 2, page 5, I think.

That was no doubt on the basis of a TSH which was unrecordable. The earlier TSH had been unrecordable at 0.01 and the T4 had, in fact, been 15.

Can we just turn up the letter? You don't need to, although please feel free to do so. It's file 2, tab 2, page 5.

He says:

"As you say, the patient appears to have been started on thyroxine in spite of normal blood tests and the repeat results on 16th August [which we have in the other file at 6, page 6] which you kindly forwarded showed that she was in the hyperthyroid range for both free T4 and free T3."

That blood test is in your own notes, I think. But in any event, he was saying she was hyperthyroid. You don't accept, do you, that simply because a TSH is low or unrecordable and T4 is very high, that that patient

is necessarily hypothyroid?

A. The T4 and low --

Q. No, T4 is low and TSH --

A. You said very high.

Q. All right. Beyond the reference range.

A. Thank you. No, I don't.

Q. And, eventually, we know that Dr Cundy reported this to the GMC and you wrote to the GMC and your letter is at page 7, I think, revealing your disappointment that Dr Cundy had made a complaint.

THE CHAIRMAN: Sorry, we're back to file ...?

MR KARK: 2, tab 2, page 7 and 8.

Just to be fair to him, I think you assert that Dr Cundy asserted that the patient had been started on thyroxine of 200 micrograms. That wasn't his error, actually, was it? It was Dr Ince who made the error?

A. I don't know who made the error. Was it not Dr Prentice who asserted this for some bizarre reason?

Q. In any event, it certainly wasn't Dr Cundy.

So far as Patient C is concerned, you put her on to thyroxine when her blood levels were such that, I would suggest to you, no endocrinologist would have started this woman on thyroxine treatment.

Do you accept that?

A. I don't know if it's in order but I keep drawing your

attention to a survey that I'm carrying out at the moment, which would rather gainsay that.

Q. Dr Skinner, let me make my position clear. You can call as many endocrinologists as you can find to give evidence before this Panel that would support your contention that they would have treated this patient in that way. All right?

A. I did not say that. I said I would like to draw attention to my survey which I have done, which --

Q. No. If you want to call evidence of that which can be tested by cross-examination, you are very welcome to do so?

A. Thank you, I would like to.

Q. Let's finish off looking at the charges in relation to Patient C. Head of charge 17: on a date unknown before 8th May 2004, you prescribed Miss C with Sodium Thyroxine.

I think your evidence has been that, in fact, you would have prescribed her with thyroxine on the day of the consultation, the first consultation, which was --

A. Yes, I think so. As I said, I can't find my copy. I don't know why.

Q. So if we were to put in the right date there, 6th March 2004, you prescribed Miss C with Sodium Thyroxine and leaving out the words "of unknown

dose" and indeed "for an unknown period of time", leaving those out, you would accept that you prescribed her with Sodium Thyroxine?

A. Yes, thank you. I think that's reasonable and I appreciate that because it's not in the note.

THE CHAIRMAN: Will you just confirm that date again on 17?

MR KARK: 6th March is the date of the consultation.

THE CHAIRMAN: Thank you.

MR KARK: On 8th May, head of charge 19b, again if we were to remove the words "for an unknown period of time" that is simply a reflection of the evidence that we had at the time. You would no doubt admit that?

A. I would.

Q. All right. The same does not apply for 21b because you say you didn't provide that prescription, that was provided by Dr Summers but upon your advice?

A. Yes.

Q. Could I just ask you about 24b, which asserts that the blood test following the results from 16th August -- and I'll try and find you the page in a moment. It is at tab 6, page 10. Could you just turn that up, tab 6, page 10?

THE CHAIRMAN: Of file 1.

A. Thank you, ma'am. I have it.

MR KARK: Okay. Can you just have a look, the T4 shows

that -- this lady's T4 is 25.5, outside the reference range. Her free T3 was 8.9, outside the reference range, her TSH was unrecordable.

The wording of the charge is that the blood test results demonstrated that Miss C had become biochemically thyrotoxic.

Ignoring signs and clinical symptoms and all the rest of it but just concentrating on biochemically, do you agree that she was thyrotoxic?

A. No.

Q. At what stage would you say a patient does become thyrotoxic?

A. When the clinical features indicate it. I'm querying this charge's wording "biochemically thyrotoxic". I don't think a laboratory test can be thyrotoxic. I'm not trying to be facetious. I would accept the charge if it said the blood test lay outside the 95 per cent reference intervals, which would seem to be an accurate display of the situation.

Q. Are you saying that -- it doesn't matter what the readings and the blood test are, the patient is never biochemically thyrotoxic?

A. I'm not saying that.

Q. Right. At what point would you say they'd become thyrotoxic, just on a blood test?

A. A blood test cannot strictly be thyrotoxic. If you're asking me if a patient suddenly appeared and said, "My F thyroxine level is 100", it would be a foolish man indeed who would not very carefully examine that patient to see if they were thyrotoxic. My quibble with this charge is the phrase "biochemically thyrotoxic". I think it's almost a contradiction in terms, not quite as strong as that.

Q. Let's move forward.

Patient D, please. Again, I think this lady was certainly not referred to you, was she?

A. Certainly not. Indeed the opposite.

Q. Because Dr Stewart didn't want to send her to you and wrote to her on 19th July 2004 to say, "Your thyroid tests are completely normal", and he wouldn't refer her to you. Her TSH level, which we have at 7/6, if anyone wants to check it, was 0.67 and her T4 level was 13.

Nevertheless the patient calls you. You then write back to Dr Stewart, having discovered what he's written about you, and you threaten at the bottom of page 7, tab 8, file 1 -- let's just start, actually at the top of the page:

"Patient D has passed me a letter from you, which makes reference to my medical practice. I'm sure you know that I've never met this patient and thus the

predication that I would be prescribing thyroxine for her would seem to be presumptuous to say the least."

It was nevertheless right, wasn't it?

A. In his predication.

Q. Yes.

A. He was absolutely right.

Q. Because this lady who walked through the door with what some would say, or anybody would say, were blood tests within the normal range, nevertheless gets her thyroxine.

At the bottom of the page, page 7, you complain that he's sullying your professional reputation and you seek legal redress. Did you?

A. No.

Q. We've got the patient's history as written out by her, page 10, tab 8. She hadn't felt completely well since her pregnancy. She was asthmatic, she had allergies and she had been on Prozac. She meets you on 24th August and you start her on thyroxine, yes?

A. Yes.

Q. Again, was there a differential diagnosis here other than hypothyroidism?

A. There is a differential diagnosis in every patient.

Q. What did you think might be her other alternative problem?

A. I didn't think there was a strong indication that there was an alternative problem at all. I think the patient herself confirmed that to the Panel, manifestly, when we saw her.
Q. She wanted to come to see you because she thought she had the signs and symptoms of hypothyroidism, didn't she?
A. Yes, she certainly did.
Q. Do you make efforts to ensure that you are not actually conducting a process whereby you're simply agreeing with the patient's belief in their own problems? Do you guard against that sort of consultation?
A. It's never occurred to me in my professional life that that was part of my modus vivendi, I have to say. Are you referring to, like Professor Franklyn, continuing thyroxine in a patient she didn't think had hypothyroidism? I try not to do that.
Q. This was a patient who comes to you hoping that this is going to be a cure for her ills, as most of your patients do, don't they? When they walk through your door --
A. Every patient's looking for a cure.
Q. Yes, but when a patient walks through your door instead of the Birmingham Endocrine Unit, so they turn left instead of right, as it were, they don't go to the

Endocrine Unit, they walk through your door because they believe in general they have hypothyroidism, don't they?

