GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Wednesday, 16 November 2011

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

Case of:

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

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

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

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

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FITNESS TO PRACTISE

THE CHAIRMAN: Good morning everybody.

MR FOSTER: Sir, thank you very much indeed for your patience. It is much appreciated. We have used the time well. What Dr Skinner has with him is a small snapshot of the literature to which he referred. Even copying the papers that are here has proved to be a gargantuan exercise. Instead of killing lot of trees and providing every Panel member with a complete copy of everything that is here, which would take a very long time, what I tentatively propose is that you are provided with a document which is a sort of index to notes which follow. That was prepared by Dr Skinner over the course of the last few years and explains in more detail what it is and what it is supposed to do. My learned friend has seen this and so has your learned Legal Assessor. I propose that that be handed out at this stage.

THE CHAIRMAN: This will be D5. (*Same handed*)

MR FOSTER: While that is being done, can I explain what it is suggested happens procedurally. I think that my learned friend and I and the Legal Assessor are agreed that I should effectively re-open my examination in chief just to deal with the question of the literature. It will not be long at all. I am not proposing to dive into the details of any of the literature. My learned friend can then cross-examination and I will then return to the re-examination on the other matters which I had come to the point of starting yesterday afternoon.

GORDON ROBERT BRUCE SKINNER, recalled
Further examined by MR FOSTER

Q Dr Skinner, you have D5 in front of you now?
A Yes.

Q What are we looking at there?
A These are part of my ongoing research. These are possibly proposed chapters in a book I am going to write. This is a summary of some of the research I have been doing towards this that I almost happened to bring with me, as I did not realise. I thought it was an assessment of my condition. I apologise for the incompleteness of it. That is what that is. It is personal and I hope it is legible.

Q At A and B we have numbered headings, 1 to 32. If we go into the body of the document we see, for example, on page 1 the heading "Thyroid Chemistry, Not Useful". Does that correspond to number 1 at page A, which is the index?
A Yes.

Q I think in almost all cases we do have a section in the body of the bundle which corresponds to the index. In a few cases that is not the case, for example, there is no number 22 in the body of the bundle which deals with the aetiology of hyperthyroid disease?
A Exactly.

Q If we go, by way of example, to page 10, this is under the heading "Reference Intervals Wrong" in section 5. Do we see there a list of the papers to which you have

referred which would form the substance of what you propose to write?
A Yes. It is a subsection of that.

Q As the Panel can see for themselves, some of the papers in this bundle refer to 2007 and subsequent papers, but not all?
A Absolutely, yes.

Q Do you have here at this hearing all the papers that are referred to here?
A The actual paper?

Q Yes?
A No. That would be enormous.

MR FOSTER: What we do have is, as I described it, a snapshot. It is quite a bulky bundle. If the Panel wants to see what lies behind these references it is here insofar as we have got it. Sir, I was proposing to leave it there.

THE CHAIRMAN: Thank you. Mr Atherton, do you want to come back on this specifically now?

MR ATHERTON: Sir, can I just say this: we have had an opportunity, these papers having been provided to us in the course of the last hour, to take a snapshot overview of it. It does seem to us that it meets the concern that we had yesterday about the absence of any evidence to demonstrative reflective practice. Some of these papers are clearly very helpful in that respect and Dr Skinner's notes are also helpful to us in demonstrating that he clearly has continued to consider the type of issue that has arise at the first hearing in 2007 and subsequently. We note, for example, that in the accompanying bundle, not the one that has the index at the front, but begins with a World Health Organisation letter of 26 July 1994---

MR FOSTER: The Panel do not have that at the moment, but a copy can be provided.

MR ATHERTON: I think it might be helpful for the Panel to see this bundle.

MR FOSTER: That is going to be D6.

THE CHAIRMAN: Yes, if you are producing it. (*Same handed*) "World Health Organisation" is the heading, D6.

MR FOSTER: That is the first tranche of the copying. We did not continue to do that exercise with the rest of the material we have, simply because there came a point when we realised it was going to be too unwieldy.

MR ATHERTON: Sir, can I preface this by saying that, for our part, we are prepared to accept that there appears to have been a misunderstanding as to the scope of this hearing on the part of Dr Skinner, that it appears that he has come for this hearing prepared only to deal with the compliance issues, when really the GMC had accepted compliance with the conditions, whereas, for our part, we had placed some importance upon that part of the July determination which stated that compliance was one aspect, but fitness to

practise was another aspect. It seems that, within that, the misunderstanding has developed which these papers are designed to remedy.

Looking at D6, you will, I think, quickly see that there are papers in here. For example, if you turn to page 28---

THE CHAIRMAN: Is it "Medical Hypothesis"?

MR ATHERTON: Yes. We have quickly looked at the summary to this paper by Rand Wheatland. Whilst we do not have the advantage of comment from our own expert on the significance of the paper, we can nevertheless recognise that it is relevant to the issues which have been addressed in cross-examination so far. Interestingly, we note at page 47 that Dr Skinner has clearly, in advance of this hearing, addressed---

THE CHAIRMAN: Hang on a minute.

MR ATHERTON: It is the last three or four pages of the bundle.

THE LEGAL ASSESSOR: "Comments on the report by Dr Akintewe".

MR ATHERTON: Exactly.

THE LEGAL ASSESSOR: That is page 47.

MR ATHERTON: Yes. We can see that Dr Skinner has applied his mind clearly carefully to Dr Akintewe's comments and has cited references, not all of which we have seen, but appear to be directed to the issues that have emerged during this hearing. For our part, we have found those comments helpful, as we have found other aspects of this bundle also to be helpful. My snapshot of what has been provided to us, of course, does not place me in a position at which I could usefully cross-examine Dr Skinner or even to decide whether cross-examination is appropriate, but it does enable me at least with those who instruct me to recognise that he his able to demonstrate some reflection upon the matters which were of concern to the previous Panel.

I think that is as far as I can take it in light of the opportunity I have had to look at these papers.

THE CHAIRMAN: Thank you, Mr Atherton. Mr Foster.

MR FOSTER: Thank you, sir.

<u>Further re-examined by MR FOSTER</u>

Q Going back to re-examination from yesterday, there is just one point. Dr Skinner, you said that about twelve times a year you might prescribe a dose of thyroxine before getting the thyroid biochemistry. What were the circumstances in which that would happen?

A I think there would be two circumstances, as I indicated. One would be a patient who, either from nervousness or another reason, does not want a blood sample taken.

Secondly, when thyroid chemistry has been difficult to get and the patient is extremely unwell, which is the situation with a lot of my patients, I think it is perfectly justifiable to start at the lower dose level and then one has the thyroid chemistry about ten days later or something like that.

Q In all of the patients would you urge that thyroid biochemistry be obtained?
A We have it in all of the patients.

Q If they consent?
A If they consent to have it. Patients usually do, of course.

Q In the twelve normally it would just be a delay before the thyroid biochemistry is available. Is that right?
A Unless it is a patient who flatly refuses.

MR FOSTER: Thank you very much.

