GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Saturday 8 September 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 Fifteen)

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

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

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

Transcript of the shorthand notes of Transcribe UK Ltd
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THE CHAIRMAN: Good morning. This is the Fitness to Practise Panel hearing inquiring into the case against Dr Skinner. We are reconvening today to consider whether the evidence as to whether the facts found proved result in the impairment of the fitness to practise of Dr Skinner. Just to remind you all that your mobiles are off. Should the name of a patient involved in this case be mentioned in error, please do not take it from the room, do not mention it outside and if you have the need to talk, could you do so outside? When we do have different breaks will you please take your things with you when you go, for security reasons. Thank you. Mr Kark?

MR KARK: Good morning. I am now, of course, addressing you under Rule 17(J) that the FTP Panel shall here receive further evidence and hear any further submissions from the parties as to whether, on the basis of any of the facts found proved, the practitioner's fitness to practise is impaired.

I hope you will forgive me a very short analysis of your findings, given that there has been a delay of the proceedings and that there are members of the public here who were not present before, and particularly Dr Skinner, of course, who will have had your findings but was not present when they were read out.

In respect of Patient A, first of all, although a number of facts were proved there were no facts proved which amounted to criticism of his conduct, apart from the failure to investigate the B12 deficiency and refer to an endocrinologist, but you found so far as that was concerned, that that was not inappropriate, etcetera, in light of the fact that he had informed Dr Cook of his suspicions.

As far as Patient B was concerned, you found that you could not be sure that the initial prescribing of 20 March 2003 with Thyroxine for a trial period was inappropriate. However, you were sure that between 20 March 2003 and 21 January 2004, which was the next visit, that Dr Skinner had failed to monitor Patient B, that on 21 January Dr Skinner had the blood test showing that his patient was biochemically thyrotoxic, you found that that thyrotoxicity was caused by Dr Skinner, that his prescribing of Thyroxine and Tertroxin on 21 January 2004 was inappropriate, unnecessary, irresponsible, not in the best interests of the patient and to place Patient B at risk of harm; that his further prescriptions on 18 March 2004 and 14 July 2004 were also both inappropriate, etcetera, because no blood tests were taken during that whole period.

Further in relation to Patient B, you took particular account of the fact that she had exhibited palpitations both before the 21 January 2004 consultation and that on 18 March.

In the light of those findings in particular, simply in relation to Patient B, the GMC would submit that Dr Skinner's fitness to practise has clearly been demonstrated to be impaired.

Patient C, you were not satisfied that the trial with Thyroxine was inappropriate on 6 March 2004. However, the further prescription on 8 May 2004, in the absence of any blood tests and given the addition of Tertroxin, you found was both inappropriate and unnecessary. You found also that the blood tests of 7 August 2004 showed that Miss C had become biochemically thyrotoxic and you also found that Dr Skinner had failed to take any steps to reduce her dose - really mirroring his actions so far as Patient B had been concerned and in fact Dr Skinner advised her to remain on the same dose.

You also found that Dr Skinner did suspect his patient may be suffering from adrenal failure and failed to refer to an endocrinologist. In respect of that can I just point you in the right direction, should you need it, to be reminded of Professor Weetman's evidence about the importance of adrenal failure, which you will find at D4/47, and so far as B12 is concerned, which is also relevant, he dealt with that at D4/29. I will not read all of his evidence about that now but you have those references.

As far as Patient D was concerned, again you could not be satisfied that a trial of Thyroxine was inappropriate, nor were the subsequent prescriptions of 17 November 2004, nor those throughout 2005, although you were critical of the lack of blood tests, and you also found that the patient had been rendered biochemically thyrotoxic as a result of Dr Skinner's prescriptions.

Finally in relation to Patient D, you found that in November 2004 Dr Skinner had suspected a B12 deficiency but failed to take any action in relation to it. Nor did he inform the patient's GP.

That is a brief summary, I hope an accurate summary, of the basis of your findings.

The question of impairment, of course, is simply a question for you, a matter of your professional judgment, sitting as an experienced Panel. Impairment has been referred to as meaning damaged or injured or less effective or devalued and you may think that those are helpful definitions. There is also very limited assistance to be found in the Indicative Sanctions Guidance of April 2005, at page S1-2, paragraph 11. It is just a few pages in:

> "Neither the Act nor the Rules define what is meant by impaired fitness to practise but for the reasons explained below, it is clear that the GMC's role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practise either with restrictions on registration or at all."

It is the GMC's submission that, based on your findings, Dr Skinner has offended some of the basic guidance set out in Good Medical Practice, so can I take you please to the relevant Good Medical Practice, which is that approved in May 2001 and issued in September 2001. I am afraid I do not know where you will find that. It looks as if it is behind your green tab 4. Could you go first to the inside cover?

DR ELLIOT: In mine it says May 2001. Is that the one you are referring to, Mr Kark?

MR KARK: Yes. It was approved in May 2001. You are quite right, it was approved May 2001, in fact it was issued in September. The inside cover, first of all:

> "The duties of a doctor registered with the General Medical Council.
>
> Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human

life. In particular as a doctor you must:

make the care of your patient your first concern;"

Then can I take you down to bullet point 7:

"keep your professional knowledge and skills up-to-date;

recognise the limits of your professional competence;

...

work with colleagues in the ways that best serve patients' interests."

Can I take you over the page please, paragraph 1:

"All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.

Good clinical care must include:

an adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination;"

You may think that, in relation to that, the lack of blood tests is relevant.

"providing or arranging investigations or treatment where necessary;"

At 3:

"In providing care you must:

recognise and work within the limits of your professional competence;

be willing to consult colleagues;

be competent when making diagnosis and when giving or arranging treatment;

...

keep colleagues well informed when sharing the care of patients;

..."

> prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs. You must not give or recommend to patients any investigation or treatment which you know is not in their best interests, nor withhold appropriate treatments or referral;"

There is, I think, one further relevant paragraph and that is paragraph 45. Of course it is a matter for you and you have reference to this entire document, but this is a specific feature that I point out to you. Paragraph 45, sharing information with colleagues:

> "If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects. If the patient has not been referred to you by a general practitioner, you should inform the general practitioner before starting treatment, except in emergencies or when it is impracticable to do so. If you do not tell the patient's general practitioner, before or after ... treatment, you will be responsible for providing or arranging all necessary after-care until another doctor agrees to take over."

I bring that to your attention specifically in relation to the failure to refer the patient for suspected adrenal failure to the general practitioner.

In addition to the heads of charge that you have found proved, can I also take you back to head of charge 33, which we have not really spent any time considering to date, but it is now relevant at this stage of the proceedings. I am going to read it through:

> "33. a. In a letter dated 1 September 2004 the General Medical Council, in the light of information it had received, invited you to agree that an assessment of the standard of your professional performance be carried out,
>
> b. In a later dated 3 October 2004 you agreed to undergo a performance assessment,
>
> c. In a letter dated 10 November 2004 you returned the PDL1a and PDL1a2 forms completed which contained an acceptance of the invitation from the screener to undergo an assessment of the standard of your professional performance,
>
> d. In a letter dated 6 January 2005 the solicitors acting on your behalf, RadcliffesLeBrasseur, wrote a letter to the General Medical Council stating that they had "received specific instructions" from you to the effect that you no longer agreed to an assessment of your

performance being carried out,

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

In relation to that, Rule 17(8) provided as follows:

"Subject to paragraph (7), where a practitioner has failed to submit to, or to comply with, an assessment under Schedule 1 or 2..."

- and that would include a performance assessment -

"...and -

(a) there is credible evidence before the FTP Panel that the practitioner's fitness to practise is impaired;

(b) a reasonable request has been made by the Registrar to the practitioner that he submit to or comply with the assessment; and

(c) no reasonable excuse for such failure has been provided by the practitioner,

the FTP Panel may take such failure into account in determining the question of whether the practitioner's fitness to practise is impaired."

In considering whether there was a reasonable excuse, when Dr Skinner gave evidence the effect of his evidence was that he had refused to comply with an assessment because of the nature of the anonymous complaints, but I think it is worth looking very briefly at the history of how that request for a performance assessment came about. I am afraid you will have to refer to file 2. Of course, if you were to find that he had a reasonable excuse then you would not be entitled to use this failure to support any finding of impairment. In fact even without it, of course, we would submit that there is substantial evidence of impairment.

We start at file 2 and page 2 in the bottom right-hand corner of that. It says tab 3. The first document there I think starts at page 2 and it is the letter from Dr Liz Jordan to the General Medical Council dated 26 January 2004 raising a concern over the prescribing habits of Dr Skinner. Could I ask you to go to the next page, which is the letter to Dr Skinner dated 9 March 2004 informing him that information had been received from Dr Jordan and she encloses - she being Ceri Floyd - a copy of her letter from Dr Jordan.

If we go to page 9, bottom right-hand side, we have Dr Skinner's response to that and enclosing his letters to Dr Blair. Can we go to page 14? Dr Skinner writes to Ms Floyd, saying:

"Thank you for your note and allowing me the opportunity to respond to the complaint..."

- and he does so, ending that page by saying:

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

A further letter from the GMC, dated 26 March 2004, informing Dr Skinner that the case is going to be referred to a medical screener. A reply from Dr Skinner. Then can I take you please to page 20, a further letter from the GMC to Dr Skinner dated 23 July 2004:

> "I write further to my letter of 9 March in relation to information we have received about you from Dr Jordan."