A. Many have come to the end of a long trail where they've believed this for many years.

Q. They think if they walk through your door, they're going to get thyroxine when they walk out of it?

A. No, I don't agree with that part.

Q. How many of your patients who walk through the door do you find actually do suffer from hypothyroidism? Can you give us a percentage?

A. Yes, I did yesterday. A very large number, but a large number, I refer -- I said to you before, half the patients are already taking thyroxine. About half of the other patients I refer to the family practitioner because I'm not always sure of the diagnosis.

Q. So of your patients that do walk through your door, you say a very large number. Can you give us a percentage who were actually, in your view, hypothyroid?

A. Of the patients who don't come on a prescription? Who don't come already --

Q. Who come for a diagnosis.

A. I would say about 95 per cent.

Q. Does that mean that about 95 per cent of those patients walk out either with a prescription for thyroxine or with advice to their general practitioner to give them

a prescription for thyroxine?

A. Yes.

Q. You write a letter to Dr Blanchard, page 13, and you are writing to Dr Blanchard because, obviously, your relationship with Dr Stewart isn't necessarily going to be a good one. So you write to another partner in the practice and I don't criticise you for that.

A. Yes, the patient asked me to write to Dr Blanchard.

MR JENKINS: At page 1 of that tab, he's given the name of Dr Blanchard as the GP to write to.

MR KARK: I'm not making any criticism. I can understand why you might not want to write to Dr Stewart having received the missive that you did.

A. Thank you.

Q. Page 13, middle of the page:

"Patient D has a five-year history of exhaustion, falls asleep most of the time, scattered aches and pains, poor memory with interesting side vision hallucinations which are very common in hypothyroidism and poor soul was weeping. She had an enlarged thyroid gland and her TSH was perfectly normal. But TSH levels are good servants but bad masters."

I just want to ask you momentarily about that. Once a patient is on thyroxine, the TSH level is, you would say, pretty irrelevant, isn't it?

A. Unless it creeps up for some unaccountable reason. It tends to shoot down pretty quickly, as Professor Weetman drew a graph emphasising the slightly one-sided correlation to the log of the TSH. It's irrelevant, with respect to how the patient feels. I do apologise for reiterating this so many times.

Q. It's quite all right. I keep asking you.

A. You do indeed, Mr Kark.

Q. Just to make this clear, you don't actually make any effort to keep within the reference levels, the TSH reference level.

A. Certainly not.

Q. You think that's an irrelevance?

A. I do, given how the patient feels.

Q. All right.

You write to the patient. If we could go to page 17 of tab 8. You enclose the blood test results that you have obtained. This consultation, just to remind ourselves, was back on 24th August so these blood test results were as a direct result of that.

The blood test results show that her T4 was 14.2 and TSH was 1.9. Now, 14.2, my maths has never been very good, but isn't it almost bang in the middle between 9 and 22 in terms of the middle of the reference range? If you put 14.2 on your diagram -- do you want to do

that?
A. Yes, by all means. We have to divide it up into integers first, don't we? I'm going to put it there (indicates). Will you accept that?
Q. I'll accept that. How much closer to the middle of the reference range would you think it could get, as it were?
A. Quite a lot.
Q. Within a point or two?
A. No, no. The mean of a non-normal distribution doesn't sit in the median value. I've counted up lots of these values and the mean runs about 17. Now, it's 0.1 away but it's not exactly up there. (Indicates).
Q. What about the TSH, TSH 1.9?
A. As Professor Weetman drew, and I have confirmed this with my own clinic, it's a skewed distribution whereby the average lies about 0.9. So the probability of getting values as you go this way becomes less and less. 1.9 would be about there (indicating). It would be in no circumstances regarded as abnormal.
Q. All right. Can I ask you this actually: have you ever had a blood test that you've had a look at and you thought, "Well, despite my observations of the patient, that patient is so dead in the middle of the TSH reference range and the T4 reference range that really

I ought to look at this again"?

A. I'm so frightened to be tedious. Again, a blood test in isolation is almost a non-concept. I have had patients where the clinical features were not dramatic and might even be marginal. Then certainly, if the free thyroxine was in the middle or higher or near the upper limit of the reference integer, you would think again.

The notion of medical practice taking laboratory results in isolation is really a non-concept. It doesn't exist.

Q. Let's see what you wrote to the patient, page 17:

"I enclose your thyroid chemistry [which we just looked at] and although it is not significantly abnormal, I believe you may benefit from a trial of thyroid replacement."

"It's not significantly abnormal"; it's not abnormal at all, is it?

A. It's within the reference intervals. If I'm allowed to say, I'm writing to a patient here and --

Q. Exactly. That's exactly right. This is a patient who is going to listen to you very carefully as to whether she should take thyroxine or not?

A. Oh, indeed, absolutely.

Q. When you write to a patient there's a duty to be clear and absolutely accurate, isn't there?

A. Within slight limits of not worrying a patient unnecessarily, but I accept that.
Q. I accept that.
A. There could be circumstances where you might not.
Q. You certainly mustn't mislead the patient, though, must you?
A. No.
Q. Why did you write though this woman "although it's not significantly abnormal"? Why didn't you just write, "It's not abnormal. It's within the reference range, but nevertheless ..."?
A. I don't know.
Q. Then you receive the letter, page 19, from the practice, asking you to discharge the patient. Can I ask you to go to page 23, please.
That's your prescription for thyroxine, which is actually a day before the consultation, isn't it?
A. Yes. That has been brought to my attention, yes.
Q. Are you disturbed by that?
A. Well, I know full well, unless I've slightly taken leave of my senses, I'm not writing the prescription out the day before the patient comes. I think it's some date thing. I do often get a bit mixed up with dates.
Q. It would be quite inappropriate, wouldn't it, to write out a prescription for a patient before you have seen

them, as if you knew exactly what was going to happen?
A. Has that been alleged by the prosecution?
Q. I'm asking you, do you agree that it would be quite wrong for you to print up a prescription for a patient in advance of a consultation, a prescription for thyroxine?
A. Yes, I understand, for thyroxine. I think "quite wrong" is strong. It would be rather odd and I can't imagine anyone doing it, honestly. It wouldn't be the end of the world. A patient might have phoned or something. I don't know, but I didn't do it anyway.
Q. Then we have the notes of the consultation at page 24. The second consultation is 18th November, which is at the top.

Do you change the dose here, can you help us?
A. I'll try. Let's see. Where are we here ... on the 17th I suggested 125 for three weeks, 150 per day for three weeks, and 175 per day for six weeks.
Q. Yes.
A. Why do you --
Q. Is that the prescription that you actually gave her?
A. I think so.
Q. Is that a change from previously, from what she had been on before? Can you help us?
A. I want to find my notes before that.