THE CHAIRMAN: It may be that the Panel wishes to look through the papers we have had this morning before considering whether they have any particular questions. I am going to look round. Yes. I think we would be best to say let us have a little time to look through the papers, to make certain we can formulate any questions which we may have of Dr Skinner. If you would kindly leave us to it, we will call you back as soon as possible. We will then ask you some questions, Dr Skinner.

MR FOSTER: Shall I leave you with this?

THE CHAIRMAN: Yes.

(*The Panel adjourned for a short time*)

THE CHAIRMAN: Thank you for that time. We have been able to study various aspects of the papers. I think Dr Jeffries may well have some questions for you first, Dr Skinner.

<u>Questioned by THE PANEL</u>

DR JEFFRIES: Yesterday there was quite an unresolved difference between GMC Counsel and yourself on normal values. I thought it would be helpful to give you the opportunity to explain the difference between a value which is normal for a patient or a group of patients and the manner in which a reference range has been obtained?
A A reference range is obtained by sampling the population. It is always a sample. The utility of it depends essentially on the precision of the sampling in terms of removal of unwanted variances. The general view in the United States was that the UK reference interval had been perhaps somewhat loosely constructed and included patients who were essentially hyperthyroid, although there is another concept, sub-clinical hyperthyroidism. They excluded people who had antibodies or people who had a family history, which evolved rather than suddenly. They actually started reducing it and then that stimulated further studies.

It became, I think regrettably, called the normal interval and people's blood tests were

described as normal without any mal-intent, but essentially it rather embedded in the mind of a lot of practitioners that this equalled health. That is why the Counsel for the General Medical Council and I had a difference of view on that. Counsel would not know, of course, not being in the field, that this is a problem almost of semantics. I think the name "normal" has produced a significant difficulty for patients over the years.

Q Another technical point really. You mentioned a number of times that labs are not doing T4 estimations. They are just relying on TSH. Could you explain what difficulties for you and patients that produces?
A It is a considerable problem because if the laboratories only carry out a TSH, which is, dare I say it, a cheaper estimation to make and there is pivotal reliance on that test, and you cannot have an FT4 done, then the diagnosis which may well be correct will be excluded at square one. This becomes a very difficult problem. If a patient is better off, in simple words, they could perhaps get this done – they can – through the private sector, it is a significant problem. It is one I am attempting to address with the powers that be.

Q My understanding is that it is actually the T4 and the T3 that has the effect or produces the deficiency effect within the body?
A Yes.

Q Not the TSH?
A No.

Q The other thorny question I would like you to clarify is that term "biochemical toxicity". I have to confess that initially I could not understand how it could possibly be that you could not accept it, but I realise there is a difference, that you are implying, I think, that there is a difference between high levels of thyroid hormones that can be measured in the absence of hyperthyroid symptoms. Is that what you mean? Is that your understanding of what biochemical toxicity is?
A Yes, exactly so.

Q You presumably accept that it is possible to make people ill by giving them too much hormone replacement?
A Yes, of course.

Q Another point I wanted to take up is the question of responsibility for follow up. You were asked yesterday what arrangements you had in place to ensure that patients did not default from follow up by their family practitioners. You said you would think about it and maybe come up with a solution. I do not see how one specialist can actually be responsible for following up a GP's patients, but have you had any more thoughts of that overnight? Do you actually think it is possible?
A I have been thinking about this, reflecting, as it were. It would be possible. It maybe considered slightly presumptuous by the family practitioner, who I have excellent relations with, to build into my return letter that they would advise if there is any shortfall in the follow up. That would not be an entirely difficult thing to do. That would certainly be possible. I was grateful for that issue to be identified. I had not really thought of it.

Q What is the patient's responsibility for ensuring that they are followed up and

follow recommendations?
A The patient should attend the follow up at my clinic. Indeed, the patient should attend the family practitioner. If the patient defaults on the appointment we write, in fact we usually telephone the patient. Sometimes it is merely forgetfulness.

DR JEFFRIES: I think we are nearly there. That is all I need to ask. Thank you, Dr Skinner.

THE CHAIRMAN: Mrs Pond.

MRS POND: I think I just have four probably quite brief questions that you could help me with. Yesterday you were asked about prescribing. I hope I am right in saying that you said you would usually start at a low level and increase, usually by 25 micrograms a day. You would look at it again in three weeks and increase if the patient had not returned to good health, I guess, if you had not seen an improvement?
A Yes, that would be the general principle.

Q Are there any safeguards that you put in place or that you need to put in place in doing that progressive increase of prescribing?
A Yes. We do give the patients the sheet which I think the Panel had yesterday. The main safeguard, I think, at the end of the day is good communication with the patient at the first consultation, to advise the patient to let myself or the family practitioner know if they feel any untoward adverse effects.

Q Are there any other checks that you need to do or that you do do routinely outside of asking the patient to advise you if something untoward is going on? Is there anything that you routinely put in place as a safeguard that might counter any risks in increasing the levels of dose?
A Yes. Routinely I ask if the family practitioner would repeat the thyroid chemistry something like six weeks. That has a double advantage, in that the patient then requires to see the family practitioner *en passant* and we follow the patient up at two months, sometimes two and a half months, either by myself or the family practitioner.

Q Given the discussion that has been going on about the TSH readings, is that a useful measure at that stage of a patient's treatment?
A That is a good question because it inevitably goes down with treatment. It is useful perhaps if it does not go down or goes up. You scratch your head a little bit there. Perhaps the patient has not been taking the medication. There is a huge controversy and debate which should have been highlighted by some of the literature I have provided what level of TSH one should be happy with. I hesitate to quote Professor Toft again, but in the 1990s he produced a paper in which he suggested that the TSH should be within reference interval. There was a patient that this was an example of yesterday. He has however admitted and agreed – perhaps changed his mind is the word – that many patients require the TSH to be zero to be consonant with optimal health.

Q In terms of the referrals that you receive from GPs, what sort of percentage of patients that you see do not receive treatment from you?
A About 30%, may be 40% - I am guessing – are not on treatment to start with, so with most of the patients in fact I am being asked advice for dose level or dose

preparation.

Q In terms of managing a patient's care, when you the advise a GP of what treatment you have given to a patient and what your advice is for their further care, do you have many occasions where GPs come back to you expressing dissatisfaction or not prepared to engage in the treatment plan that you are proposing?
A Yes, that certainly happens. I have a lot of discussions with family practitioners, mainly be telephone and we are able to work towards a reasonable agreement on the matter. There are patients who the family practitioner does not deem to be hypothyroid, which is a perfectly respectable position, and in fact would prefer not to prescribe the medication. This is a slightly uncomfortable position because in a way you do not want to be prescribing something in opposition to the family practitioner's wish, but someone has to come to a decision eventually for the patient's sake.

Q You would have that discussion openly with the GP?
A Always, yes.

Q The last question partly follows on from a question I asked to Dr Akintewe yesterday, but also from bundle D6 that we have been given this morning, which is the one that starts with the World Health Organisation page at the front?
A My bundle has been slightly cut down since I submitted it for copying. Is this the letter about WHO?