A screener has been appointed and Dr Skinner should provide his response. It sets out at the bottom what the screener is going to consider in relation to the information received from Dr Jordan. Over the page it sets out that there were also other complaints and it is those, as I understand it, to which Dr Skinner essentially takes exception.

There was then a flurry of correspondence about whether Dr Skinner had got that correspondence. Then it was sent off to him again on 1 September 2004, as you see at page 30. Dr Skinner, perfectly understandably, asking for an extension of time, which he got. Then page 37, he thanks Ms Floyd for her prompt response and agreement to a postponement. He writes:

> "It is impossible for the MPS solicitor, with whom I have an appointment on 1 October 2004, to provide optimum advice, indeed any sensible advice when the patients and, indeed, some of the complainants are anonymous, although some are clear to myself who is or was their carer. Why are they required to be anonymous."

Then page 39, a letter dated 28 September:

> "The medical screener has decided on the basis of the same information sent to you that you should be invited to agree to a performance assessment."

Dr Skinner writes back on 29 September, including the complete correspondence in relation to his patient, saying:

> "I believe the screener may have waived the requirement for a performance assessment following a review of the complete material."

Then this at page 45:

> "I refer to your note of 28 September 2004. I agree to a performance assessment, which I hope will at last stimulate an evaluation of three of the outstanding problems in the diagnosis and management of

> *(inaudible)* hyperthyroidism, namely the criticality of clinical evaluation and diagnosis and management."

Over the page in summary he says:

> "I look forward to an opportunity to not only clear my reputation of these unworthy allegations but would be pleased to know what is the precise evidence of any wrong-doing or substandard care or poor relations with colleagues."

At the end he says:

> "I can provide documents which flag up serious shortfall in our care of hypothyroid patients."

The GMC write back to him, formally acknowledging his agreement and he is sent back forms PDL1a and 1a2, as you see at page 48. That is dated 10 November 2004.

In order to make sense of this, one keeps a finger there and if you go to tab 4, at page 2, you will see a letter dated 12 November to Dr Skinner from the GMC:

> "I am writing to confirm that we are now making the arrangements for your performance assessment.
>
> We are aware that your specialty is General Practice. I enclose information describing the nature of the assessment processes for doctors in that specialty. Please let me know if any of the details require clarification."

Then it sets out what is going to happen in terms of the assessment.

SJ2, starting at page 9, you will see the portfolio that Dr Skinner was required to complete and which he did complete, headed, "The portfolio for general practitioner undergoing assessment by the GMC". Throughout that portfolio Dr Skinner makes it clear that his specialty is the treatment of thyroid disease, that most of his patients are hypothyroid. If we go to page 64, which is the section dealing with his "Confidence and familiarity ratings", there is a very mixed bag, as it were, in relation to his confidence in dealing with specific general clinical skills, specific clinical skills, and over the page to page 67 - we did look at this briefly during the evidence - his ability to identify psychological problems, dermatological problems, paediatric problems and the rest. Page 68 is revealing. I do not mean that unfairly, but under the heading "Medical problems", in relation to all but three of them he indicates that he deals with these particular problems very rarely, but of course he deals, he says, with hypothyroidism very frequently, he deals with thyrotoxicosis he says rarely and he deals with anaemia rarely.

We then have to go back to page 53 at tab 3, which is a letter from RadcliffesLeBrasseur, dated 6 January 2005 and RadcliffesLeBrasseur write:

> "We write to advise you that we have received specific instructions

> from Dr Skinner to the effect that he no longer agrees to an assessment of his performance being carried out. He makes this decision in the light of recent correspondence which he has had with the Council, and appreciates that the Council may take the view that an assessment panel has now been convened. Dr Skinner's contention is that it is neither necessary nor appropriate."

You will have to consider what the true reason lying behind the refusal to the performance assessment was. The GMC's submission, we suggest, that it must have become very apparent to Dr Skinner when he had filled in the portfolio that there is no way that he was going to meet, be able to perform properly an assessment that would be required of somebody in general practice, but equally he would realise that he would not be able to meet an assessment for somebody specialising in endocrinology.

If you find that failure was unreasonable, you are entitled to take that into account when considering the issue of impairment.

It is the GMC's submission that even without that failure to undergo an assessment, there is a considerable body of material before you, on the basis of the facts that you have found proved, that his fitness to practise is impaired.

There is a document that Dr Skinner himself has produced, which I have been shown - it was handed to me by Mr Shipway this morning - and I gather this is going to be put in as part of the defence case of impairment. I will say only this about it, that when you read it through you may feel that it demonstrates a complete lack of insight and amounts to evidence that he has no intention of changing his ways and you may consider that it reflects his view both of your findings and whether he has demonstrated any insight into what you have found him to have done. When considering whether he is now impaired, you would be entitled, in my submission, to take that into account. I know Mr Jenkins intends to put it before you at this stage in any event.

Those are my submissions.

MR JENKINS: Madam, I am going to call one or two witnesses, if I may. Can I tell you why I am proposing to call them? I am going to call Dr Asha Ahmed, who works with Dr Skinner in virology work, but also has a role in the clinic that you heard about in Alcester Road in Birmingham. She is relevant because she can talk about the Health Care Commission and how the practice is presently set up, the level of communication with GPs and the regulatory process that this private clinic is part of under the Health Care Commission. In deciding the general question whether this doctor's fitness to practise is impaired, plainly the position as it is today, so far as the frequency of blood tests, the communication with GPs, those are relevant issues, I say, and I will call Dr Ahmed in that regard.

Mrs B is here and I will call her as a witness. She is obviously able to talk about her own treatment and her views of Dr Skinner.

I have got a number of other patients that I would like to call. I know there is an objection to me calling other patients at this stage. I will deal with the objection later, if I may, but I

would like to call the patients.

I also have a number of letters, testimonials from GPs, other health care professionals, some of whom have been patients of Dr Skinner, and obviously they express a view in their letters. Others are doctors, GPs, who have referred patients to Dr Skinner and again I would like to place those before you. I anticipate there may be an objection to that as well.

Again, just to set out my position on Dr Skinner's behalf. You have to decide whether this doctor's fitness to practise as at today is impaired. You have looked at four specific cases, but you are looking at a wider question, not merely in respect of these four patients: was his fitness to practise impaired? You are looking at the present question: is his fitness to practise impaired? Plainly, having found criticisms in respect of some of the allegations raised against him, if the general standard of his practice is extremely high then that must be relevant as a consideration when you come to consider the specific allegations that have been admitted and/or found proved against him, but I say that by way of preamble.

I have also got the document that Mr Kark has referred to and I think it might be sensible to hand that out now.

MR KARK: Yes, can I say, on the witnesses that Mr Jenkins has indicated that he wants to call, first in relation to the doctor, I can see that there could be relevance of that, so that at least he should know the current position. It may be helpful if we put before you the cases of *Campbell* and also *Donkin*, so that you set some parameters as to what other evidence you could hear, which could be relevant to impairment. It would certainly be my submission that patient evidence by way of testimonial, effectively to say what a good doctor Dr Skinner is or how much he has helped the patient, could not help you at this stage. Certainly it may be relevant to sanction, but it cannot be relevant to impairment, and there is authority specifically on that. I do not know when you want to hear that particular argument, but it might be helpful to have the law set out insofar as we can agree it in advance of hearing any evidence and in advance of making any rulings that you will have to about whether you will hear the patient evidence.

MR JENKINS: I do not mind at all. I am perfectly happy to have the argument now if that is felt to be appropriate. I do not have copies of *Campbell* or *Donkin* but if they are available...

MR KARK: I do not have them for the Panel yet. We can have copies made.

MR JENKINS: Why do we not organise that and I will organise for one passage from Dame Janet Smith's fifth report into the case of Shipman to be photocopied because that has a bearing on the same issue. It may be that that can be photocopied as well, but perhaps I can start, whilst the photocopying is being done, by calling Dr Asha Ahmed.

THE CHAIRMAN: Excuse me, just a minute. I just wanted to ask the Legal Assessor if there is anything he wanted to say at this stage. You are suggesting, Mr Jenkins, that we proceed with the doctor?

MR JENKINS: With Dr Ahmed, who is a professional colleague of Dr Skinner, but she is not a medical doctor.

THE CHAIRMAN: Mr Kark is not---

MR JENKINS: He is content with that.

THE CHAIRMAN: Right.

MR JENKINS: Then I will call Mrs B and I think Mr Kark similarly has no objections, given the Panel considered her case at some length.

MR KARK: Can I just mention in relation to the copies, that they are, I am afraid, slightly marked, not with any comments but with lines, but they are actually lines to the parts that I will be drawing your attention to, so I do not think there is too much damage.

THE CHAIRMAN: Mr Kark, I just want to ask you, am I right in thinking that you are contending that it is all right to hear Dr Ahmed, you are objecting to Patient B?

MR KARK: I am objecting to Patient B. At the moment I do not know what Patient B is going to say, but on principle I am objecting to Patient B. You having made your findings in relation to Patient B, it is difficult to see how at this stage she can assist you, interesting though her evidence might be. That is why I say I think it might be useful to establish the principles, as it were. Obviously you will have to know the legal principles before you can make any ruling. I do not know exactly what Patient B is going to say and she may fall into the same category as other patients. It is effectively testimonial evidence.

In the meantime we can have these copies made, then I suggest you hear the evidence of Dr Ahmed and you may then wish to read Dr Skinner's document.