Q. Well, the earlier consultation is page 11.
A. Yes. On that occasion, I suggested she took at the same sort of time integers, 50, 75, and 100, and I've noted when she came back on the 18th that is what she was doing. That's that wee note on the top right.
Q. This is a change of dosage, isn't it?
A. Do you mean after I had seen her?
Q. Yes.
A. Yes.
Q. I didn't mean between the prescription and the --
A. Yes, yes, was the answer I should have given.
Q. It's an increase in dosage?
A. Yes.
Q. You next see her on, I think, 23rd February 2005.
A. Yes.
Q. And we have that at page 24. Again, can you tell us what happened to the dosage there?
A. I recommended that she can increase the dose to 125 per day, alternating with 150 per day, for three to four weeks, and then proceed to four weeks -- sorry, four weeks at 150 per day, but proceed on the 125 for another month and I wrote to Dr Blanchard to advise that I was increasing the programme.
Q. Your last blood test was, of course, back in August of 2004. Do you think now, on reflection, you should have

taken further blood tests or do you think that would have been redundant?

A. I think you do if you judge it necessary. It's not necessary to do it as an unflagging routine in a patient who's not showing any signs of thyrotoxicity. That has been my strategy.

Q. Can we turn, please, to what happened the following year. That was your third consultation, I mean, sorry, in 2005. That was your third consultation, February 2005. You write to Dr Blanchard to talk about the patient fiddling with the dose. Let's just look at that page, 29, please.

"She seems to be on reasonable track [you write] and she has certainly noticed a significant reduction in her hypothyroid features, although she does seem somewhat nervous of this perfectly safe medication and I am not too concerned about effectively her fiddling with the dose within sensible limits."

That is still your view, is it?

A. About a patient changing the dosage?

Q. Yes.

A. Yes, I'm not too concerned in a small change in patient's dosage. It's much better that they do it and tell you rather than fly off and make eccentric doublings and triplings which some patients could do.

Q. Page 31, just to finish this section. There's the fourth consultation with you, I think, on, is it 18th August or 16th August, at the top of the page?
A. I think it says 16th.
Q. Right. Did you alter the dosage on that occasion, if you look at the bottom of that note.
A. Yes.
Q. Can we look over the -- sorry, did you think it was the 16th or the 18th?
A. I don't know dates. Something like that.
Q. Right. We can see over the page, page 32, that you seem to have increased the dose to 175 micrograms and 200 micrograms thereafter. Yes?
A. Yes.
Q. Then you write this to Dr Blanchard, page 33, and I just want to understand what you say here:

"A note on D who continues to improve. But it's still a long way from being euthyroid which may, of course, relate to the relative dose body weight."

How may I ask, did you assess whether she was euthyroid or not? The last blood test, I think was in June of 2005, if you look at page 26. No, sorry, that's the one that goes back to 2004.

Did you have a blood test in 2005, a relevant blood test in 2005, before you wrote this letter?

A. I haven't had a blood test since 2004.
Q. No. Again, on reflection, do you think that's something you should have done before stating that the patient was a long way from being euthyroid?
A. I think it was about time to perhaps check it, which I do say in my notes of 16th or 17th or something of August. The matter has been considered.
Q. Right. You are being asked in the meantime, if we go over the page, to discharge her again, which you of course don't do.

You do write back saying you don't know what to do and you write to the GMC. Then we have the fifth consultation with you which, again, we have to go back to page 31 for.

"Feeling quite well."

Do you chang her dose on that occasion?

A. Well, this is the one where the dose was changed -- no, the dose stays the same.
Q. And on this occasion, I think you do take blood in order to see what's happening with her levels. Is that right? If we go to page 42 we'll see the results of that blood test.
A. Yes.
Q. Her T4 is outside the reference range at 27.2 and her TSH is unrecordable. You describe those readings at

page 43, when you write to Dr Stewart, as being "on the high side, but I think quite acceptable, in relation to her clinical status".

Do you stand by that now?

A. The Panel have seen the result of reducing it, which was simply going the wrong direction, again, the patient said that herself. I certainly stand by that.

Q. Again, I'm going to ask you: did you think at any stage with this patient, having seen those blood results, "I ought to go and get the opinion of an endocrinologist"?

A. No.

Q. You're asked again to discharge and just to finish this off, page 46, you write back to Dr Stewart:

"I do understand your concerns on thyroid chemistry, but thyroid chemistry can be a good servant but a bad master, and I could detect no evidence of hypothyroidism."

Then at page 49 your letter, which we have, in fact, to -- in fact, it has been included, a letter to Mr Shipway of Radcliffes le Brasseur, where you write:

"She is the only patient in 40 years of practice when the family practitioner has asked that I discharge her from my care."

Was that actually genuinely your belief at that

stage or do you think you had forgotten the earlier events?

A. I think it's true. I don't know what earlier event you're referring to.

Q. The previous complaints.

A. I think we're talking here -- it says in 40 years of practice, whereas the family -- where the family practitioner has asked that I discharge her from my care.

I'm in the aware of that event happening in my professional life, which is why I wrote to the General Medical Council seeking advice.

Q. If you don't take any note of the TSH tests, can we take it that you have read the product licence data sheet for thyroxine?

A. I think I've read it. I can't remember what it says.

Q. I'm not going to test you on it, as it were, but I'm going to ask that those be handed out, please. (Handed)

THE CHAIRMAN: This will be C8.

MR KARK: Levothyroxine tablets. 25, 50, and 100 micrograms.

Down towards the bottom of the page, contraindications:

"Thyrotoxicosis, hypersensitivity to any component. In patients with adrenal insufficiency without adequate

corticosteroid cover."

Turn to the right-hand side of the page, just down from the bottom:

"Subclinical hyperthyroidism may be associated with bone loss. To minimise the risk of osteoporosis dosage of levothyroxine sodium should be titrated to the lowest possible effective level."

Did you abide by that, do you think?

A. I haven't found that bit yet, I'm so sorry to delay proceedings.

Q. Six lines or so down from the top right-hand corner of the page.

A. I was looking at the bottom.

Q. "To minimise the risk of osteoporosis dosage of levothyroxine sodium should be titrated to the lowest possible effective level."

Do you think you abided by that caution?

A. That caution is not relevant to my patients. It's subclinical hyperthyroidism.

Q. You see, I'm going to suggest that you caused three of your patients to become hyperthyroid?

A. Yes, you've made that clear before.

Q. Can we go further down the page, please, right-hand side:

"Undesirable effects.

"The following side effects are usually due to excessive dosage, and correspond to symptoms of hyperthyroidism. They include arrhythmias, anginal pain, tachycardia ..." and there are a number of others.

Again, did you think that was relevant to any of your patients?

A. It's relevant to any patient taking thyroid replacement and one looks for it extremely carefully. As written, it's slightly circular this, it says:

"Corresponds to symptoms of hyperthyroidism."

And then they give symptoms of hyperthyroidism. It's slightly axiomatic what they're saying.

Q. You see, I suggest in reality these patients may have had many problems, but you weren't actually treating a thyroid condition, you were giving them thyroxine to make them feel better. Do you accept that as a premise?

A. I don't, actually, no.

Q. You purported to treat a thyroid condition in the face of blood tests which plainly revealed that whatever was the matter with them, their thyroid was actually working perfectly okay. Do you accept that?

A. I don't accept that.

Q. I appreciate that you say that TSH testing has a very limited use in your practice. Is that fair?

A. Yes, I would say that is fair.

Q. You have quoted from American examples. Do you know the British Thyroid Foundation?
A. Do I know them?
Q. Yes.
A. I know they exist.
Q. Have you ever addressed them?
A. Yes. I've invited them to my conference.
Q. Right.
A. They didn't come.
Q. Again, I'm sorry to hear that.