Q Yes, it is from that bundle that starts with that letter?
A Yes.

Q You may or may not need to turn to the page I am referring to, but I will tell you which one it is. I have labelled it as page 36. It is a letter from the Department of Health addressed to a Mrs Whitlam?
A Yes, I have got it.

Q Do you know Mrs Whitlam?
A Yes, I do.

Q Is she a patient of yours?
A She is indeed, in the present room.

Q In that letter at the bottom of the first page the issue about GPs prescribing unlicensed products is addressed and it says that GPs are allowed to prescribe any product including, unlicensed products or products not licensed for a particular indication that they consider to be a medicine necessary for the treatment of their patient, subject to provisos. The second proviso is that GPs are prepared to justify any changes to their prescribing by their Primary Care Trust. Is that an issue that has arisen to your knowledge in relation to any of the patients that you have been treating?
A I think it may have with certain… I think a few GPs, family practitioners, have contacted the Primary Care Trust. I think Dr Akintewe drew this to our attention. They must have said they do not agree with prescribing it. However, many family practitioners do prescribe it and so do hospital consultants in the NHS, so I would slightly diverge from Dr Akintewe's broad sweep on that one.

Q In terms of your patients where you are aware these issues have arisen, how do you manage that treatment if the GP has been advised by their Primary Care Trust that they should not prescribe it, because I am guessing that then goes against this? That is one of the provisos that has not been met?
A In that circumstance the next best thing is for me to prescribe it, if I believe it should be prescribed and the GP will not. That is a much preferable approach to the patient shooting off to the Internet and getting unusual preparations. It is definitely the lesser of two evils, if it is an evil.

Q Again, if you were doing that, you would advise the GP that, in spite of the difficulties they had, you were going to continue to prescribe for that patient in that way?
A Yes. Sometimes the family practitioner is quite relaxed in that circumstance.

MRS POND: Those are all the questions I have.

THE CHAIRMAN: Thank you, Mrs Pond. Stay on that page if you would, Dr Skinner. I note that that letter is written by a civil servant, but on behalf of the then Chief Medical Officer of Health. Is that right – in the first line?
A Yes, it looks like it.

Q Would you like to read out the third paragraph and then comment on it?
A

> "Doctors are encouraged not to rely too heavily on the results of blood tests, but to use their clinical knowledge and an assessment of the symptoms experience by individual patients in making a diagnosis for thyroid treatment. Doctors are free to use whatever guidance they feel is appropriate when making a diagnosis. This includes guidance published in other countries."

Q Would you like to comment?
A I would agree with that. It is reassuring that there is a view from a higher authority, so to speak, in that direction. Basically it is obvious.

Q Thank you. Can I take you briefly to C1, the big bundle, and to the index immediately after the cover page and number 20 on the index at the top of the second page? That is a letter from you to the GMC dated 6 April 2010 enclosing information on thyroid replacement. Those are between pages 72 and 75?
A I have them.

Q Can you turn to pages 72 to 75? Pages 72 and 73 are clearly the 6 April 2010 letter. Pages 74 and 75 are the information on thyroid replacement. That is dated on the top 23/07/07. I am just not quite clear. Was that a document that you prepared in July 2007 which was then sent in only on 6 April 2010, as would be inferred from the index, or in fact did that 23/07/07 document come before the previous Panel---
A Yes, it did, sir.

Q ---because it was written during the time of the previous Panel?

A Yes, it came before the previous Panel.

Q It came before the previous Panel. I just wanted to know that. How are you able to assess whether the responses you have had to the thyroid treatment is not a placebo response?

A I hesitate, but will quote the art of medicine, but the critical issue to take a thorough history. I think a placebo response in a patient who has been ill for 20 years – and these are seriously ill patients – and then say they feel better is unlikely on *a priori* grounds. It can never be excluded, but a patient where 20 symptoms have disappeared – we have the testimony here – is unlikely to be a placebo. I think there has to be a common sense assessment. You can never quantitatively or objectively in some way say it is not.

Q When you have found the need to use Armour Thyroid, which I believe is really when the thyroxine has not kicked in properly or has not worked?

A Yes, in general, sir.

Q Does it always work?

A In a very large proportion of cases and including the patients I mentioned yesterday who have had thyroidectomy for possible reasons I suggested, I think it would be a bit sweeping to say that it always worked. I have had patients who started taking Armour Thyroid for one reason and another and who then took the synthetic preparations and improved. The individual patient variations, as you know, sir, is one of the major difficulties in medicine.

Q One final questions. On the paper that Mr Atherton took us to in D6, the papers which start with the World Health Organisation, on page 28, headed "Medical Hypotheses" "Should the TSH test be utilised in a diagnostic confirmation of suspected hyperthyroidism?" Have you got that?

A Yes.

Q The summary of the article makes it quite clear there, if I can quote from halfway down:

> "The TSH test should not be utilised in a diagnostic confirmation of hyperthyroidism because the diagnostic accuracy of the TSH test in confirming hyperthyroidism is unknown. Several aspects of the TSH test indicated poor diagnostic utility and thyroid hormone trial therapy is the best method for achieving diagnostic uncertainty."

It goes on to say:

> "Diagnostic confirmation of suspected hyperthyroidism should be accomplished by evaluation of the patient's response to a trial administration of thyroid hormones supplements."

That was published in April 2010. Are you aware of any papers which have specifically countered that statement, that conclusion in that paper?

A Yes.

Q You may have been able to produce them to us?
A Yes, there have been counter arguments to it, as one would expect. There have been rather few. If we go to, "TSH reference intervals should be maintained", that would be… May I address Mr Foster? I am not quite sure.

THE LEGAL ASSESSOR: Is that D5?

MR FOSTER: It is D5, number 6, page 11.

THE WITNESS: I have here got on the page before, which is not what you asked, the my initial research into people who agree with Dr Weetland, basically, and on the next page I have been trying to trawl for people who tend to the opposite view. I want to give my book balance.

THE CHAIRMAN: I am talking about since 2010?
A I am sorry. I have not found any in that since 2010.

Q Those who would have argued against Weetland, had Weetland been published before 2010, have not actually come back since 2010 to argue against it?
A No. I found no reposts, no academic reposts so far.

THE CHAIRMAN: Thank you very much. That is all I have. Mr Atherton.

<u>Further cross-examined by MR ATHERTON</u>

Q It seems from the paper we were just looking at at page 28 in D6 that the important recommendation is for evaluation, evaluation of the patient's responses. We see that three lines from the bottom of the summary on page 28 the best method for achieving diagnostic certainty and diagnostic utility and thyroid hormone trial therapy is the best method for achieving diagnostic certainty.

> "Diagnostic confirmation of suspected hyperthyroidism should be accomplished by evaluating the patient's response to a trial of thyroid hormone supplements."

What is your system for evaluation?
A I would say there are two strands to it. The essential system is to talk to the patient, as I have suggested, at follow up and ask what symptoms remain. We do augment that with – I think it was presented to the Panel yesterday – a symptom sheet which the patient fills in when they come before they talk to anyone. At every visit the patient fills a symptom sheet in which very usefully augments. I think the more important point is talking to the patient and asking what symptoms remain. I cannot think of any other approach really.