THE CHAIRMAN: Right, thank you. What do you say about that?

MR JENKINS: Why do we not have the legal argument now, if Mr Kark is concerned about the parameters of where evidence can go. Why do we not sort that out now? I am going to invite you to take a short break, a ten-minute break, so that the photocopying can be done, so that the legal parameters can be set. I think that is the most efficient way forward, rather than having the argument several times. If Dr Ahmed may have a view which is relevant and if the issue is going to arise whether she is entitled to give that view or not, I think we are better off sorting out the legal argument now, so I will invite you to take a short break now.

MR KARK: Yes, apologies for not having those copies ready. We will get them done and then we will be able to proceed.

THE CHAIRMAN: Thank you. We will take a break. Will 15 minutes be sufficient?

MR JENKINS: It should certainly be sufficient, yes.

THE CHAIRMAN: Also you were going to submit what would be D21 to us?

MR JENKINS: I am afraid it would be, yes.

THE CHAIRMAN: Thank you. *(Same handed to the Panel)*

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Jenkins, I would just like a word first, if I could. I wonder if I can ask Dr Skinner if he would not mind saving his comments to his solicitor and barrister until we are out of session. One or two of the Panel members and others are finding it a bit distracting. Many thanks.

Could I ask, Mr Jenkins, we have now your - are these the 12 and 13?

MR KARK: Well, they are legal authorities, they are not really exhibits in the case. If you need to give them a number you can give them a C number, but they are not really exhibits at all. They are just matters put forward that may help you.

THE CHAIRMAN: I think we will call them C12 and C13 just to know what they are, to give them names. Thank you.

MR KARK: C12 is *Campbell* and C13 is the later case of *Donkin*?

THE CHAIRMAN: Yes, that is right.

MR KARK: Can I also mention in passing, before we turn to these, that my instructing solicitor has noticed that in the copy of Dr Skinner's document, page 2 in her copy was missing. I have a page 2, but I do not know if the Panel are in the same position.

MR PAYNE: Well, I have pages 1 and 3.

MR KARK: There is a page 2 missing.

THE CHAIRMAN: I have a page 2.

MR KARK: We need two more copies of page 2. Shall I in the meanwhile launch, as it were, on the authorities. The case of *Regina (Campbell) v the GMC [2005] WLR 3488*, I suspect, you will all have heard of. It has been relevant to Panel decisions for some time. *Campbell* was a case decided by the Court of Appeal in March 2005 and Mrs Campbell was in fact appealing the decision of a High Court Judge who was refusing her application for judicial review of a decision of, as was then, the PCC, who dismissed a charge of serious professional conduct against a doctor called Dr Birkin. That is why it is called the case of Campbell. In fact the doctor involved was Dr Birkin. It involved the use of character evidence at the stage when the Panel were considering, under the old rules, serious professional misconduct. Could I take you to paragraph 19? You will recall that this was under the old rules, but it plainly has relevance to the issue that you are now considering of impairment. Paragraph 19 first of all:

"The phrase in rule 28(1) most likely to produce confusion on first

A

reading is "the character and previous history of the practitioner" set in the context of arguments and evidence relating to "serious professional misconduct". This is a difficulty only if it is assumed that character and previous history can never be relevant to the question whether the practitioner is guilty of serious professional misconduct. In truth evidence which may be relevant both to this issue and, if proved, mitigation may overlap. Thus, the professional history of the practitioner may support a finding of serious professional misconduct on the basis that he has previously been found to have committed an identical professional error. This may not be regarded as serious professional misconduct on the first or previous occasion, but the "history" may lead the Committee to conclude that on this occasion it does, just because the conduct in question was repeated. Without the previous history an acquittal would be appropriate. In a different context, the error under consideration may need to be examined in the context of a dedicated practitioner working in isolation and under huge pressure of, say, an epidemic. Such circumstance may be relevant to the question whether he should be found guilty of serious professional misconduct. It may indeed provide mitigation of circumstances, unrelated to penalty...

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In short, the same facts may on occasion impact both on the question whether the practitioner's conduct amounted to serious professional misconduct, and on the appropriate consequential sanction. Nevertheless, although the same evidence may be relevant on both questions, it does not follow that they cease to be distinct issues requiring separate determination.

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Notwithstanding some potential difficulties with the language of the rules, as a general proposition it would be surprising if rules governing the disciplinary procedures for the medical profession were to achieve the somewhat startling result that the question whether a practitioner was guilty of serious professional misconduct..."

F

- or I would say impairment -

"...could be influenced by matters of personal mitigation which went to the appropriate disposal of the complaint. It is in our view elementary that any evidence considered by the Committee should be *relevant* evidence. Mitigation arising from the circumstances in which the practitioner found himself or herself may be relevant to the level of culpability: once serious professional misconduct is proved, personal mitigation will be relevant to possible penalty. In our judgment, these are distinct issues, to be determined separately, on the basis of evidence relevant to them."

G

H

Can I take you on to paragraph 25? Just above paragraph 25 it sets out the determination

of the GMC, of the Panel on that occasion, and why it had gone wrong.

> "After noting something of the history of Dr Birkin's contribution of paediatric and neonatal work on the Isle of Man the Determination continued:
>
> > "The Committee consider that the two cases about which it has heard evidence appear to be isolated incidents against a background of otherwise unblemished medical practice of over 30 years.
> >
> > They have also considered the outstanding testimonials that have been submitted on your behalf, both in person and in writing, by your patients and colleagues, all of whom state that you are a highly committed, caring and professional doctor who cares deeply about your patients.
> >
> > In all these circumstances, the Committee have concluded that you are not guilty of serious professional misconduct."
>
> The inevitable conclusion is that evidence relevant to personal mitigation was used by the Committee to inform their decision that the proved misconduct did not amount to serious professional misconduct."

Then the challenge is set out.

I think I am going to ignore the next arrow in fact, but can I take you to paragraph 43, where it makes brief reference to much earlier cases of Rao and Silver.

> "It seems clear to us that the approach of the Board in Rao as apparently followed in Silver was based on a misreading of its earlier decision in Preiss, and that Preiss itself demonstrates that the issue of culpability and mitigation are distinct. That is consistent with our reading of rule 28. The judgment..."

- and to make sense of this one has to add the words, I think, "as to" -

> "The judgment [as to] whether proved or admitted conduct amounts to serious professional misconduct is a separate question from evidence in mitigation, which arises from consideration by the Committee after it has made the appropriate finding of serious professional misconduct. The issues are addressed sequentially in the rules, and they should be decided sequentially. The fact that in some cases there will be an overlap, or that the same material may be relevant to both issues, if they arise, does not justify treating evidence which is exclusively relevant to personal mitigation as relevant to the prior question, whether serious professional misconduct has been established."

Can I take you down to the summary at 46:

> "We would summarise this judgment by saying:
>
> (1) professional conduct committees should first determine in accordance with Rule 27(2) whether the conduct, which is found to be proved or admitted, is insufficient to support a finding of serious professional misconduct;
>
> (2) if they conclude that the facts proved or admitted are not insufficient for that purpose, they should then proceed to consider whether the relevant facts constitute serious professional misconduct; although the same material may sometimes be relevant to both questions, they should keep separate in their minds matters going to proof, or otherwise, of serious professional misconduct and matters going to personal mitigation;
>
> (3) although, they can, if they think it right to do, consider the circumstances in which the practitioner found himself when committing the relevant misconduct, they should always be alert to the possibility that such circumstances may be more properly relevant to the question of penalty rather than to the question whether the professional misconduct was serious; in particular committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct.
>
> (4) at this stage, the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of the appropriate penalty;
>
> (5) only when the committee has decided whether the practitioner was guilty of serious professional misconduct, should they proceed to make a direction in relation to penalty..."

Well, of course, serious professional misconduct is no longer relevant, as it were, and one considers simply now impairment, but there are still the separate functions of the Panel, very much in the same way as there always were.

Can I take you then, rather more briefly, to the case of *Donkin v Law Society [2007] EWHC 414 (Admin)*. *Donkin* was a case not before a General Medical Council Panel but before the Law Society's disciplinary tribunal. What happened in that case was that a solicitor was accused of dishonest conduct, part of which was misappropriating client funds. His Counsel sought to put character evidence in as part of the fact finding stage. Can I take you to paragraph 22, which is under the general heading of good character:

> "In this court Mr Williams'..."

- and Mr Williams was for the Law Society, just to make sense of this -

> "In this court Mr Williams' first submission in his skeleton argument was that the material was not relevant to the issue of dishonesty, but only to sanction. He resiled from this position in his oral submissions. He was undoubtedly right to do so. Whilst it is true that in some professional disciplinary cases evidence of character is only relevant at the second stage, there are other cases where it has potential relevance at the earlier stage. The example of irrelevance at the first stage will be a case where the alleged misconduct does not require proof of a guilty state of mind. Once the conduct has been proved or admitted it cannot avail a person charged to say that his previous exemplary character prevents the conduct from being misconduct. These issues were authoritatively canvassed in The Queen (Campbell) v The General Medical Council [2005]. Giving the judgment of the Court of Appeal, Judge LJ referred to issues of culpability and mitigation as being distinct and the need for them to be addressed when decided sequentially. However, the court did not suggest that material relevant to discreet issues is always mutually exclusive."

The same passage continues, and then the passage you have already heard.