Again, I'm just going to cite from their view. Do you know their view on the importance of TSH testing?
A. I think I know most of their principal views, yes.
Q. I could short-circuit this, I suppose. There's the British Thyroid Foundation. There's something called Thyroid Patient Advocacy. Are you one of the medical advisers to Thyroid Patient Advocacy?
A. I don't think I've been actually asked to advise but I think I've said I'm prepared to help if they have medical problems. As far as I can, but ...
Q. I think you're down on their website, actually, as one of their -- the TPA medical adviser. Did you know you were the TPA medical adviser?
A. I think I do. It's an honorary position.
Q. Certainly on their website their heading is:

"Standard test for thyroid disease, laboratory test for thyroid disorders need to be carried out."

A. Sorry, "Standard test"?

Q. "Standard test for thyroid disease, laboratory test for thyroid disorders needs to be carried out to check if your thyroid is working normally, find the fault, (3) to tell whether the problem is mild or serious, (4) to help find the correct dosage of any medication, (5) to monitor progress. No test is 100 per cent accurate."

Do you accept that?

A. That they have said that? Yes, I'm sure they have.

Q. Do you accept it's right?

A. I wouldn't agree with that, no. I wouldn't even agree -- well, the last sentence. The thyroid tests are extremely accurate, I think. That's not the issue we have before us. It's interpretation.

Q. Dr Skinner, as you appreciate, I suggest that you allowed patient-led consultations, you ignored the TSH tests, and I suggest this: the reason you didn't agree to a performance assessment was because you wouldn't have passed it by UK standards of endocrinological competence. That's right, isn't it?

A. Are you asking me a question?

Q. Yes.

A. I don't agree.

MR KARK: Thank you.

MR JENKINS: I'm going to ask about three matters, if I may. I know the Panel will want to take a break, but if I re-examine first then the Panel may want to take a break and think about what questions they want to ask and it may help them if they have heard from me first. I will be quite short.

THE CHAIRMAN: Yes.

Re-examination by MR JENKINS

Q. Can I ask you about Patient B. You were asked about palpitations with Patient B and it was said that this was the first time she had experienced any palpitations. If there had been any earlier incidents of palpitations I would raise it. I'm going to.

All right? So I'm going to ask you to turn to bundle 1, please, the larger bundle, tab 3, page 21.

You saw Mrs B in 2003 in January. These are GP records.

A. Tab 3?

Q. Tab 3, page 21.

A. This is family practitioner's notes?

Q. It is. You won't have seen them when you treated Mrs B, but again the question was: had she ever suffered from palpitations before? Looking at her GP's note, on 27th July 1992, so just over ten years before you saw

her, there appear to be several complaints that have been raised at that consultation with the GP. The third one is:

"Flutters in chest going on for a month on and off."

Yes?

A. I think that is what it says.

Q. It is query for about half an hour and the GP then refers to stress of moving house, heart sounds tick, regular pulse 80 per minute, see in two weeks' time. Yes?

On 21st September 1992 the patient apparently has written a diary of palpitations, quite frequent, each day, "sometimes single ectopic only", someone has written. There's then an arrow and we can't see what's been obliterated in the photocopying because the page is at an angle.

If we then turn to page 49, that I think ties in with it. There's no letter that relates to this. The date may assist us. It's the same date, 21st September 1992 as the one of the entry we've just looked at.

Does it appear as if she has had -- was it an ECG?

A. Yes, there's an ECG there.

Q. It's a measurement of her heart function, yes?

A. Yes, the heart, electrical.

Q. If we go back to page 21, the doctor's written, of that ECG I take it:

"NAD", no abnormality detected?

A. Yes.

Q. It appears she had had palpitations for a month in 1992 and then more palpitations between July and September 1992?

A. Yes.

Q. Thank you.

You were asked about a hoarse voice and we were told of this patient that at some stage she had complained of having a hoarse voice because she was inhaling cleaning products such as Pledge and what have you. I just want to look at the notes just to see when that was.

If you look in the same tab, please, page 25. There's an entry for 3rd November 1995, in other words, just over seven years before she saw you.

"Query allergic to spray polish", it's not clear whether the next word is "bothered" or "brother very allergic to propellent", can't read it, "dust mite perfume", and there's a reference one line down, not clear of the first word, but "deep hoarse voice".

She's referred -- and if we look at page 79, I think we'll find what's seen on the referral.

Again, the date will help us. We've just looked at

an entry for 3rd November 1995. This is a letter from a doctor, it's the referral letter talking about one of the cleaning ladies at work insists on using spray polish. There then appear to be some investigations.

If one looks at 105, I think -- sorry, I'm taking you on to something different. If one looks through the next few letters one sees she's being investigated. Page 82 might help. There's follow-up in 1996 where a consultant physician, Dr Thompson, is asked:

"I would be grateful if you or one of your staff could review this lady who has a problem which I don't see much of", and there are references to Pledge and carpet cleaner and other aerosols, but again this was six years before you saw her?

A. That's true.

Q. Thank you.

Can I turn to Patient C. Patient C, we know, you took a blood sample from in August 2004, which was the last time you saw her. We've seen that blood sample on a number of occasions and we know that it's outside the reference range.

Can I just ask you about your prescribing for Patient C. We've been through it already. Can I ask you to look at bundle 1, tab 6, page 8. This is your notes for 7th August 2004.

You told us that, where you have written D in the top right-hand corner, that is the dose that she said she was taking --

A. That's what I usually do, write it up.

Q. -- 150 micrograms of thyroxine. 20 micrograms of Tertroxin and B12. We don't have an indication that you were prescribing for her from that day and you've told us, and we've seen the records from Dr Summers at the practice in Pimlico in London?

A. That's correct.

Q. If you go on, please, to page 11 you've been asked about Norwich Union and a private medical insurance claim. The letter that we have at page 11 of tab 6 is a request for you to indicate matters about Patient C. You were asked about details of all treatment that have been carried out to date and what further treatment is proposed. Your reply is at page 14, in response to the numbered paragraph number 3, where the question is for you to give details of all treatment that has been carried out to date. You indicate:

"Thyroid replacement using thyroxine and Tertroxin and oral B12."

Did you prescribe her with Armour Thyroid?

A. Until the August -- the Armour Thyroid?

Q. Armour Thyroid, yes?

A. No, no.
Q. Can you turn please to the other bundle, because again we've had mention of it. Bundle 2, it's tab 2, page 2. This is the patient registration document that Patient C completed to go to the other practice surgery where Dr Ince and Dr Cundy were practitioners. It's the Wimbledon Village Surgery and it's completed on 31st August 2004, so three weeks or so after you last saw her.
A. Yes, that would be right.
Q. We see she's a lawyer as her occupation, so it's possible she's highly intelligent.
She is on three forms of medication: one is thyroxine, one is Tertroxin, and the other is Armour Thyroid. That's what she has put as the medication that she's on. Did you prescribe Armour Thyroid?
A. No.
Q. There's no indication of when she was taking it or how she got it, but if I ask you to turn back to the other bundle, please, tab 5, these are the GP records. We went through these with Dr Ince, you will recall. The first page of this bundle, we know that she was registered with the practice the day after the document we've just looked at, 1st September 2004, and various readings, body mass index, weight and what have you were

put in.

We then have, a third of the way down the page for the same date, 1st September 2004, patient registration, so that is when she registered, and the address of the previous practice in Pimlico Road.