Q That would be a subjective response, clearly?
A It cannot be other than a subjective response if it is a symptom.

Q That is what I am wondering, whether there can be some objectivity in the

response by way of reference to blood testing?
A May I answer your first point first? You asked if there were any objective features. If we consider that symptoms are not, one can take the pulse, the temperature, one can look and see if the tongue has less – the general appearance of the patient. It would be tedious to go on, but these would be, if you like, signs rather than symptoms. I do repeat the thyroid chemistry. As I indicated, if there is something odd, then you obviously start thinking about the matter, if the TSH has gone up or something like that.

Q Would it be useful to have the data which would enable you to compare the subjective responses, as might appear on the patient's response sheet, with results of biochemical testing? Would that be a useful system to adopt in assessing?
A I think, with respect, that is our system. Maybe I do not understand your question and I am not being obdurate in the matter.

Q I will try to simplify it, if I can.

THE LEGAL ASSESSOR: Mr Atherton, if it helps, I have got down that he did say, "We do repeat the thyroid chemistry".

MR ATHERTON: Yes. I am not sure that quite answers the question. I bear in mind that you repeat the thyroid chemistry, but would it be useful to have a system, a comparative system between the results of the repetition of thyroid chemistry and comparison with the subjective responses as it appears on the sheets, or would that not be useful?
A Yes, that is very useful and that is what we do.

Q Is that done in a scientific way which might be incorporated into a response paper or a paper which would be of useful scientific value?
A Yes, indeed, and that was how we wrote this paper in June 2000, which I think was a very important contribution. It is a clinical response to thyroxine, clinically hyperthyroid, but biochemically euthyroid patients. That allowed that correlative analysis to which you are referring.

Q Has that been an ongoing practice since 2007, such that you would be able to produce yet another updated paper of that type?
A I am so presently doing.

Q Is there anything in the material that we have seen to that effect or is that still in your files?
A The paper I am talking about I have a rough draft of. I have not brought it with me.

Q Similarly, with regard to Armour Thyroid, it would be useful, would it not, to have an evidence base for the value of that treatment?
A Yes. That is also ongoing as part and parcel of the clinical practice. The Care Quality Commissioner is quite rigorous in that matter. They ask for your up to date appraisal etc.

Q You are in a position to be able to provide it?
A Yes.

Q What is the result of it?
A The result, as far as I can judge – as you say, I have not completed that particular paper – is enormous benefit from Armour Thyroid.

Q Evidence based by reference to subjective responses and to biochemistry?
A Yes, and by the patients sitting behind me who could not have come here once.

Q Subjective responses?
A It can only be subjective, a symptomatic feature, built in.

MR FOSTER: I have no re-examination, sir.

THE CHAIRMAN: In that case, thank you very much for giving your evidence, Dr Skinner.

(*The doctor resumed his seat*)

THE CHAIRMAN: We will now adjourn for lunch and come back at five-past two.

(*The Panel adjourned for lunch*)

MR FOSTER: Sir, that is all the evidence at this stage, so it is time for submissions.

THE CHAIRMAN: Thank you, Mr Foster. Mr Atherton.

MR ATHERTON: Sir, can I submit that it is appropriate for you to take as your starting point for this review the main findings that were made in 2007 and particularly those that were made with regard to Patient B. You have the Panel's determination in the yellow sheets and also in bundle C1. In my submission, there must be no doubt as to the seriousness of the findings that were made against Dr Skinner.

Picking up those findings with regard to Patient B in paragraph 8, the Panel first recorded the admitted fact that Dr Skinner saw Miss B as a private patient without a referral from her general practitioner. At the consultation it was found proved that he became aware of the fact that results of her blood tests showed her thyroid chemistry to be within the reference range. That he took an inadequate history was found not proved on the evidence of the patient, similarly sub-paragraph (d). Sub-paragraph (e) was that Dr Skinner provided the patient with a prescription for sodium thyroxine and after 17 June 2003 increased the prescription for three months.

As we go down, we see the other findings that were made. In paragraph 10(a) it was recorded when the doctor next saw the patient. In sub-paragraph (b), that between March 2003 and January 2004 he failed to monitor the patient adequately or at all and sub-paragraph (d), that the results of a report showed that the patient had become biochemically thyrotoxic and that that over replacement was a result of Dr Skinner prescribing thyroxine. On 21 January 2004 he again provided the patient with a

prescription for thyroxine.

The Panel found that that prescribing was inappropriate, that it was unnecessary, irresponsible, not in the best interests of the patient and placed the patient at risk of harm. The Panel added that head 11 was found proved on the basis that Dr Skinner continued prescribing thyroxine and added a prescription for Tertroxin when Miss B had become biochemically thyrotoxic and had exhibited palpitations.

The next paragraph alleged that on 18 March 2004 he saw the patient again and provided her with another prescription for sodium thyroxine and Tertroxin and again it was found that that prescribing was inappropriate, unnecessary, irresponsible, not in the best interests of the patient and placed the patient at risk of harm.

Similarly, in paragraph 14, moving on to 14 July 2004, there was again a prescription of sodium thyroxine with the same findings made by the Panel, with the comment that head 15 was found proved on the basis that Dr Skinner continued and increased the prescription of sodium thyroxine in the absence of any tests to establish whether the patient was not still biochemically thyrotoxic.

In respect of Patient C, there were also findings critical of the prescribing as inappropriate and unnecessary.

It is against that background that the Panel went on to provide its determination. Having said on page 15 of the determination that it had not made its judgment based on Dr Skinner's personal beliefs, it did observe the weight of the evidence to the effect that all the doctors who had given evidence had indicated that they would undertake blood tests when assessing the patient's condition and deciding on future management. It also recorded that Dr Skinner had stated that he believed biochemical thyrotoxicity to be a misconception. You will recall that Dr Skinner, in the course of this hearing, contends that that was a misrepresentation of his position by the Panel.

The Panel went on on page 15 to express concern that Dr Skinner had shown a lack of insight into his behaviour as clearly demonstrated by a statement provided to the Panel dated 7 September 2007, which clearly was before the Panel reached its determination, quite obviously, but in the course of the proceedings which extended over several months. In that statement he had stated his reasons for refusing to accept the earlier findings of the Panel and gave as an example:

> "In fairness to myself the text should be re-written and the term biochemical thyrotoxicity, which is a non-concept, removed."

The Panel observed that that approach was not supported by any other clinician.

The Panel went on at the bottom of that page:

> "The Panel is most concerned that your refusal to acknowledge that this approach may be flawed demonstrates that you have failed to reflect upon your practice."

In its determination on sanction on page 18, whilst recognising Dr Skinner's care and compassion and taking account of the written testimonials, it went on, nevertheless, to record the importance of the collective reputation of the profession and, on page 19, to express concern that he had prescribed thyroxine without taking blood tests and without regular review and monitoring.