> "The fact that in some cases there will be an overlap, or that the same material may be relevant to both issues, if they arise, does not justify treating evidence which is exclusively relevant to personal mitigation as relevant to the prior question, whether serious professional misconduct has been established. In other words, it is the context which determines whether the material which would be relevant to matters of mitigation is also relevant to the prior question. The mischief, which was the concern of the court in Campbell has found the situation where personal mitigation might be misused to downgrade what would otherwise be serious professional misconduct."

They concluded that in this particular case of *Donkin* the evidence of good character was relevant to the issue of dishonesty, just as it would be in a criminal trial.

Those cases set the legal parameters, as it were, and you have to be very cautious, in my submission, to distinguish between evidence which can genuinely go to impairment and evidence which is effectively testimonial evidence. I know that the defence are keen to call Patient B. They have not been able to furnish me with a statement from Patient B, but if it is simply intended to say, "Well, I was very happy with the treatment that Dr Skinner provided to me", that does not, in my submission, undermine your findings one iota, nor could it truly go to the question of responsibility or irresponsibility because either Dr Skinner's treatment was medically irresponsible or it was not.

It would be my submission that the evidence of Patient B at this stage is irrelevant to your consideration. I can see that the evidence of a doctor who is currently working with

Dr Skinner may be able to give evidence about it.

MR JENKINS: She is not medical.

MR KARK: Thank you. A person working with Dr Skinner at the moment and could give you evidence about his current practice could be relevant because you do have to decide the question of impairment as it is now, although, of course, it is based upon the evidence that has been produced to you, but on behalf of the GMC I cannot see that evidence from patients at this stage is relevant or admissible.

MR JENKINS: Before Mr Kark sits down, I wonder if I can distribute the other document that I said I would. It is an extract from a book on professional regulatory proceedings. It is a book that is well-known to Mr Kark. I just take a particular section from it, which I am sure he is familiar with and it may be that he wants to comment on that as well before he sits down. I wonder if I can cause this to be distributed please.

THE CHAIRMAN: I think this is D22.

MR JENKINS: I think it is. *(Same handed to the Panel)* I am sorry about the brevity of the extract, but I hope I have just given you what is relevant. There is a discussion of *Campbell* on the preceding page and I am more than happy for that page to be copied as well, but the first third of the page discusses the very issues that we have been dealing with and gives Dame Janet's gloss on the new rules. *(Pause)*

MR KARK: I am invited, I think, to comment on this. This is not a ruling, it is part of a very, very long report, as you know, written by Dame Janet. With all respect to Dame Janet, I do not accept that it represents the current law. The current law is as stated in *Campbell* and as affirmed in *Donkin*. I do not think you will be assisted by matters which are purely mitigation at this stage.

MR JENKINS: Well, Dame Janet's view is interesting because she did spend a very long time writing her lengthy reports and one assumes that she paid very careful consideration to matters before writing the reports. Mr Kark says that present law is set out in the case of *Campbell*. That cannot be right. That is dealing with the 1988 rules and, as you know madam, the old rules dealt with the two-stage process, the Panel had to decide factual questions and then go on to decide whether the doctor should be found guilty of serious professional misconduct and whether any sanction should be imposed. It used to be a two-stage process.

The objection that you have seen in *Campbell* was to mitigation being put in before the Panel decided whether the doctor was guilty of serious professional misconduct. The rules have been changed and it is now a three-stage process and the Panel have to decide, I would say, in all the circumstances, as Dame Janet says in the extract that you have seen, the Panel have to decide whether the doctor is guilty, whether his fitness to practise is impaired as at today, not whether it was impaired, by virtue of matters which may have been found proved.

The learned Legal Assessor, I am sure, will direct you to the terms of Rule 17(J) and will remind you that at this stage the Panel shall receive further evidence and hear any further

submissions from the parties as to whether, on the basis of any facts found proved, the practitioner's fitness to practise is impaired and I anticipate that the learned Legal Assessor may say that it is just really those facts that you are entitled to consider and no others because it is on the basis of any facts found proved, but I say that is the starting point. Plainly, there are the allegations that you have been considering, but you do have to consider the wider question: is his fitness to practise impaired? I say that that must be a wider question than merely: do the facts found indicate impairment?

Can I give an example somewhat removed from this case? If a doctor four years ago made a clinical error because of a gap in his knowledge and/or skills, but since then has been on courses and has remedied that defect in his knowledge, is his fitness to practise impaired at the date of the hearing? Well, it may have been at the time he made the error, but times have changed, his skills have been improved and should the Panel necessarily say, "We are not allowed to look at anything that has happened since then, we are not allowed to look at any changes, we are not allowed to be informed that he has been on courses and his practice has changed." That would be the absurd result if the contention that Mr Kark suggests held sway.

Yet again you have been asked to consider Dr Skinner's manner of prescribing for patients who may have an underactive thyroid and you have had an attack from Professor Weetman particularly on the approach that he has taken generally. Again, you did not want to hear from Mrs Conway - I do not criticise you for it - on the question of the facts, but before you go on to consider whether this doctor's fitness to practise is impaired surely you must know a little bit more about other patients that he has treated, the degree of success he has had, because so far you have not heard from other patients. I say it is plainly relevant.

What would other doctors say about his standards of treatment for patients? What would other doctors and health care workers, who themselves have been patients, say about him? That must be relevant to this doctor's fitness to practise. Mr Kark contends that it is not, but you have to look merely at the allegations that have been found proved. I say that is to shut yourself off from receiving evidence as to this practitioner's fitness to practise.

As far as Mrs B is concerned, plainly she will have a view of the doctor. It would be absurd for you to say, "Well, we have considered her case at great length, we have looked at many, many pages of medical records, but we do not want to hear from her."

Part of the question that you will have to grapple with is, of the allegations you found proved in respect of Mrs B, how serious are the failings that you found against Dr Skinner? The issue of palpitations has been raised. I will remind you in due course that palpitations may be a symptom of an underactive thyroid, we have the documents, but several of your findings against Dr Skinner are that he was not checking this lady's blood tests at a time when she had had an episode or two of palpitations. Well, how many episodes of palpitations had she had? How severe were they? Mrs B can give some evidence on that question. If she had very severe palpitations on every occasion that she saw him, then you may think, if he is culpable, he is to be criticised more heavily. If, on the other hand, the palpitations were isolated, then the criticism may be less or may be none at all. I suggest that plainly Mrs B can give evidence that will assist you in that regard, but she can also say how she found him as a doctor and how she found him as a

man dealing with her as a patient. For those reasons I say you should accept the evidence.

Again, it is not merely personal mitigation. Merely personal mitigation may be his neighbour across the back fence who says what a nice man he is, or someone who could say that he does good work in some charitable organisation. This goes to his professional practice and this hearing is irreducibly concerned with issues about his professional practice and for those reasons I say you should not be guided by an old decision about the old law. What you should be guided by is a commentary on the new provisions and Dame Janet Smith has provided one, saying again that you are making a decision in all the circumstances and having a look in the round at the practitioner.

Those are the arguments I advance in favour of wider evidence being available at this stage. I do not know if Mr Kark wants to come back.

MR KARK: No, only in relation to Patient B and the issue of palpitations. You have found factually that there were two occasions when the patient complained of palpitations. I do not think it has been suggested that it was any less than two, as it were, so on one view it could get worse for Dr Skinner. It is difficult to see how Patient B is going to help him make it better, as it were, despite the fact that she may be willing to say, "Well, I was very happy on the treatment that I received".

As far as old law/new law, *Campbell* is still relevant, in my submission, in that it requires the Panel, this Panel in 2007, to ensure that it makes the medical distinction, as it were, as to what is relevant at the different stages of its process. That is why *Campbell* is still relevant. If you are being invited, if you took the view - let us take an extreme view - you were being asked to read 100 testimonials to say that Dr Skinner was very nice and had a very good bedside manner, then you would be entirely entitled, in my submission, to say, "Well, that cannot conceivably be relevant at this stage to impairment, although it may well be relevant to the later stage as to what we do with this doctor." so *Campbell* is still relevant in that it forces you to distinguish carefully and think about the relevance of the evidence you are being asked to listen to.

THE CHAIRMAN: Legal Assessor, have you any comment?

THE LEGAL ASSESSOR: At this stage you are being asked by Mr Jenkins to admit evidence of a nature which, on the face of it, I think it is accepted may amount to personal mitigation, may amount to methods in which the doctor worked, may amount to the way in which patients found the doctor and found the way in which he treated them.

You have been referred to the case of *Campbell* and it is quite rightly said that *Campbell* refers to the old practice directions, the old procedure. It is, however, the only legally binding authority still available on this Panel and it has been adopted successfully in many hearings of present up-to-date fitness to practise hearings.

You have been referred to extracts from Dame Janet Smith's report on the case of Harold Shipman. Can I say at this stage I am afraid I profoundly disagree with Mr Jenkins in the way in which this has been put before the Panel and the reason that I say that is that your task at this stage is specific to the fitness to practise rules, which is how you behave and how you approach matters. You are dealing with matters at this stage on Rule 17(J). You

receive further evidence and hear any further submissions from the parties as to whether, *on the basis of any facts found proved*, the practitioner's fitness to practise is impaired. The words that I have emphasised are important because it is on the basis of any facts found proved and that is emphasised, in fact, by other cases which have pointed out that at this stage your finding of whether the practitioner's fitness to practise is impaired or not is a matter for your professional judgment. It is not a matter of taking everything in the round, or, as that extract from Dame Janet Smith says, whether in all the circumstances the doctor's fitness to practise is impaired, because you are bound specifically by the rules. You can only find whether on the basis of any facts found proved whether the practitioner's fitness to practise is impaired.