Dr Ince told us about the consultation she had on 7th September. In the middle of the page there's an entry:

"Had to chat to patient. Seeing private consultant, Devonshire Place. Not sure if happy with treatment. On 150 micrograms of thyroxine and two others to potentiate effect?"

Were you prescribing her with two other drugs?

A. I wasn't prescribing at all at this stage.

Q. We know that a blood test was done and we've seen it. If she had been taking Armour Thyroid leading up to the blood test being taken, might one anticipate that that would have an effect on the reading?

A. Yes, interpreting thyroid chemistry on a patient taking Armour Thyroid isn't the easiest thing in the world because the patient's taking thyroxine, Tertroxin, which tends to depress T4 readings, or can. There may be some dioidal compound there. So it could well do.

It is quite a difficult task, it's one of the reasons, I think, why -- one of the reasons

practitioners don't like using it.

Q. Can I ask to you turn back to tab 6, please, page 9. This is your letter to the patient on 1st September. You told us you knew she was changing GP and, indeed, it was that very day that she registered with her new practice. But you've said to the patient:

"If you are planning any of your increasing strategies then perhaps you would let me know."

Just tell us: why did you put that to this patient?

A. I put it -- I mean, I prefer if patients don't fiddle about. I know I have indicated to the Panel I don't go berserk with rage and send the patient away. Basically, I'm saying to her, which is quite reasonable, "Please let me know what you're doing". And, indeed, that advice seems to fall on stony ground because, after she left my practice, she seems to have taken Armour Thyroid in some way.

Q. It's not clear when she took it, I think, from the documents we've got?

A. That's true.

Q. She was saying she was taking it, on present medication, on 31st August.

You knew nothing about it?

A. Nothing whatsoever.

Q. Right. The third matter I want to ask you about is this

survey you referred to. Can I just ask you how it was conducted.

A. I knew because of this Fitness to Practise hearing, I actually wrote to, I think, about 580 endocrinologists.

Q. We heard Professor Weetman say that there are 200 endocrinologists in his organisation. You said 580. Are they all practising in the UK?

A. This is England, Wales and Scotland.

Q. Right.

A. I asked them -- this is not giving an example of the usual practice, because that is an impossible question for someone to answer. I asked them if they had ever treated a patient in three different ways, once when the FT4 was low and the TSH was normal, and 95 per cent said they had done it on one occasion.

MR KARK: Are we going to hear any evidence to back up that assertion?

MR JENKINS: I know Dr Skinner has put it in tabular form.

MR KARK: No, my learned friend knows my objection on this and it was quite apparent when I was cross-examining Dr Skinner. If he wants to call any any endocrinologist to back up that assertion he's perfectly able to do so, but introducing it in this way by the back door, which is frankly not cross-examinable, is inappropriate.

MR JENKINS: I'm content to leave it there.

You appreciate you may be asked questions by the Panel?

A. Yes, of course.

MR JENKINS: I suspect after a break.

THE CHAIRMAN: Right. I think we will break until 4.00. What we will do is take 20 minutes for our tea and then go into private session where we will discuss the questions that we will ask Dr Skinner.

Thank you.

(3.25 pm)

(A short break)

(4.15 pm)

Questions from THE PANEL

THE CHAIRMAN: Dr Skinner, the Panel would now like to ask you some questions and we will begin with Mrs Whitehill.

MRS WHITEHILL: Good afternoon, Dr Skinner.

A. Good afternoon.

Q. I've only got a couple of questions for you, you'll be glad to know. At the very end of your cross-examination by Mr Kark, Mr Kark asked you a question about why you didn't undertake a performance assessment, his answer to that you denied. I would like you to say why you refused to undergo a performance assessment.

A. I was reluctant to undergo this principally because

I couldn't establish the nature of the complaint, the complainant, and which patients -- this was probably the most important part -- were the subject of these complaints.

So I didn't know either of those three factors. My view was it was a little unreasonable to base an invitation to a performance assessment on such a paucity of information to me.

Q. Thank you. I want to talk now about your career, really, the career path you've taken. Initially, you were an educationalist, that is right, is it not, after your house officer posts?

A. An educationalist?

Q. Yes.

A. Um ...

Q. You explain to me what you were. That would be a better ...

A. Right. I was at the University of Birmingham. Well, University of Glasgow and qualified in medicine and then carried out about three years of what's called house jobs. One year of that is pre-registration and then a couple of years of that would be post registration. Essentially, a sort of senior house officer level.

Then I became a research fellow at the University of Birmingham with an honorary registrar position in

obstetrics so I continued to do that.

Q. So in the research fellow post after your house posts, how much patient contact did you have?

A. I would -- I did about two outpatient clinics, and was on call for Birmingham Maternity Hospital, in the registrar level, once a week.

Q. Right. So you did two outpatient clinics a week?

A. Yes.

Q. And did you do that right up until 1980, until you left that post?

A. Yes, it would be about then. And then I gradually tailed that off because of other heavy commitments.

Q. And when did you gradually tail that off?

A. I'm trying to get the dates clear in my mind, I think it would be about 1978/79.

Q. If we say 1979 onwards, how much patient contact did you have then?

A. What then happened was, I developed this interest in sexually transmitted diseases and I would have one clinic a week in relation to that.

Q. And you carried on with that level of contact until?

A. That I phased out really when my interest in thyroid problems -- I got an increasing interest in thyroid problems. So that, I think, would be more or less completed in early 2000.

Q. So you are saying you stopped those clinics around 2000?
A. Yes.
Q. And from that point, when you became interested in thyroid conditions, did you undertake any further training to help you develop your practice and expertise in that area?
A. I didn't undertake any specific training, no.
Q. So you went -- did you undertake any training around clinical skills, examination?
A. I didn't.
Q. Did you feel that you didn't need to?
A. I perhaps mistakenly thought I was getting a bit long in the tooth for that to be perfectly honest. I had been round the track a long time.
MRS WHITEHILL: Thank you.
THE CHAIRMAN: Mr Payne?
MR PAYNE: Good afternoon to you, Dr Skinner. I have a few questions and I'll try to be as brief as I possibly can.
As you can appreciate, we have had evidence over two days and my questions may feel to you as though I'm jumping about a bit, but it's as they've come up to me. Please bear with me if they're not in chronological order.
I think this was answered, but I'm not 100 per cent certain so I will ask the question again. How many

patients do you see per year?
A. I do approximately 1,000 consultations per year.
Q. Right. Let me break that down and say how many new patients a year do you see, approximately?
A. 100 to 150. That kind of level.
Q. How do they fall? Do the majority of your 100 new patients fall within the accepted reference area?
A. Do you mean within it?
Q. Yes.
A. Yes, most of these would, but not exclusively but any manner of means.
Q. So some fall within the reference area and some fall outside of the reference area?
A. Yes.
Q. Would it be 50/50?
A. I would say more 66/33 really. There would be more patients within it in one of the tests than out of it.
Q. I see. Of the ones that are outside the reference range, you instigate a course of treatment for them. Where do you try to get their readings to be?
A. It's not my predominant aim at all to get the readings to any given point. My predominant aim is for the patient to one day say, "I feel fine, with no residual clinical features".
Q. Really your reliance on the reference range, correct me

if I'm wrong, but in my opinion, is very small, you have no real reliance on the reference range whatsoever?