Further to that, it was clear from the determination in July of this year that compliance with the conditions was but one aspect of the responsibilities of a reviewing Panel.

The essential question for you, in my submission, which has been raised by Panel members in the course of the hearing is the importance of ensuring the safety of patients. This case is remarkable for the support that has been demonstrated for Dr Skinner from his very many satisfied patients who have contributed hundreds of pages of testimonials, and remarkable for the strength of the support which has been sustained, indeed throughout the course of the last three days.

You have guidance in the Indicative Sanctions Guidance as to the treatment of references and testimonials. Although I do not think you will need to refer to it, to be reminded of it, the guidance says that testimonials will need to be weighed appropriately against the nature of the facts found proved. The quantity, quality and spread of references and testimonials will vary from case to case. This will not necessarily depend on the standing of a practitioner.

There is no doubt, therefore, that there is a substantial body of subjective opinion upon which Dr Skinner can rely and which has been taken into account on a previous occasion. It is right to observe, however, that each one of those testimonials is an individual expression and it is an expression which has been untested by reference to the surrounding medical evidence and untested for its value in terms of the scientific effect of Dr Skinner's prescribing.

It is clear from the documents received this morning that from page 28 of D6, the paper from the United States, even in that paper there was emphasis placed upon the importance of evaluation. Dr Akintewe reminded you, insofar as any reminding was necessary, that medical practice depends upon evidence based medicine.

I observe that, while on the opposite side of the room there are bound volumes of testimonials ready for production, although understandably not having been produced, there is no such bound volume of evidence relating to the results of Dr Skinner's prescribing practices which have been ongoing now for something like a decade or more. I observe, respectfully, that when asked about his ability to evaluate subjective and objective responses to his prescribing, in almost the last moments of the evidence he picked up from the desk and held up his apparently published paper in the year 2000, whilst also asserting that there was yet more objective evidence accumulated for the purposes of a forthcoming book.

In my submission, it is worthy of comment that, having received the report from Dr Akintewe and having responded to it in writing, as we see from the documents produced this morning, Dr Skinner has not thought that it was appropriate or necessary to present to you evidence accumulated over many years of practice in support of an

unorthodox course of practice which is not supported by the main body of UK practitioners in this field.

It seems that Dr Skinner has approached this hearing without regard specifically to the need to demonstrate to you the steps taken by way of remediation. That is the position notwithstanding the observations of the Panel in July of this year. You may think that it is somewhat surprising, or would be somewhat surprising, that a practitioner of his obvious intellect and ability would fail to observe the prime function of this Panel when exercising its reviewing responsibilities.

The material produced this morning, you may think, goes some way to demonstrate that Dr Skinner has been reflecting on the main issues of which he has been a proponent, but you may be concerned that it does not demonstrate an objective reflection upon those issues which, although he asserts he has not evidentially demonstrated, in my submission. For example, the letter from the Department of Health, you may think, is a rather surprising document. In light of the evidence which clearly was before the Panel in 2007 and which has been before you in the context of this hearing by Dr Akintewe, that letter clearly fails to recognise expressly the main body of opinion in this field in the United Kingdom. In a short sentence it conveys a message of great importance to the effect that such prescribing would be acceptable if a general practitioner could justify it to his or her Primary Care Trust.

I invite you to accept the evidence of Dr Akintewe that a doctor would have very great difficulty in justifying such prescribing to a Primary Care Trust. You may think it also surprising that an official within the Department of Health would assert that it was appropriate for a practitioner in the United Kingdom to have regard to practice elsewhere in the world as a justification for embarking upon practice that was not accepted within the main body of the medical community in the United Kingdom. The author of that letter has not presented himself for cross-examination and the comments and observations, therefore, remain untested, although they are relied upon by Dr Skinner to support his position.

I invite the Panel to exercise some caution where there is an understandable invitation to elide the issue of the prescribing of thyroxine, which was raised as a concern by Dr Akintewe, with the more specific concerns that led the Panel in 2007 to find that Dr Skinner's fitness to practice was impaired. The Panel in 2007 did not expressly resolve the issue as to the propriety of the prescribing of thyroxine or grain Armour Thyroid. In light of the evidence that was before it, it clearly felt that it was not in a position to find that Dr Skinner's prescribing *per se* in that respect was a matter for criticism or action on his registration and nor is it now.

Dr Akintewe was invited to comment upon any concerns that had occurred to him as he was reviewing these many cases. He did so and his observations, it appears, reflect the gist of the evidence that was called for the GMC in 2007.

What this does mean is that Dr Skinner is at one end of the views on this issue. It may be that in years to come his influence will bring about a change of culture. We do not know, but where a practitioner is in private practice prescribing in this way in the face of the body of medical opinion, then in my submission it is incumbent upon that practitioner to

take all steps to ensure that he is able to present his position objectively and to support it, so far as possible, evidentially.

In my submission, he does not discharge the second of those requirements simply by producing volumes of testimonials, nor with obvious subjective support. More is required. In my submission, in the absence of more, there remains a concern as to his ability to achieve objectivity and also to demonstrate insight and flexibility. What seems apparent from all of these 662 cases, save, I think, one is the fact that Dr Skinner has been prescribing thyroxine.

The Panel on the last occasion clearly endeavoured to take steps, so far as possible, to ensure the safety of the patients who were being prescribed thyroxine. They did it by ensuring that the referrals to Dr Skinner came from other medical practitioners, general practitioners, that they were properly referred and that his actions and intended actions were effectively communicated.

It seems from Dr Skinner's evidence this morning and, not surprisingly, you may think that some general practitioners who are so made aware express their concerns. It is unsurprising that they should do so because they would become aware that the prescribing was at one extreme of acceptable practice. It remains an open question as to their individual responsibilities for accepting such advice and for prescribing accordingly. It may be that even in those circumstances they would have to justify their positions to their PCT and, indeed, may be in difficulty in the event of something going wrong.

In my submission, the evidence that has been presented to you should fail to satisfy you that there is in place a sufficient system of monitoring, evaluation and feedback from which Dr Skinner, responding objectively, would be in a position fully to assess the results of his prescribing. In my submission, in the absence of an effective system, however difficult it may be to achieve in the case of a private practitioner, in the absence of such a system, this Panel cannot be satisfied that there does not remain a risk to patients as a result of the prescribing of thyroxine and/or Armour Thyroid in any given case.

I submit that in assessing the question of whether the doctor's fitness to practise remains impaired the relevant question is whether this Panel can be satisfied that, in the absence of any condition upon his registration, the safety of patients can be ensured and whether it is able to accept his assertions that his practice henceforth would incorporate the changes imposed upon him as a result of the conditions imposed in 2007.

In my submission, looking at this hearing and the way in which it has developed, there remains a lurking concern as to whether Dr Skinner has been able to demonstrate the flexibility of thought, objective reflection and, perhaps most importantly, insight into the matters which were of prime concern to the last Panel, or whether the picture here is one of a doctor, to use the metaphor, rowing his boat with ever greater strength in his intended direction. In my submission, those concerns are sufficient for this Panel to justify a finding that the doctor's fitness to practise remains impaired.