I have taken a little bit of time to emphasise that to you. Of course you will be aware, as the matter has been raised before, of Rule 34.

> "(1) Subject to paragraph (2), the Committee or a Panel may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law. (2) Where evidence would not be admissible in criminal proceedings in England..."

- that is dealing with matters which really would not be allowed in criminal courts -

> "...the Committee or Panel shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable."

Well, as I said, you are at the position of saying whether, in your professional judgment, the doctor's fitness to practise is impaired on the basis of the facts you have found proved. As such, although it is a three-part process, it falls fairly and squarely within the ambit of that summarised judgment at paragraph 46 of *Campbell*. Adapting that, you did not have to find whether conduct found to be proved is insufficient to support a finding of serious professional misconduct, but you go on to consider whether the relevant facts constitute impairment and I have substituted the words "impairment" for "serious professional misconduct" and that is exactly how that has been read in other cases and should be read here.

> "...they should then proceed to consider whether the relevant facts constitute [impairment], although the same material may sometimes be relevant to both questions, they should keep separate in their minds matters going to proof, or otherwise, of [impairment] and matters going to personal mitigation."

What I have done there is substitute the words "impairment" for "serious professional misconduct". There is no difference whatsoever at this stage. Although you bear in mind that:

> "although they can, if they think it right to do, consider the circumstances in which the practitioner found himself when

> committing the relevant misconduct, they should always be alert to the possibility that such circumstances may be more properly relevant to the question of penalty rather than to the question whether the professional misconduct was serious;"

That is probably not so helpful, but this particular quote is:

> "in particular, committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct.
>
> At this stage the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of the appropriate penalty;"

That is the case of *Campbell*. That is the authority which is the only authority directly on this issue. *Donkin*, of course, was a matter which dealt specifically with matters of dishonesty and sometimes you look at *Donkin* and you think, well, that was pretty obvious, why did it have to go there, but it deals with dishonesty and equates them to a criminal trial. Matters there of good character and matters of dishonesty would always be relevant, you may think. It would be exceptional if it were not to be, so that may be a side issue, but *Campbell* is still the authority, Dame Janet is not. Her book may be helpful and may be of assistance to practitioners, but what she says is not authority. The only authority that you have in front of you are the Rules and those cases which have been relevantly passed down by either the Administrative Court, the Administrative Division of the Queens Bench Divisional Court or the Court of Appeal thereafter.

I do not think I can assist you any further. Do either side have anything to say?

MR JENKINS: Can I just break down once more the categories of such evidence that I want to call, because it may be that your learned Legal Assessor would want to give further advice in relation to those specific categories.

First is Mrs B. I hoped to call her on the facts. Secondly, Mrs B could deal with her opinion as to Dr Skinner and the *Campbell* objection I think relates to the second part of her evidence. Mr Kark has a separate objection to the first part of her evidence. He says you have made your findings and it is not relevant.

The second category of evidence that I seek to call are patients, including, as I have indicated, doctors and other health care workers who have themselves been patients of Dr Skinner.

The third category are GPs who have referred patients to Dr Skinner. Their view as to his practice I would say is relevant, but it may be that your learned Legal Assessor would break down what he says to cover each of those, or it may be that he would say that his advice covers all three, but I give him the chance to deal with it.

THE CHAIRMAN: Can I just ask one question? There was Dr Ahmed. What category does she fit into?

MR JENKINS: I think it has been conceded that she can give evidence. I do not think the objection relates to her.

THE CHAIRMAN: Thank you.

MR KARK: Well, provided it is relevant to the issue and it is not simply character evidence.

MR JENKINS: It is relevant to the issue. Perhaps for the sake of playing it safe, she too could give character evidence about Dr Skinner and his approach to patients, so perhaps we should include her as a fourth category. Thank you for reminding me, madam.

THE LEGAL ASSESSOR: May I just clarify at the beginning please, Mr Jenkins. Mrs B, you say, can give evidence to the facts. Are you saying that she can give evidence to the effect that the Panel incorrectly found facts in relation to the treatment of Mrs B?

MR JENKINS: No.

THE LEGAL ASSESSOR: Because obviously and clearly that would be wrong, would it not?

MR JENKINS: I do not seek to undermine any of the findings of the Panel.

THE LEGAL ASSESSOR: Right. In that case what facts? I am not sure that I quite understand.

MR JENKINS: Well, the issue as to palpitations has been flagged up and it has been one to which the Panel have made findings. I think it is fair to Dr Skinner for the Panel to know the extent to which she may have complained of palpitations, whether it was on a very regular basis, whether it was throughout the period that she saw Dr Skinner, or what, because the level of criticism that has been applied to Dr Skinner may be seriously affected by the extent of palpitations. If she was having palpitations all the time and as a result of his prescribing, well, that is plainly very serious. If that is not the position, well then you ought to know.

THE LEGAL ASSESSOR: I think what slightly concerns me, Mr Jenkins, is I could understand Mrs B giving evidence, being called by you quite correctly at the appropriate time, which was in relation to the facts, but it just seems to me that at this stage you want to call her to the facts to seek to undermine the Panel's decisions that in relation to, for example, on Mrs B, that the prescribing was inappropriate and unnecessary for example.

MR JENKINS: I am trying to provide information for the Panel about Mrs B. They have had some. She was not called by Mr Kark and certainly she was not called by me, but the Panel are making judgments based on allegations raised against Dr Skinner, some of which they have found proved. In deciding whether those should amount to impairment of his fitness to practise I am trying to provide more information for the Panel. That is what I am seeking to do. I am not seeking to undermine any of the findings, or say that they should not have been reached, just trying to provide more information.

If I may say so, I am somewhat surprised that there is a resistance to hearing from patients. This hearing started off with a general attack on Dr Skinner's prescribing, saying it was irresponsible from the start, he should never be doing this, for none of his patients.

THE LEGAL ASSESSOR: Forgive me, Mr Jenkins. Can we concentrate on the matters that we have to deal with rather than have a general speech at this stage?

MR JENKINS: Yes.

THE LEGAL ASSESSOR: Is there anything further you wish to say?

MR JENKINS: I was saying, but I will stop.

THE LEGAL ASSESSOR: I think I just need to clarify something else. I do apologise, Mr Jenkins. It was in relation to Dr Ahmed. I know that I and I think most of the Panel and I think Mr Kark assumed originally at the outset, when you mentioned Dr Ahmed, that Dr Ahmed was a medical doctor.

MR JENKINS: No.

THE LEGAL ASSESSOR: Is Dr Ahmed therefore part of the actual business as a doctor of philosophy?

MR JENKINS: She has a PhD, she has done research and does research with Dr Skinner and she is involved in the clinic that you have heard a lot about. She is involved on the management side, if I can put it that way. She has done a lot of work with the Health Care Commission and their regulatory functions. She can tell you about policies, protocols, she can tell you about letters to GPs, she can tell you how frequently blood tests are now done and that, I suggest, is information that the Panel will want to know. That is why I seek to call her. Incidentally, she could give, if asked, a view about Dr Skinner's dedication and the way in which he treats patients, but that is something separate and to which I think I have identified Mr Kark would have objection.

THE LEGAL ASSESSOR: Right. Thank you very much.

Well, members of the Panel, I am not sure that there is anything further that I can assist you with. It is a matter for you at this stage. You have in front of you the case of *Campbell*. As I have I think correctly identified, that is the only legal authority at this stage. It may be that some matters hopefully may clarify it further, but at the moment that is the only binding legal authority, that and the practice rules that you have in front of you. Beyond that I cannot assist. Thank you.

THE CHAIRMAN: Thank you for your help. We will now go into *camera* to make a decision on this issue.

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

STRANGERS HAVING BEEN READMITTED

DETERMINATION

THE CHAIRMAN: The determination on admissibility of evidence. Fitness to Practise Panel hearing, 8 September 2007. Dr Gordon Robert Bruce Skinner.

Mr Jenkins: you have made an application to adduce evidence under Rule 17(2)(J) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004 (the Rules). The Fitness to Practise Panel shall receive further evidence and hear any further submissions from the parties as to whether, on the basis of any facts found proved, the practitioner's fitness to practise is impaired. You submit that the evidence you seek to adduce is relevant to the question whether the practitioner's fitness to practise is impaired. The evidence does not, you have told the Panel, solely involve personal mitigation, or any matter other than current impairment.

You wish to call a number of categories of evidence. The evidence of Miss B, the evidence of patients, including health professionals that Dr Skinner had treated, the evidence of GPs who have referred patients to Dr Skinner and the evidence of Dr Ahmed. You have submitted that the evidence of these witnesses is relevant to the factual question of whether Dr Skinner's fitness to practise is currently impaired.

You have referred the Panel to an extract from Dame Janet Smith's comments made in the Shipman Inquiry, Fifth Report, about Panels in general taking a view in the round of the doctor's fitness to practise so all mitigation is relevant.