A. I think maybe "whatsoever" is a wee bit strong, but you're quite right, it's how the patient feels. I know I've said that to people many times, I'm sorry.

Q. Your major reliance is on the way that the patient speaks to you, tells you the symptoms?

A. Yes.

Q. How do you treat someone who has difficulty communicating with you, perhaps can't communicate their feelings well, perhaps is not physically able to communicate with you? How would you take a measurement of that?

A. It's part of my job to make sure that they do communicate or I can get as much out of that as I can. I think most patients can communicate that they don't feel right and what they feel wrong. I don't know if you're referring to language problems in Birmingham, perhaps. That can be a problem. Sometimes you do need an interpreter, which does make it quite a difficult task.

Q. That was one aspect I was considering. I was also thinking of some physical aspect or perhaps the ability to communicate for whatever other medical reasons, people like that. If you would like to comment.

A. It doesn't seem to arise -- I'm just trying to be honest with you -- terribly much. Some patients are quite -- I know there are patients in the room -- quite sort of "rambly" and they're feeling very frustrated with some of their previous consultations, I'm not criticising colleagues and they have so much to get out, that can sometimes be a difficulty to sometimes extract the facts from quite a long, sometimes unfocused, consultation. I hope I'm answering your questions, sir.

Q. Yes.

A. I'm not sure.

Q. Yes, you are answering my questions. I'm fine with your answers. But if there's someone like that then would you use a blood test to try and ...

A. Oh, I think it has -- I don't recall a situation where it's been to that extent. I have to tell you that you can get a fairly decent idea. Even with the Commission of Healthcare -- I'm not registered to see children nowadays in England, but even with young children I think ... well, there's mum but even when mum doesn't get involved in the consultation, I think you can get a pretty good idea. And also with very old people. I do understand, a patient might have Down's syndrome, there are some patients where there are genuine problems but that does not seem to have arisen very much. I'm

not evading your question.

Q. I accept that. What worries me slightly is, you may get someone come to you who can't communicate too well and the communication could be for -- they may tell you some symptoms but it might be because they have got depression, it may be because they have something else, and I'm saying that the other side of the argument, the other side of the debate would say that they can tell by taking a blood test. How would you --

A. If a patient was -- I can hardly think of an example, but if there was no way of getting a history and no way of examining the patient, I would certainly -- you've only one port of call, which would be the blood test and you would act on that, if that very unusual situation occurred.

Q. Then the question is, Dr Skinner, what if the blood test falls within the reference range?

A. I think in that instance, if the patient couldn't communicate you could still examine the patient. So a situation where you have just a blank sheet and no way of taking the pulse, looking at the tongue, is very unlikely to arise. I think you are asking me really if you never saw the patient and you had a series of blood tests, could you come to a decision then? It's hard to envisage the situation, but in that case you would have

no choice but act on your best guess on the blood test.

Q. I think you told us that there are some people who would fall, if there's a blood test taken, outside the reference range but yet they'd feel perfectly well, they'd feel okay, they wouldn't know, I think that was part of your evidence.

A. Yes.

Q. How would we know? Why would we take that blood test?

A. Well, I wouldn't really see patients that are feeling all right in any case. But I think that was what Professor Weetman was alluding to and if, for example, the TSH was raised and the patient felt all right, that would probably come into the diagnosis of sub-clinical hypothyroidism which hasn't really obtained in our indications or perhaps shouldn't have.

In that case there is a debate and a very sensible debate because it's quite a difficult problem, to know whether the patient should be treated at that stage. And I think you asked Professor Weetman on that issue because there is evidence that the higher the TSH in an asymptomatic patient, the more likely will that patient develop hypothyroidism in the future.

Now, it's not part of my clinical practice de facto because people don't come to me if they're feeling all right, or won't be referred, but in that instance

I think there is reasonable debate whether to treat the patient or not.

Q. Just bear with me a second. (Pause)

Let me ask you this anyway: is it your belief that each individual has their own reference range and the actual reference range that everyone else goes by is not really an ideal measurement because each individual patient has their own reference range; is that your argument?

A. Well, I suppose the reference range sort of implies that you've taken a reasonable number of people and worked out that 95 per cent lie within a given value.

So an individual patient can't really have a reference range unless you're talking about the daily variation. An individual patient, of course, will have a kind of a widely varying starting level of thyroxine. That is indeed one of the possible criticisms of overreliance on thyroid chemistry.

Q. But two thirds of your patients lie within the reference range?

A. Yes, indeed, but I feel that these were hypothyroid patients by and large -- or almost all.

Q. And some people who are outside the reference range are hyperthyroid?

A. Are hyperthyroid?

Q. Yes.
A. If they have symptoms --
Q. But well, if you understand me --
A. Exactly and if, indeed, you were a staunch believer in reference intervals it is curious that colleagues who are such aficionados of reference intervals don't apply the reciprocal argument to someone who -- I think you raised the point -- who might be a little bit outside the reference interval.

They may say you cannot be hypothyroid if you're within it, but they don't say you must be hyperthyroid if you're out of it, which is an argument that has been put up a number of times in these discussions.
Q. When the patients come to see you, do you explain to them your method of symptom diagnosis and your lack of reliance on the reference range?
A. Yes, I do. They usually know it before they come, mind you, I would think. Patients are very well-informed these days.
Q. But most of your patients come through a referral?
A. Yes. No, not most, all now.
Q. But even in the past did most of them come through a referral?
A. Oh, a vast, vast number. It's a rarity patients don't. I understand the Panel might have had a slightly

contorted view from the four patients under discussion. But the whole practice depended on referral from family practitioners or other medical, registered medical practitioners.

MR PAYNE: Just bear with me a second. (Pause)

That is all the questions I have for you, Dr Skinner. Thank you very much.

THE CHAIRMAN: Dr Elliot now.

DR ELLIOT: Good afternoon, Dr Skinner. I want to ask you, first of all, if you have any written information that you give to patients coming to your clinic?

A. Yes, we do, and I think ...

Q. I think it's probably in the -- if I've got the right place -- file C2, tab 4, page 92, something which is headed "The Patient's Guide".

A. Yes, indeed. Should I try to find this, Dr Elliot?

Q. It might be helpful if you could just confirm that.

A. Tab 3?

Q. Sorry, tab 4. File 2, tab 4, and it's page 92. It's amongst all the bundles of protocols and so on that you produced for the Commission of Healthcare.

A. Yes, the patients receive this.

Q. It says, the first sentence says:

"This guide is available to any patient or party."

Is it actually available or is it given to people

who attend your clinic?

A. It's laid out as one of the documents that every patient gets.

Q. How long has that been the case?

A. Really since the Commission of Healthcare register as part of their ongoing advice. It's been very helpful.

Q. I was not able to find anything about complications of thyroxine in this patient's guide. Could you confirm that it doesn't deal with that aspect?

A. No, the patient's guide doesn't have that in it.

Q. Do you have any other written information that you give to patients that contains advice about potential complications of thyroxine treatment?

A. Yes, I think we do, but I'm not sure where it is, to be honest with you, at the minute. I don't think we do. I'm not sure that that would be a usual way to practise medicine, to write what might happen to you if you get a certain type of medication. I'm a little bit ambivalent on that one.

In complaints management, you will see some reference to that, the patients get that as well, which does give some general guidance on that. I could certainly incorporate that if that was felt to be useful.