Those are my submissions.

THE CHAIRMAN: Thank you, Mr Atherton. Mr Foster.

MR FOSTER: Sir, the starting point is procedure rule 22(e):

> "The FTP Panel shall receive further evidence and hear any further submissions from the parties as to whether the fitness to practise of the practitioner is impaired or whether the practitioner has failed to comply with any requirement imposed upon him as a condition of registration."

As to compliance with conditions, there is no doubt. What we are arguing about at this stage is whether fitness to practise is impaired.

The starting point, as my learned friend has acknowledged, is the original determination. At C1, page 18 in the top paragraph, the Panel said:

> "It is not the remit of this Panel to decide on whether your approach to a treatment is correct or incorrect."

Nor, because this is a review hearing, is it your remit. The Panel noted that by the time Dr Skinner came before them he had changed his practice in a number of ways. We can see that at the foot of page 18. The Panel noted that following the intervention of the IOP and the Health Care Commission Dr Skinner had changed his practice in a number of ways since the incidents in this case took place. It notes, for example, that without exception he now only sees new patients with a doctor's referral.

> "The Panel also notes that it is your usual practice to confer with a patient's GP before instigating treatment and that you undertake regular ongoing monitoring in tandem with him or her. It is evident from the testimonials that, notwithstanding the cases considered by this Panel, such liaison with patients' GPs was your usual practice even prior to the imposition of the interim order."

What, then, were the concerns of the Panel? My learned friend has referred to some of these. My submissions will take the form of addressing each of the concerns.

At C1, page 15, we see a concern about rigid approach. It is concerned that that rigid approach has put patients at risk of harm. That is in the penultimate paragraph. In the final paragraph of C1, page 15:

> "The Panel has been concerned throughout this hearing that you have shown a lack of insight into your behaviour…"

It gave the specific example of refusing to accept the concept of biochemical thyrotoxicity, an idea to which I will return.

At C1, page 19, in the first substantive paragraph we see other concerns:

> "The Panel remains concerned that in the past you have prescribed thyroxine without taking blood tests and without regular review and monitoring."

It was concerned that there was prescription without review and knowing that a patient was biochemically thyrotoxic and had palpitations.

Rigid approach. In my respectful submission, that is an allegation which is more appropriately levelled against the view articulated by Dr Akintewe. His approach was that you judge whether a patient should have thyroid supplementation purely by reference to their biochemistry. So, if an extremely ill patient of the sort that Dr Skinner routinely sees came into Dr Akintewe's surgery, if they had normal biochemistry, he would send them away saying that he had no help to offer them. That, in my submission, is rigidity. It is not a rigidity of which Dr Skinner is guilty.

Essentially, all that Dr Skinner has said is that you should take into account all the available evidence. Of course, he acknowledges that a crucial part of the evidence which should be available before you consider thyroid supplementation will be the thyroid biochemistry, but he is sophisticated enough to acknowledge that that might not tell the full story. You might think that that is something to be commended in a doctor and not criticised.

It is not that Dr Skinner is dogmatically evangelistically committed to a particular approach. You have seen at C1, page 579 the 1997 letter to the BMJ in which he called for a randomised controlled trial. That is a 1997 letter saying, "We need more information. We need a randomised controlled trial". There is no element, and never has been, of Dr Skinner trying to suppress what the orthodox scientific way of doing things has to say.

We do have a very small randomised controlled trial. It is the 2001 trial which has been referred to in the course of evidence and argument. It is at C1, page 580. You will remember the criticisms which were voiced in the course of cross-examination of Dr Akintewe about it. It is a very, very small study and even the authors of that study acknowledge very frankly its limitations.

THE CHAIRMAN: One moment, Mr Foster. In order to make absolutely certain that we can refer to the pages, C1 only goes up to page 568.

MR FOSTER: Sir, there is an addendum which continues in the numbering.

THE CHAIRMAN: That is actually in C2.

MR FOSTER: I am obliged.

THE CHAIRMAN: That is the addendum which starts with the medico-legal report from Dr Akintewe.

MR FOSTER: Indeed, sir. Dr Skinner has been calling for a long time now for more science to be brought to bear. You will have seen that he has an encyclopaedic

knowledge of the literature and that is a subject to which I will be referring in the course of my submissions about insight and reflection.

My learned friend referred in his submissions to the Department of Health letter which you have at D6, page 36. He referred to the need for GPs to justify the prescription, for example, of Armour Thyroid to their PCT as in some way indicating that there was a doubt about the safety of this. At least, that was the implication behind his submission. Of course, that is not what we are concerned with here at all. This is a letter written entirely about, as it expressly says, NHS patients and the concern which a PCT would have is that of funding. The medical members of the Panel will be aware that it is very commonly the case that unlicensed preparations are prescribed, particularly as was discussed with Dr Akintewe in the context of paediatric medicine.

The patient cohort that is seen by Dr Skinner is tremendously important because Dr Skinner is essentially a physician of last resort for many of these patients. You will have seen the referral letters. Many of these patients have gone through many other doctors before they come into the hands of Dr Skinner. Those doctors essentially have failed them. Lots of them, as Dr Skinner told us and as the testimonials indicate, are very gravely ill, so they are very difficult patients.

One sign of rigidity in practice would be, for example, a reflex prescription of thyroxine to all these patients. My learned friend said in a throwaway comment that there is evidence here of the prescription of thyroxine to all the 662 patients looked at by Dr Akintewe. That is certainly not in evidence. Of the 662 patients a tiny number attracted the unfavourable attention of Dr Akintewe because thyroxine was prescribed in the presence of what he described as normal thyroid biochemistry. Taking the GMC's case at its height and assuming that Dr Akintewe is entirely right to describe the British levels as representing normal thyroid biochemistry, we have 20 out of 662 patients who had normal thyroid biochemistry in respect of whom thyroxine was prescribed, hardly evidence, in my submission, of a unthinking, reflex prescription of thyroxine.

That is even more so in relation to Armour Thyroid. We have twelve out of 662 patients. We went in detail through those patients and it was demonstrated, in my submission, that in every respect Armour Thyroid was shown, exceptionally, to be the last resort treatment of choice.

In each of the letters back to the GP, a number of which you have seen, you will see evidence of Dr Skinner's bespoke treatment, bespoke consideration of these patients. The very fact that we have got a vast number of GP referrals to Dr Skinner indicates in itself that there are lots of people out there who think that Dr Skinner has something to offer. You will note that Dr Skinner is sometimes referred to when consultants are at the end of their tether. An example of that is Patient 2, whose records you will find at page 80.

Was Dr Skinner unreflective in his consideration of what these patients should have? He frequently refers to the dilemmas which face a clinician. He frequently refers to not being quite sure what to do. This is not the mark of an uncritical evangelist blanket bombing his patient population with thyroxine and Armour Thyroid. I have already pointed out that he is very aware of the debates in the literature, clearly to a much greater extent than his critic, Dr Akintewe, was.