With the exception of Dr Ahmed, Mr Kark has objected to your calling these witnesses, on the grounds that such evidence is relevant to the question of sanction and not at this stage of the proceedings. He submitted that the decision of the *Court of Appeal in Regina (Campbell) v the GMC [2005] WLR 3488,* prevented the Panel from admitting the evidence which Mr Jenkins wishes to adduce at this stage. Mr Kark referred the Panel to paragraph 46 of the said judgment which states:

> "46. We would summarise this judgment by saying:
>
> (1) professional conduct committees should first determine in accordance with Rule 27(2) whether the conduct, which is found to be proved or admitted, is insufficient to support a finding of serious professional misconduct;
>
> (2) if they conclude that the facts proved or admitted are not insufficient for that purpose, they should then proceed to consider whether the relevant facts constitute serious professional misconduct; although the same material may sometimes be relevant to both questions, they should keep separate in their minds matters going to proof, or otherwise, of serious professional misconduct and matters going to personal mitigation;
>
> (3) although they can, if they think it right to do, consider the

> circumstances in which the practitioner found himself when committing the relevant misconduct, they should always be alert to the possibility that such circumstances may be more properly relevant to the question of penalty rather than to the question whether the professional misconduct was serious; in particular committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct;
>
> (4) at this stage, the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of the appropriate penalty."

The Panel has noted and accepted the advice of the Legal Assessor, who advised that the *Campbell* judgment is the only legally binding authority that is available to the Panel on this issue. He stated that the extract from Dame Janet's report, referred to by you, may be of assistance to it in its deliberation, but it is not a legal authority and as such should not be relied upon as legally binding.

The Panel has given careful consideration to your application, Mr Kark's objections and the advice of the Legal Assessor. It has also taken account of Rule 34 of the General Medical Council (Fitness to Practise) Rules 2004. Rule 34 states:

> "1. Subject to paragraph (2), the Panel may admit any evidence that it considers fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law;
>
> 2. Where evidence would not be admissible in criminal proceedings in England the Panel shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable."

The Panel's duty at this stage is to determine whether or not Dr Skinner's fitness to practise is impaired. Although evidence of matters relating to Dr Skinner's current professional competence and conduct might be of assistance to the Panel, the statutory rules preclude that evidence at this stage.

The Panel looked at all of the categories of evidence that you wish to adduce, namely;

1. The evidence of Mrs B;

2. The evidence of past patients including health professionals who Dr Skinner had treated;

3. The evidence of GPs who had referred patients to Dr Skinner; and

4. The evidence of Dr Ahmed.

Number 1. The evidence of Mrs B would have been to say how she was treated by Dr Skinner and what her symptoms were. The Panel has already made findings of fact on these matters and would not wish to hear evidence relating to those findings of fact. Mrs B may also have given evidence of a testimonial basis in relation to Dr Skinner's treatment of her. The Panel does not consider her evidence to be helpful in addressing the issue it must deal with at this stage.

2. The evidence of the patients that Dr Skinner treated does not appear to amount to more than testimonial evidence and the Panel does not consider this evidence would be helpful in addressing the issue it must deal with at this stage.

3. The evidence of GPs who have referred patients to Dr Skinner does not appear to amount to more than professional testimonial evidence and the Panel does not consider this evidence would be helpful in addressing the issue it must deal with at this stage.

Your application to call these above witnesses at this time is therefore not successful.

4. It is unclear precisely what evidence Dr Ahmed will give. However, she can apparently inform the Panel about the nature of the practice after the Health Care Commission's report. She can apparently give evidence concerning the taking of blood samples. The Panel does consider that her evidence might be helpful in addressing the issue it must deal with. It does, however, consider that it would not be assisted by evidence of a testimonial nature from her at this stage.

In the circumstances the only evidence that the Panel considers may help at this stage is the evidence identified from Dr Ahmed. Mr Jenkins.

MR JENKINS: Ma'am, thank you for that. I will certainly call Dr Ahmed, but I wonder if you can pause for a moment because I am going to ask that those patients who are here, and had anticipated that they might give evidence, can come and sit at the back of the room. As a courtesy to them I would like that to happen, if that is possible and also Mrs B, of course.

MR KARK: Mr Jenkins has mentioned this to me. They are going to become, as I understand it, character witnesses. As character witnesses the normal course of events would be that they are allowed in.

THE CHAIRMAN: Yes.

MR JENKINS: I wonder if they can be invited in together with Dr Ahmed.

THE CHAIRMAN: Yes.

<u>ASHA AHMED, affirmed</u>

THE CHAIRMAN: Good afternoon, Dr Ahmed. Do sit.

A Thank you.

THE LEGAL ASSESSOR: Can I clarify one thing? There is just one matter, please. It

has been brought to my attention the fact that Dr Ahmed, who I think you are presenting as a witness of fact---

MR JENKINS: Yes.

THE LEGAL ASSESSOR: ---has in fact been present during quite a lot of these proceedings.

MR JENKINS: Yes, that is absolutely right.

THE LEGAL ASSESSOR: Then you make an application under Rule of Procedure 15.

MR JENKINS: I suppose I should. Let me check the rules. Can I explain the position? A decision was made this morning that it might be appropriate to call Dr Ahmed to give evidence just as to the way the practice is presently set up. I had not anticipated that she would give evidence but we made that decision this morning. Forgive me, you are directing me to a particular rule.

THE LEGAL ASSESSOR: I was and I got the number wrong. It is Rule of Procedure 35(6):

> "A witness of fact shall not, without leave of the Committee or Panel, be entitled to give evidence at a hearing unless he or she has been excluded from the proceedings until such time as he [or she] is called."

MR JENKINS: I am grateful. Again, I do make such an application for Dr Ahmed to give evidence before you and she has been present during much of the hearing. I am not asking her about any of the cases A to D, I am asking her about how the practice is presently set up and the Health Care Commission. You have heard nothing about that so far, nothing she has heard, and Dr Skinner or other witnesses I think, could cause difficulties so far as the evidence she could give, but that is clearly a matter you will need to consider before I take it any further. I do not know if Mr Kark has any observations.

MR KARK: In light of the limited evidence that the witness is likely to give and the stage we are now at, I do not have any formal objection to the evidence being given, although it might be worth establishing at some stage, if it becomes relevant, what parts of the evidence Dr Ahmed has heard, when she was in. That may not be possible, but perhaps we can see.

MR JENKINS: Just to deal with that. I think you were here for much of the first week, Patients A to D, and some of the doctors, but not present for much of the second week?
A I think I was not here when Dr Hertoghe was giving his statement and I think I was not here---

MR JENKINS: Mr Lynn was Day 6.
A I was not here for Mr Lynn. I was here for Professor Weetman.

Q Professor Weetman was on Day 5, much of his evidence and I think he was

continued on Day 6. We then went on to other witnesses. Did you hear much of Dr Skinner later in the case?
A Yes. I was here for the first day and part of the second day.

MR JENKINS: I understand. I do not know if there is anything more the Panel want to know about that before making a decision.

THE LEGAL ASSESSOR: Well, it is a matter for the Panel to decide amongst themselves and, unless you feel that it is a matter for which you need to retire *in camera*, we normally do it on a nod.

THE CHAIRMAN: There is one member who would like to discuss it and so we will have to do that *in camera*.

MR JENKINS: Of course.

THE CHAIRMAN: Thank you.

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

STRANGERS HAVING BEEN READMITTED

DECISION

THE CHAIRMAN: Mr Jenkins: Dr Ahmed is being presented as a witness of fact. She has been present through much of these proceedings, including the evidence of Dr Skinner. Therefore, under Rule 35(6) the Panel have decided it is not appropriate to hear her evidence. Over to you now.

MR JENKINS: Well, in those circumstances I will not call her. What you have seen in Bundle 2 and towards the back of it are a number of documents, towards the back of tab 4. Let me give you an example. If you turn to page 78, tab 4. This is one of a number of documents, the others go on throughout the rest of the bundle, which are available at the practice. You heard in Dr Skinner's evidence of various types of leaflets that are handed to patients. These have been prepared either by Dr Skinner or by Dr Ahmed, who is effectively the practice manager of the practice for the purposes of the clinic. The evidence she would have given will be that because it is a private clinic it is regulated by the Health Care Commission. They carry out inspections, they have a series of requirements of any clinic that is outside the National Health Service system and these are examples of the sort of documents that have been prepared and are kept in a much larger bundle at the clinic and are available for the Health Care Commission. I was going to ask her about that, but the documents perhaps speak for themselves.

The other issue she would have given evidence about relates to contact with general practitioners. You will know from the documentation in the case that Dr Skinner writes to GPs, does so after he has seen a patient and you have seen examples again and again through the documentation. That happens now as happened during the period with which

you are concerned, dealing with these four patients. The thing that is important now, which Dr Ahmed would have confirmed, is that blood tests are dealt with on a very regular basis. If a patient is due for a review they are written to, they are asked questions: when did you last see a doctor? When did you last have a blood test? If one has not been done within the last six or nine months, the patients are asked to speak to their GP for a blood test to be arranged, or they are told that they will have a blood test when they come to the practice. To the extent that there may have been concerns historically that you have had, patients are now regularly blood-tested and the blood test results obtained by GPs are forwarded to the practice so that Dr Skinner has them available.

Can I turn to questions of impairment? You have listened to the evidence in the case and you have made factual findings on the various heads in the Notice of Hearing. Those are separate factual statements that you have been asked to consider and plainly to some of those there may be a criticism of the doctor, to others plainly there will not and it is for you at this stage to decide in relation to those various factual elements whether there should properly be a level of criticism aimed at the doctor. Let me give you an example.

The first paragraph, that at all material times Dr Skinner was practising as a private doctor from an address in Birmingham, that is admitted. Plainly, there is no criticism attached to him for that, it is just a question of fact. As we go on, obviously there were other allegations.