Q. Okay, thank you. I have just have some general

questions now about this whole kind of issue. I want to ask you first of all, what happens if you give thyroxine to somebody who is not hypothyroid, who has normal thyroid function, as you would define it?

A. I.e. a patient who feels perfectly well?

Q. Yes.

A. Well, one doesn't do this, it would only happen by chance. It used to happen many years ago. Nurses used to take thyroxine when we worked in hospitals so that they would be rather jollier at the dance. It didn't work. But the answer to your question, I think, is: not much initially. Certainly at 25 micrograms a day, maybe 50. Patients will vary enormously with body weight and various other factors.

What would essentially happen is they would eventually start to develop signs of thyrotoxicity and we've discussed these symptoms and signs, and it will be obvious what is the matter.

Q. Sorry, I didn't quite understand what you said there. Did you say nurses used to take it to make them jolly at the dance?

A. That's what they said. This is some years ago.

Q. Right. Then perhaps related to that, I would just like to go to page 157 of your book. I know that you're talking about -- I'll give you a minute to find that.

You're talking here about the effect of thyroid preparations and you say:

"I can see no particular reason to disbelieve that there cannot be some direct effect on the psyche of Tri-iodothyronine."

Which, of course, is the active -- the way in which T4 works?

A. Yes.

Q. Could you enlarge on that a bit? Do you think that T3, or T4 when it's been converted into T3, has a direct effect on the psyche?

A. I started thinking it didn't and couldn't, and that was certainly the teaching from endocrinological colleagues and books. But I've been struck by a number of patients, they don't say they have become jolly or anything like that or euphoric or something or like amphetamine or something, but some patients do say, in my experience, that perhaps two or three hours after taking, particularly Tertroxin, which has a quicker half-life and so on, they can start to feel a sort of benefit.

This is what some patients say. A few patients say that quite soon after taking thyroxine, but one understands there is a possibility of a placebo effect in these circumstances.

Q. I think you heard Professor Weetman and Mr Lynn -- Mr Lynn from his own personal experience -- talking about the wellbeing effect of being hyperthyroid. Postulating that this was a possible reason why patients liked taking thyroxine and felt better for it?

A. Yes.

Q. Whatever the reason for their not feeling well, they felt better if they took thyroxine. Could you comment on that, in the light of the remarks that you've just made?

A. Yes. I think here we're talking not a minute or two or an hour later, I would presume Professor Weetman and Mr Lynn's statement was about.

I don't agree with this and I don't know if Professor Weetman or Mr Lynn were suggesting that these patients had signs of thyrotoxicity. If you become thyrotoxic you don't feel well at all, you feel jittery and out of sorts, and I don't think I could go along with that view.

Q. But the patients that we are talking about, the four patients that we are talking about, were not clinically thyrotoxic, were they?

A. No, exactly, that's the point I make.

Q. They were not clinically thyrotoxic by your own definition, and I don't think there was any real

evidence that any of them was.

A. No.

Q. Let me phrase this in a way that is acceptable to you. Their thyroid tests were outwith the reference range and they have been described by others as being biochemically thyrotoxic.

A. Yes, they have.

Q. Could the fact that you felt these patients -- the patients told you that they felt better, do you think that could have been explained by the effects of thyroid hormone?

A. I don't --

Q. On an elevated level of thyroid hormone?

A. I don't agree with that at all. It seems a very convoluted torturous explanation for something which is much more simply explained.

Q. Okay. I just want to ask you now about blood tests and I actually think that you've already answered -- I think Mr Kark phrased this to you in this form. I'll just put it again very briefly. In relation to patients B, C and D, and the charges about them being rendered biochemically thyrotoxic, which you have not admitted, I believe you to have said that you did admit that the blood tests were outwith the reference range. Is that --

A. I have admitted that from square one.
Q. Then again in relation to blood tests, this is something that you say in your book on page 147:

"Blood tests are a grand waste of time, energy and money."

Which may have been, I accept, overdramatising things.

A. A little arresting.
Q. I'm not quite clear in my mind why you do blood tests at all.
A. I think in the context of this I was talking about treatment, if I might have just one second, while a patient is under treatment, I haven't ... here we are, yes. That slightly avant-garde statement, "attempting to be arresting", is talking about patients on treatment where I think thyroid chemistry is not particularly useful.

But I have said that in a patient who comes there are many -- if you suspect a patient's hypothyroid on clinical grounds and you find a TSH of 16, it would be a foolish man indeed that would not rethink the problem. So I take thyroid chemistry -- I take cognisance of it and consider it in conjunction with the clinical features.

Q. Could I just challenge you about that, because you say

you take cognisance of it but you do thyroid function tests during treatment, you don't just do them at the diagnosis.

A. Yes, I do.

Q. Why do you do them if you don't think that they're -- if you don't think that they're worth the time, energy and money and don't take cognisance of them?

A. Well, for example, if you're treating a patient and the TSH stays the same or goes up, this would alert you to that there might be something not quite right in the state of Rome. For example, the patient might not be taking the medication. That's the common sense use of it.

Similarly, if for some reason you're giving the patient thyroxine and the free thyroxine reading's going down, you would wonder if the patient was taking the medication or, conversely, if it was shooting up it might raise the possibility that the patient, as we have seen with Patient C, putting her own dose up perhaps intemperately.

Q. Now, I've got some specific questions about patients and I'm really sorry if I jump about a bit.

The first one is about Patient C and B12 deficiency. This relates to charge -- it's a specific question I have. It is a charge that you have admitted. It's

23a, charge 23a, and although you have admitted this I think that when you were giving your evidence yesterday you faltered a little about that particular admission and couldn't -- you seemed to be questioning about whether you had actually admitted it or not so I would like to take you through that if that's possible.

A. 23a?

Q. 23a, which is that you suspected a diagnosis of B12 deficiency in Patient C. The only mention of B12 that I can find in Patient C's records is in file C1 at tab 6, page 8.

A. Yes.

Q. That is in the top right-hand corner of your notes. I'll give you a minute to find that.

A. Yes, I've got it.

Q. It's ID, which means that is what the patient is taking --

A. Correct.

Q. -- at the time of the consultation?

A. That is correct.

Q. And I think that you said in evidence this morning that you thought the patient was taking this off her own bat.

A. Yes, she was.

Q. I can't find anything in your record to suggest that you

advised it; I can't find anything in your record to suggest that you suspected B12 deficiency; and I can't find anything in the record to suggest that you mentioned this to the GP as a clinical possibility or that the GP should investigate it.

A. That is correct. I am not quite sure why I admitted something there. I'm grateful to you.

Q. I wasn't quite sure either. That's why I thought I should run that past you.

A. Yes, thank you, that is very kind of you. I don't know why I admitted that. There hasn't been a mistake somewhere?

MR JENKINS: Can I say there's one other reference on page 14.

DR ELLIOT: Right. Yes, but that is just what she's taking?

A. Yes.

Q. It's not -- it is just for information to the insurance company.

So I really couldn't find any evidence in the written record that you had diagnosed this or suspected it, that you had prescribed for it, or that you had -- and I couldn't work out why you had admitted it.

A. I don't know myself. I'm grateful to you for spotting that. I certainly never started this patient on B12.

Q. Okay. The next patient I want to ask you about is

Patient D and again this is about the prescription of B12.

In this patient, you do seem to have advised that she took B12, I would direct you to C1, T8, page 27. It's under your RX that you advised B12.