That is rigidity. What about lack of insight and failure to reflect? My learned friend very fairly conceded this morning that the material which you have in the form of the index and the associated papers indicate a very, very, very great deal of reflection on these matters. Whatever criticisms can be directed against Dr Skinner it is not lack of erudition and it is not lack of research into these matters. You will see in the index of the book which he proposes to write that there are chapters devoted to considering the case against the one which he sometimes clinically articulates.

One of the comments about the insight of Dr Skinner which was raised by the original Panel in 2007 related to biochemical toxicity. It may be that there was a misunderstanding. It has now been cleared up. It is plain from Dr Skinner's evidence this morning that of course he acknowledges that if you give someone too much thyroxine or too much Armour Thyroid, then they become thyrotoxic. That was always his position. It was with that concern in mind that he instituted his regime of monitoring to which I will come in a moment.

Another of the concerns which the Panel raised was the prescription of thyroxine without blood testing. That can be answered shortly. It does not happen. Dr Skinner has told you repeatedly what a valuable part of the composition of any responsible treatment regime thyroid biochemistry is. He has told you how he makes sure that he has it. There is a tiny number of cases each year in which a very ill patient will be given a small dose, for example, of thyroxine in order to improve them because they need thyroxine supplementation very urgently. That is not as an alternative to thyroid biochemistry. The thyroid blood sample is taken immediately and the subsequent progress of that patient is monitored by reference to that thyroid biochemistry.

That brings me to issues of review and monitoring. Dr Skinner is very well aware, of course, of the possible complications. Evidence for that is the sheet which is handed to all patients indicating the things which they are to look out for. Evidence also includes the chapters in the proposed book which deal with the known complications of thyrotoxicosis. The written warnings are reiterated orally by Dr Skinner in the course of his conversations with the patients and the sheet itself you have at D4.

In each of the letters back to the GP that you have seen you will see specific provision for review by Dr Skinner. He never gives a patient a prescription for more than three months. If a repeat prescription is asked for it has to be done by the sheet which you have at D3, which is specifically designed to ensure that these potentially dangerous drugs are not handed out irresponsibly, that the clinical justification for a repeat prescription is articulated.

All communications with the patients are logged on a special sheet which you have seen at D2. The GPs are specifically asked in the letter which goes back to them to monitor the thyroid biochemistry. A point was raised in evidence and was adverted to by my learned friend a few moments ago about how Dr Skinner would know whether a patient had defaulted in going back to the GP. With respect, that is an unrealistic issue to raise. Of course, the provision which Dr Skinner has to chase patients is really rather better than that which we see in most NHS institutions. If someone is referred by a GP to a hospital and then does not come back to the hospital for their appointment there may be a chasing

letter, but there certainly is unlikely to be an attempt such as Dr Skinner makes to chase the patient by telephone. Often the question of non-attendance will be simply notified to the GP in whose hands the subsequent responsibility rests.

The system which Dr Skinner has in place is better than that which exists in most referral NHS institutions. Nonetheless, Dr Skinner had the humility to acknowledge that the suggestion made that perhaps more could be done along those lines was a sensible one and one which he will think about further.

In the light of that discussion, is Dr Skinner's fitness to practise impaired? In my submission, the answer is that there is not one little bit of evidence that it is. In fact, Dr Akintewe refused to say whether he thought Dr Skinner's fitness to practise was impaired. We can see that at page 575 in C2. Dr Skinner has complied with the conditions. One may not agree with is views on the treatment of hyperthyroid patients with normal thyroid chemistry nor with his use of Armour Thyroid.

> "I note that the letter from the GMC said that my conclusion should answer the key question as to whether the standard of care provided by Dr Skinner fell below that expected of a reasonably competent doctor of the same discipline and grade. I may not always agree with the type of treatment provided by Dr Skinner, but believe the question of his competence is up to the Panel to decide."

The position really has not moved from that in the course of this hearing. In the absence of any expert help as to fitness to practise, in the circumstances of this case, I respectfully submit that it is impossible to say that Dr Skinner's fitness to practise is impaired.

How did my learned friend put it? He acknowledged that there was no evidence that Dr Skinner was outside the bell curve representing acceptable opinion. He said that Dr Skinner was at one end of the views expressed. That, of course, does not begin to amount to evidence of impaired fitness to practise *per se*.

In attempting to justify his suggestion that fitness to practise was impaired my learned friend said that he was concerned about objectivity, insight and flexibility. In my submission, I have addressed all of those issues very specifically and there is nothing left. In commenting on objectivity, my learned friend appeared to be saying that he would like there to be in the literature a randomised controlled trial, a better evidence base for the prescription of these compounds *per se*.

I have two observations about that. Firstly, it is essentially a suggestion that you should go outside the remit of the original Panel and that is something that you must not do. Secondly, you have heard that Dr Skinner himself has repeatedly called for that evidence and is compiling a paper which sets out exactly that, so it may be that the best point that the Counsel can make against Dr Skinner, if that is the line about impaired fitness to practise that they are taking, is simply that he has not got round by now to publishing his own trial, which is hardly a strong basis on which to stand a submission of impaired fitness to practise.

There has been no evidence, either in the course of the investigation of the original allegations or in the 662 patients looked at by Dr Akintewe, of any harm whatsoever which has been done to patients. Even the original Panel had to talk in terms of risk of harm which did not eventuate. On the contrary, the original Panel commented at C1 on page 18:

> "A large body of evidence has been submitted throughout this case demonstrating…"

a very strong word,

> "…that many patients have benefited from the medication which you have prescribed."

One must add to your determination of fitness to practise the huge volume of testimonials which are available in this case. They are from patients who attended Dr Skinner, often in a grievous state, whose lives have been turned round. You will find them in the bundle at pages 110 to 211, then again from 282 to 417, then from 432 to 568 and in the addendum from 512 to 616. I have already said that I could, but will not, add that enormous weighty bundle to your consideration.

What the complete absence of any evidence of harm indicates is that the safeguards to ensure patient safety which Dr Skinner has put in place, quite without any coercion from the Panel, are working, that he selects patients appropriately, that he prescribes appropriately.

Sir, for all those reasons, I suggest that it has been demonstrated, not only that there is no evidence that Dr Skinner's fitness to practise is impaired, but there is a great deal of evidence that he is a very competent doctor indeed. In its determination on sanction at C1, page 19, the Panel noted in the second paragraph that there was no evidence of harmful deep seated personality or attitudinal problems and no evidence of general incompetence. This Panel has had before it evidence which allows you to go rather beyond that, to say that this is a doctor of very great ability and reflection and insight.

Sir, those are my submissions unless there is anything else I can help you about.

THE CHAIRMAN: Thank you, Mr Foster. Legal Assessor.

THE LEGAL ASSESSOR: You have heard very detailed and accurate submissions on the legal framework and on the issues from both representatives which I commend to you, but I make no apology for repeating at times what both representatives have said.

This is a review hearing and, accordingly, is governed by rule 22. Rule 22(f) now requires you to consider whether Dr Skinner's fitness to practise is impaired or whether he has failed to comply with any requirement imposed upon him as a condition of his registration.