Let us go on, as an example, to Patient A. There was an allegation in respect of headaches, allegation 7A. There were telephone conversations between Patient A and Dr Skinner about headaches, and you have found the allegation 7A not proved and you have explained the basis upon which you found that not proved, but as to 7B, the allegation is that Dr Skinner made no record in the patient medical notes of such conversations. Now plainly you are entitled to consider whether there should be some criticism of Dr Skinner in that regard. It is an allegation that you have found proved, which Mr Kark has invited you to consider. Well, I take this as an example. This may be a case of an allegation which you found proved but where there is no criticism to be attached to Dr Skinner whatsoever. You will recall the evidence of Mr Lynn on Day 6 to the effect that, well, there were frequent occasions when one has a conversation with a patient and these do not get recorded. Perhaps they should be, for the notes to be absolutely complete, but it is frequently the case that a busy practitioner may not make a record of something. In addition, so far as that allegation is concerned, plainly the view of Mr Lynn and also of Dr Skinner was that Mrs A's headaches could not be linked to the medication that she was on, so it is not something which is pertinent to the prescribing that was going on for her. I take that as an example just to illustrate the proposition that the fact that something has been found proved does not mean that the doctor falls to be criticised in respect of it because when we come to Patient B, obviously you have made findings as to the facts and what I suggest is that, notwithstanding the findings, the criticism of Dr Skinner is limited.

Can I take you to Head 10(B)? This is the allegation, which you found proved, that between 20 March 2003 and 21 January 2004, Dr Skinner failed to monitor Miss B adequately or at all. The question there is what level of monitoring should he have been providing? Well, you have not heard from Miss B, plainly, but what you know is that you were referred by Mr Kark to Good Medical Practice and he referred you to the passages

which deal with if you are providing care for a patient and you are not the GP you should keep the GP informed of what is going on and obviously you have seen the letters from Dr Skinner in March 2003 telling Dr Blair what he was proposing to do, telling Dr Blair that he was proposing to treat this patient and that he provided her with a prescription. Dr Skinner is not the GP. You cannot treat him as a GP. He has informed the GP of what he is doing for the patient and he next sees her in January 2004, ten months later, so if one follows Good Medical Practice, Dr Skinner has done precisely what he should do. He is not the GP, he has kept the GP informed of what he is doing. Is he supposed to be contacting the patient on a monthly basis, or three-monthly or six-monthly to say, "How are you doing?" He is not. He has followed good medical practice as far as that is concerned.

Notwithstanding the finding that you made, that Dr Skinner did not monitor Miss B adequately or at all, I say that following good medical practice and the principles that Mr Kark has outlined to you, you should not be critical of Dr Skinner in that regard. He is not her GP and it would be inappropriate to put him in the position where he was her GP. He was not.

You recall from Mr Lynn again, his evidence that the standard of Dr Skinner's communication with GPs was very good.

If we move on with the same patient, Miss B, you have found in paragraph 10(c), the one about the blood test result and that Dr Skinner was aware of it. Clearly that has been admitted and found proved. 10(d), the results of the blood test report show that Miss B had become biochemically thyrotoxic. You found that proved and you found the following allegation, 10(e), proved as well. "This over replacement was a result of you providing Thyroxine." The issue with Miss B always is, was she clinically thyrotoxic. What you have not found is that she was clinically thyrotoxic.

You have read Dr Skinner's document D22 and can I please check that you each have the three pages. I know some had just two pages and we must ensure that you have all three. I am not going to take you through it. When you all have the complete document you will have the chance to read it. You will see that Dr Skinner is very concerned about the concept of biochemically thyrotoxic. I am going to assume that you will all have a chance to read it later, but biochemically thyrotoxic means that the patient is outside the reference range. It does not mean that the patient is clinically thyrotoxic or is exhibiting signs or symptoms that they have been over-treated, it just means that the blood test result is outside the reference range.

You will recall from the evidence again of Mr Lynn, Day 6, page 66 of the transcript, that there are millions of patients who may be hypothyroid. It has come out as hyperthyroid on page 66. Mr Kark told you yesterday - sorry, Wednesday I think, that some of the transcripts may be wrong.

THE CHAIRMAN: Hypo or hyper?

MR JENKINS: I am talking about hypothyroid. I was asking Mr Lynn if he could give us a sort of ballpark figure about hypothyroidism in the population, and he said:

"I think people realise it is very common."

He told us that it depends on the age group and talked about in a 60 year old patient it must be somewhere in the region of 3-5% of a raised TSH. I asked him, what about hypothyroid patients, it appears on the transcript as hyperthyroid patients, and he said most likely the same sort of percentage. I asked:

"Q So are we talking about millions of patients in this country?
A Absolutely.

Q Millions of people?
A Yes.

Q I will come back to the reference range. If we are talking about millions of people and 5% of the people in the reference range fall outside reference range chemistry, we are talking about hundreds of thousands of patients who would fall outside the reference range?
A Yes, I take your point…"

- but he went on to say that:

"…because they fall outside the reference range does not mean they need any treatment."

was his complete answer. That is at the top of Day 6, page 66.

You found as a fact plainly that Dr Skinner's treatment rendered Mrs B outside the reference range. What is she like clinically? Well, there are references on two occasions to palpitations. How long did those last? You have heard all the evidence you are going to hear on that question. Is it evidence of over-treatment? You are not going to hear from Mrs B. Might it be evidence of over-treatment? It might be. Might it be evidence that she is hypothyroid? In other words, that she is being under-treated? Again, it might be. You have got the documents in front of you.

You will recall Miss D filled in some questionnaires online. I am going to invite you to look at them, I am afraid. It is the big bundle, C1, tab 8, page 8. It is 30 or so pages in from the back of the bundle. This is a document which was not produced by Dr Skinner, it was a document that Miss D got off the Internet. It is a checklist of symptoms for the signs of symptoms of hypothyroidism and you will see at the bottom of the first list under "Physical", palpitations is given as a sign of an underactive thyroid. If you look at the second column, the fifth entry down, trembling is given as a sign or symptom of an underactive thyroid. Again, you are not to hear any evidence from Mrs B as to the palpitations. What you know is that Dr Skinner has made a note on two occasions that there were palpitations. Are you entitled to say that those palpitations were as a result of her being over-treated, or because she was under-treated? I say you are not. The findings that you made plainly are that she fell outside the reference range, but does that mean that Dr Skinner has done anything which is inappropriate? You will recall the evidence from Dr Skinner himself, that some patients may feel clinically normal when they have readings outside the reference range. You will recall the evidence of Dr Fink last week

who talked about a Professor Hoffenberg, a distinguished physician, from whom he, Dr Fink, inherited a patient and this was a lady who needed mega doses of thyroxine, and her T4 level was 36 and it was at that level that she felt well.

As to the question did Dr Skinner treat this lady, which was to render her clinically thyrotoxic, there is no evidence; biochemically thyrotoxic, if that is useful, that means that he took her outside the reference range and that is the finding that you have made, but I say it is not appropriate, nor should you find, that he rendered her unwell as a result of his treatment. Again, you are not to hear the evidence of the patient herself, but I do say that on the factual findings that you have made thus far it is not open to you to say we are sure that Dr Skinner put her in a worse position than she should have been, or that he rendered her clinically thyrotoxic. The evidence, you will recall, as to Dr Skinner and his consulting was that he was extremely thorough, he would always spend an hour with the patient when he first saw them, would see them for half an hour at least on subsequent visits and what I say to you is that in relation to Patient B, notwithstanding your findings, that it is not appropriate for you to say that the treatment he provided for her rendered her clinically thyrotoxic. That surely is the real issue.

Again, what would have been said of Professor Hoffenberg's patient treated by Professor Hoffenberg? Would there be criticism of him for putting a patient's T4 level on the blood test to 36, well above the reference range? Well, again, you heard from Dr Skinner, from Dr Hertoghe and from Dr Fink on that question. Some patients in order to be clinically in-thyroid may need to have their chemistry outside the reference range. Again, to come back to the point that there will be hundreds of thousands of patients, millions, who fall outside the reference range.

Can I come on to Patient C? The factual findings that you have made plainly are that on 8 May 2004 there were no blood tests and you found that it was inappropriate and unnecessary for the doctor to treat her in the way that he did. Again, we have not heard from Patient C. Dr Skinner plainly examined her, gave her the sort of thorough examination that he gave his other patients. What I say is that the clinical picture may have made the prescribing for her acceptable. As far as the August blood test is concerned, you will recall in August 2004 Patient C did see Dr Skinner, there was a blood test at the start of the month, he was prescribing two medications for her and Patient C at that time we know was taking three. You will recall that she said in her questionnaire to join another practice - you will recall it is in bundle C2, tab 2, the second page, where she went to join the Wimbledon Village Surgery, we have looked at it many times before - she put down that she was taking armour thyroid as well. One issue is, is Dr Skinner to be criticised for this patient having chosen to take another form of medication over and above what he was prescribing? Plainly he is not.

Is he to be criticised in relation to the prescribing that he provided to that patient? It is clear that he did not tell her to reduce her dose, but you have his letter to her in September 2004. Forgive me, if I remind you of the page. It is the one in which he talks about her blood chemistry results and talks about, "…if you are planning any of your increasing strategies, please let me know." It is bundle C1, tab 6, page 9. If you have the page in front of you, you will recall that it is when he gets the blood results from August that he writes the letter dated 1 September 2004. He says:

> "Here are your thyroid, chemistry and cortisone which indicate the level are a little on the high side."