A. Yes, on 18/11/04, I did do that.

Q. Now, one of the arguments I think that you put forward for not carrying out laboratory investigations in patients in whom you suspected B12 deficiency was that the GP was informed of your suspicion.

I can't find any evidence in Patient D that you did actually inform the GP that you suspected B12 deficiency.

A. No, that's correct, I haven't done.

Q. You haven't done that in this case? You can confirm that. Again, Patient D, and this time it's on page 14 of the same section, section T8, and this is just for clarification, this is a letter that you wrote to the doctor. Section 8, page 14.

A. Is that the end of my letter?

Q. It is. It's the top line.

A. Yes. Thank you.

Q. "If the blood tests do not show anything au contraire ..."

What -- this is the thyroid function testing we're

talking about?
A. Indeed.
Q. What sort of contraindication would you have regarded in those results which would have meant that you wouldn't have prescribed thyroxine?
A. This is one of the good reasons for doing the blood test. If a patient seemed hypothyroid to the best of your clinical judgment, let us say not dramatically so, and the free thyroxine level came back at astronomical levels or even very high levels, I think you would be foolish to not put a higher level of scrutiny on your clinical diagnosis, you would be thus guided and helped by your blood test.
DR ELLIOT: Thank you.
THE CHAIRMAN: Thank you, Dr Skinner. I shall be brief because we're having to finish at 5.00. Could you tell me, if you give thyroxine to a healthy thyroid gland, what happens to it?
A. To a patient with --
Q. To a patient with a healthy thyroid gland.
A. You will gradually suppress the endogenous activity of the thyroid gland.
Q. And the thyroid shrivels, does it, does it become atrophied?
A. Yes, it will atrophy. However, the whole thing will

recover if you stop the thyroid replacement. I have seen that in quite a number of patients.

Q. Over what period of time, can you give me some guidance? If you treated someone with thyroxine and there was atrophy within the thyroid gland, for five or ten years, would it recover?

A. I haven't, of course, done pathology on it. My only evidence on this would be sometimes patients after 30, 40 years, for some reason or other, perhaps through persuasion, perhaps just forgetting, and stop taking it, the thyroid seems to recover in terms of thyroid hormone tests. That has been my observation.

Q. Has that happened in any of your patients? Have you suggested to any of your patients that they stop? Would you then have followed them up if you felt it wasn't necessary to go on giving them thyroxine?

A. Yes. There are certainly patients who are not improving and I've certainly stopped it. I've sometimes stopped it in patients who feel strongly or have been perhaps slightly persuaded that this is a dangerous medication. That's one set of patients. But I myself -- if it seems the patient's having no improvement then I would certainly stop it.

I can think of patients who have turned out -- one patient was diabetic and not hypothyroid. I can

remember that patient very clearly.

Q. Thank you. We know that the signs and symptoms of hypothyroid are similar to those of depression and I'm not going to through tabs, et cetera, but we know that out of these four patients depression has been mentioned, there was a Beck test, et cetera.

A. Yes.

Q. Now, I just wonder. In all of the papers I've read so far, you very seldom mention depression. What is your feeling about depression, either separately or combined with hypothyroidism?

A. In the generality of the point, depression will almost always accompany hypothyroidism because I cannot envisage a patient who will be happy if they have hypothyroid features.

The second part of your question: I don't feel quite so unconfident or nervous that a proper clinical history will not discriminate to. For example, you're not going to get an enlarged tongue inter alia if you have depression and so on. I think there are features and the combination of features would exclude, in most practitioners taking a careful history, that the patient was fundamentally depressed and not hypothyroid.

There are characteristic appearances. There are so many features. I don't feel personally -- I respect

colleagues' views, but I don't feel that's a major problem.

Q. Thank you. Again, we can refer mainly to Patient D if you like, but within the allegations on each patient it has been suggested that your history taking is inaccurate, as is your examination.

A. Yes.

Q. We have had two slightly conflicting opinions on this from the experts and I just want to ask you -- I have a little bit of medical knowledge or practice, but record taking I think, as we know, is important, it's in good medical practice, et cetera. Would you say that your history taking on the initial visit of the patients, and sometimes, remember, some of these patients have come without referral?

A. Yes.

Q. So you have nothing to go on other than what the patient says to you. Do you feel that perhaps the history taking is somewhat askance and perhaps -- how do you feel about your history taking on a initial visit?

A. At the time I must say I thought it was doing the job, but I'm quite receptive to input from colleagues and I'm quite prepared to look at this and write fuller notes on patients. I'm quite open to that.

Q. I'm going read to you from Professor Weetman, his

comments on Patient D and your history taking, et cetera:

"There is no record of clear family history or past medical history that although the patient was taking medication, Dr Skinner has not recorded in his notes what dosage of medication the patient was actually on."

And it goes on:

"It was incomplete in the context of a patient who has had multiple aches and pains and tiredness. There is no record of any neurological, respiratory system, muscular skeletal system or abdominal system examination, and the examination of the cardiovascular system was inadequate."

Could you comment on that for me?

A. Yes, ma'am. There are quite a number of things to comment on there. Taking the last point, the examination, I do always listen to the heart. If I don't find anything abnormal, I don't write anything down. That might be a matter I could improve.

If the history does not suggest it, I don't think it is necessary, particularly in a second referral -- and I take the point absolutely that this was not for some mild reasons the patient had not been referred. I certainly don't think most practitioners would do a neurological examination; I would be absolutely

staggered if they said they did.

Unless there's a reason, and I do it very frequently, I wouldn't normally do an abdominal examination. I'm not quite sure what the practice among my colleagues would be on that. I think one of the shortfalls is I don't write down everything I ask, and that a matter which I would be prepared to improve.

Q. Do you feel that this comment by Professor Weetman was legitimate or otherwise in your case?

A. I think it has directed attention to some matters that could be improved. It seems a little bit severe.

Q. Thank you. I just have one more. It's Patient D. We don't have to go it, I don't think, unless you feel it necessary. Tab 8, 31:

"The patient is feeling well but you increased the dose."

Now, just in general, is there a reason why you would do that with any patient?

A. Yes, I think this may again be the same criticism. Perhaps I should write: feeling well but not yet feeling 100 per cent. Feeling well means she's kind of all right, but it doesn't say we're right there yet. Again I do acknowledge it's something of a shortfall in my note keeping.

Q. Monitoring. You basically monitor your patients,

am I right, by appearance and by the patient's comments? Is that how you basically judge the patient's wellness or ill health?

A. Yes, but I do take blood tests, as I hope has been obvious to the Panel. Fundamentally, the most important thing is what the patient says to you when she comes to see you.

THE CHAIRMAN: Thank you very much. The next stage is questions from Mr Jenkins and Mr Kark. It is 5.00 and someone has to leave by 5.00. Would it be best then to have Dr Skinner as a witness again tomorrow morning?

MR KARK: I do have a few questions arising, I'm afraid. I'm sorry if it puts Mr Jenkins in difficulty because I know he can't speak to Dr Skinner, but there are just a few questions and I am uncomfortable asking them now if a Panel member has to leave.

THE CHAIRMAN: That is fine. Dr Skinner, tomorrow morning at 9.30.

A. Thank you.

THE CHAIRMAN: The same for everyone. Thank you.

(5.03 pm)

(The hearing adjourned until 9.30 am on Thursday, 12th July 2007)