Mr Chairman, I see you scribbling away. I can get this printed off for you if you want it.

In this case it is not contended that Dr Skinner has breached any of the conditions imposed upon him by the previous Panel, so the only question for you is whether his fitness to practise is currently impaired.

When deciding this question I remind you that neither party bears any burden of proof, so Dr Skinner does not have the burden of proving it to any standard. However, as has been mentioned before, your starting point is the determination of the previous Panel. That Panel made it clear that it had not made its judgment based on Dr Skinner's personal beliefs as to methods of treatment, save insofar as those beliefs showed disregard of his clinical responsibilities towards his patients. It noted that following intervention he had changed or consolidated his practice in a number of ways since the incidents that gave rise to the charges took place. It noted, for example, that without exception he only saw new patients with a doctor's referral, that he usually conferred with a patient's GP before instigating treatment and that he undertook regular monitoring in tandem with that GP.

However, the Panel remained concerned that in the past Dr Skinner had prescribed thyroxine without taking blood tests and had prescribed without subsequent review. Accordingly, it imposed the conditions it did to address these matters.

Although the GMC do not argue that Dr Skinner has breached any of his conditions, it has expressed concerns about his treatment of 20 of his patients with thyroxine in spite of normal thyroid chemistry and possibly solely on the basis that thyroid chemistry is a good servant but a bad master, and also his treatment of other patients, some twelve, with drugs that are not licensed in the UK.

These concerns have not been made the subject of any new allegations or charges. I would therefore advise you to treat the question of those concerns on the same basis as the previous Panel, namely, to consider whether his current practice and beliefs still show disregard of his clinical responsibilities towards his patients and whether they demonstrate that he now has insight.

As background to your deliberations you should bear in mind that to practise safely doctors must be competent in what they do. They must establish and maintain effective relationships with patients, respect patients' autonomy and act responsibly and appropriately if they or a colleague fall ill and their performance suffers. Doctors have a respected position in society and their work gives them privileged access to patients, some of whom may be very vulnerable. A doctor whose conduct has shown that he cannot justify the trust placed in him should not continue in unrestricted practice while that remains the case.

The public is entitled to expect that their doctor is fit to practise and that he follows the GMC's principles of good practice by ensuring, firstly, the provision of good clinical care, secondly, the maintenance of good medical practice, thirdly, the maintenance of good relationships with patients and with colleagues, fourthly, honesty and trustworthiness and, fifthly, that their own health does not endanger patients.

Impairment of fitness to practise is not defined in the Medical Act 1983, as amended, so how, then, do you go about it? First of all, a finding of impairment of fitness to practise is arrived at, if at all, by five routes as set out in section 35C(2), where it is stated that a

person's fitness to practise shall be regarded as impaired by reason of misconduct, deficient professional performance and other matters which are not relevant to this case because you are invited to find impairment solely by misconduct and/or deficient professional performance.

I remind you of what Mr Justice Cranston said in the case of *Cheatle v GMC* at paragraph 19:

> "Whatever the meaning of impairment of fitness to practise, it is clear from the design of section 35C that a panel must engage in a two-step process. First, it must decide whether there has been misconduct, deficient professional performance or whether the other circumstances set out in the section are present. Then it must go on to determine whether, as a result, fitness to practise is impaired. Thus it may be that despite a doctor having been guilty of misconduct, for example, a Fitness to Practise Panel may decide that his or her fitness to practise is not impaired."

Mr Justice Cranston went on to say:

> "There is clear authority that in determining impairment of fitness to practise at the time of the hearing regard must be had to the way the person has acted or failed to act in the past."

He quotes Sir Anthony Clarke MR in *Meadow v General Medical Council*, who said:

> "In short, the purpose of [fitness to practise] proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past"

Mr Justice Cranston continued:

> "In my judgment this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct."

Impairment is not a variable concept. You are to focus on the question of whether Dr Skinner's fitness to practise is, as of today, impaired. The benchmark by which to gauge impairment is the standard required of a competent registered medical practitioner. Conduct falling far below that expected of a medical practitioner so as to be obvious that intervention by the regulator is necessary for it to carry out its role establishes impairment of fitness to practise.

I remind you that the role of the regulator is to ensure, firstly, the protection to members of the public, including patients; secondly, the protection of public confidence in the profession and, thirdly, the upholding and maintenance of standards.

I also draw your attention to what the Honourable Mr Justice Silber said in the case of *Cohen v GMC*, which, for completeness, I should direct you on. He says at paragraph 65, and this has relevance to what factors to take into account in considering impairment:

> "…It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated…"

He also mentions:

> "There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of a medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practice has not been impaired… Indeed section 35D (3) of the Act states that where the Panel finds that the practitioner's fitness to practice is not impaired, '*they may nevertheless give him a warning regarding his future conduct or performance'*."

However, notwithstanding what the Honourable Mr Justice Silber says about the possibility of imposing a warning, if you do conclude that Dr Skinner's fitness to practise is, as of today, not impaired, my advice is that you do not have the power to consider the question of a warning. This is because rule 22(g) limits the sanctions that can be imposed to those referred to in section 35D(5) (6) (8) (10) or (12), which, namely, are suspension, further conditions or erasure, but makes no mention of section 35D(3) which deals with warnings.

Moreover, rule 22(h) which considers what a Panel may do as an alternative to imposing sanctions only refers to the possibility of accepting undertakings and makes no mention of warnings. In the various guidance to the FTP Rules and in the Indicative Sanctions Guidance, again, in these circumstances, the possibility of issuing a warning is not mentioned.

Finally, whatever your decision on impairment, and I repeat that it is your decision alone – the fact that one party or another has made what might be considered concessions along the way, it is your decision alone. I remind you also that you are to give reasons for your

conclusions. Thank you.

THE CHAIRMAN: Do either Counsel wish to comment on the Legal Assessor's advice? Mr Atherton.

MR ATHERTON: No, thank you.

THE CHAIRMAN: Mr Foster.

MR FOSTER: No, thank you.

THE CHAIRMAN: Thank you very much, Legal Assessor. In that case, we will go into *camera* to consider the matter.

I am quite sure that we can release the parties for the rest of the day. Mr Atherton, I believe that you have a particularly important engagement in the morning.

MR ATHERTON: I do, sir. I can make arrangements to cancel that if you feel it would be appropriate.

THE CHAIRMAN: As we are *in camera* now and because it is very important that we not only consider accurately and completely, but write a determination which is accurate and complete, it takes a considerable time. I do not see any problem in not starting early in the morning, not starting at the normal time. I would in any case imagine that we would not be ready before, at the earliest, eleven o'clock. Should we be and you are not here, then obviously we will wait for you, but I do not suppose it will be too long after that.

MR ATHERTON: I am very grateful.

THE CHAIRMAN: I release the parties at least until eleven o'clock in the morning.

STRANGERS, THEN, BY DIRECTION FROM THE CHAIR, WITHDREW AND THE PANEL DELIBERATED IN CAMERA

(*The Panel later adjourned until 9.30 a.m. on Thursday, 17 November 2011)*