This may be crucial, tab 6, page 9:

> "...but if you are not feeling any adverse effects then I think you should stay at the same dose."

Again, it is the clinical picture that Dr Skinner regards as the vital element in the treatment of the patient, and he says:

> "Or if you are planning any of your increasing strategies then perhaps you would let me know."

Again, is he to be criticised for not suggesting that she should reduce her dose? You found that he did not suggest that she should reduce her dose, but the answer is what was the clinical picture of the patient at that time? He was guided by the clinical picture. Again, where you know that hundreds and hundreds of thousands of patients fall outside the reference range. Can you say that he ought to have told her to reduce the dose? If she was not feeling any adverse effects, "I think you should stay at the same dose." Surely that is consistent with an appropriate approach.

The last element, as far as Patient C is concerned, is also dealt with in the same letter. He is clearly monitoring the cortisone level. Is he concerned about the adrenal level? Well, it is a thought at the back of his mind. Was it imperative to refer her off to an endocrinologist or other doctor? No, we would suggest, and notwithstanding the factual finding that he did not refer her to an endocrinologist, I would say again that it is not a case where he stands to be violently criticised. It is a point that Dr Skinner makes in his observations in the letter which you have at D22 and which I know you will read completely.

Mr Kark did read big sections of Good Medical Practice. He referred you to the passages which require the doctor to make care of his patients his first concern. Plainly, Dr Skinner's first concern was that of his patient in every case. Again, the detail of the consultations from the patients that you have heard from and again I would remind you of Patient D, she found the consultation with Dr Skinner mind-blowing because of his empathy and the fact that he seemed to understand what her condition really was. He should keep colleagues well informed. Well, plainly he does and I remind you again of Dr Lynn. He should share information with colleagues, tell the GP the results of any tests that he does. Again, he does that and again, if he is not the GP, he should keep the GP informed and he does that.

I would invite you to question seriously whether, on the basis of these four patients, this doctor's fitness to practise is impaired. Clearly, there are others who have a view. Professor Weetman, Mr Lynn and some other GPs have strongly held views about what is appropriate, but there may be disagreements in any branch of any profession. What you know is that Dr Skinner was highly motivated for the patients and he achieved success, sometimes fantastic success for his patients.

The other element of the case that you have to look at is his initial acceptance and then refusal to undergo an assessment by the General Medical Council and you are invited to say that he has no reasonable excuse for not agreeing to an assessment. You will have to look at that with care. You have seen the letters that Dr Skinner has written, initially responding by saying that some of the complaints had no basis in fact. You recall Malcolm Prentiss, who was involved in Patient C, was suggesting that Dr Skinner had not written to the initial GP after he saw the patient. That was just wrong. It was suggested that Dr Skinner had started a patient off at 150mg of Thyroxine. Again, just wrong. You have got Dr Skinner's response. His evidence has always been and that of the patients has been that he starts people off in a very careful way: 25, then up to 50 and increases the dose very gradually. How does a doctor feel if complaints are made about him which are factually incorrect? Complaints made by individuals who have never seen the patient, who have never looked at the patient and for a number of these complaints the patients were simply not seen by the doctors who fired off letters to the General Medical Council. He is entitled, is he not, to regard with some concern a suggestion or an invitation from his regulatory body that he should undergo an assessment when, in his view, the allegations against him are based on a complete misreading of much of the facts.

It does go further, does it not? When he is asked to undergo an assessment and he is given the form, he is told he will be assessed as a general practitioner. He is not a GP, he does not work as a GP. Mr Kark took you to the documentation in Bundle 2. Much of it is completely inappropriate for the work that Dr Skinner does. You have been referred to one particular page, tab 4 in Bundle 2, page 68. Mr Kark invited you to look at Dr Skinner's completion of the medical problems:

> "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.
>
> Please base your response on how frequently you find yourself undertaking consultations for that particular problem."

Well, Dr Skinner treats patients who may have an underactive thyroid. He does not treat patients who come to him with a suspected brain tumour, or epilepsy, or influenza, or heart failure. He may see patients who have other conditions, but he is not frequently seeing patients for those other particular problems. It is crystal clear, is it not, that the form of assessment that was then anticipated is that for a general practitioner. Well, he is not. Should he have agreed to an assessment as a GP? I suggest he should not have done, it is not appropriate. Should he have agreed to an assessment as an endocrinologist? Again, he is not an endocrinologist. There are other conditions that an endocrinologist will treat with which Dr Skinner may not have a great area of experience. That is the issue, I would suggest. Should he have agreed to an assessment as a GP, which was clearly inappropriate for him? In those circumstances I say it is not unreasonable for Dr Skinner to say, "On the one hand the underlying point is based from people who know nothing about the patients themselves, certainly have never assessed them, some of them are based on factual inaccuracies and, secondly, the assessment that I have been asked to agree to is one which is wholly inappropriate for the work that I do."

Madam, in those circumstances I suggest that you should ponder long and hard before

finding that Dr Skinner's fitness to practise is impaired. Indeed, that the answer you should come to is that his fitness to practise is not impaired. Thank you.

MR KARK: Can I just raise two matters by way of clarification, because it is not normal for the GMC to reply to those submissions.

The first is to raise the status, just so that it is clear as a matter of evidence, the status of Dr Skinner's document, which is unsigned and undated, which you are being asked to take account of. Can we take it, from his representative Mr Jenkins, as his agent, that those are his thoughts, as it were, to date and they are said to represent his current thinking? It may be that we ought to have a signed and dated document at some stage just as a question of formality, so that if you do take it into account it is formalised. That is the first matter.

MR JENKINS: Can I just deal with that whilst it has been raised? There is no problem at all. Dr Skinner is the author. If it is felt to be appropriate we can sign a copy and then it bears the date when it was written, 7 September.

MRS WHITEHILL: Can I ask, Mr Jenkins, are we then to take it that we give weight to D21?

MR JENKINS: The Panel can give such weight to it as they see fit. It does come from Dr Skinner, is the point.

MR KARK: I think as a matter of formality it would be sensible to have a signed and dated document, if Dr Skinner would not mind, because then it is formalised and we all know exactly where we are.

The second matter was in relation to Mr Lynn's evidence that Mr Jenkins raised when he was dealing with the issue, I think he was dealing with the issue really of thyrotoxicity and he relied on Mrs B. I think one ought to look - I am sorry to do this - to Day 6, page 65, to see what Mr Lynn was actually talking about and to make sure also that Mr Jenkins is right when he says that the transcript on this occasion has got it wrong. I am afraid it does mean finding Day 6.

THE CHAIRMAN: Bear with us.

MR KARK: Yes, of course. Day 6, page 65 is where it started. If everybody has it, I think we start at line 18, where Mr Lynn was asked:

> "Q What proportion of your patients are thyroid cancer patients roughly?
> A 100 a year new ones. I was seeing one in 15 of cancers in the country. Oh, but you see, they go on for ever, I would say in the clinic of 50 patients there would be ten thyroid cancer patients."

Then this part, and Mr Jenkins asked him:

> "Q Are you able to tell us what view is there taken [between] medical practitioners as to the levels of hypothyroidism in the

population?"

I was not talking about thyrotoxicity I do not think.

"A I think people realise this is very common."

Now, Mr Jenkins thought that that should be hyperthyroidism, but can you read on.

"Q We are talking about 1 per cent of the population or 10% or more?
A I do not know what their perceived view is, but it is common and many of them will treat the patients within their clinics themselves.

Q I understand that. But I mean, common, are you able to give us a sort of ballpark figure as to common?
A It depends on age group. I suspect in a 60 year old patient it must be somewhere in the region of 3-5% of a raised TSH."

Then, he is asked:

"What about hyperthyroid patients."

Now, it is a matter for you, but it looks to me there as if the transcript is correct, and Mr Lynn was indeed talking about hypothyroid, because he is talking about a raised TSH in those patients. It is just that if you do rely on what Mr Jenkins has just said and you formulate it as part of your determination, I think perhaps in fact the transcript on that occasion is correct. I do not know if Mr Jenkins agrees with that.

MR JENKINS: I do not need to say much in reply. Perhaps the relevant part is the bottom of the page, my question:

"Q I will come back to the reference range. If we are talking millions of people, 5% fall outside the reference range, we are talking about hundreds of thousands of patients who fall outside?
A Yes."

Whether the first was a hypothyroidism and the second was a hyper I do not think it matters because he is talking about the same percentage, 3-5.

THE CHAIRMAN: Thank you. Legal Assessor, do you have anything further to say?

THE LEGAL ASSESSOR: Yes, briefly. There is no binding authority yet available on the meaning of impairment of fitness to practise. Fitness to practise means not only capacity or ability to practise in the sense of having a requisite knowledge, experience and technical skill, but also suitability to practise by reference to the character and conduct of the doctor, as demonstrated by the findings made to the facts alleged against him. Thus, a doctor's fitness to practise may be found to be impaired, even though that doctor is highly skilled, if he has behaved in such a way that in your judgment his conduct is such as to call into question his suitability to provide medical services, either with restrictions or at

all.

Now that secondary meaning of fitness to practise does not necessarily equate to what was formally described as serious professional misconduct and so, as such, some of the authorities may not be terribly helpful.

Dealing with impairment, Section 35C(2) of the Medical Act 1983, as amended, provides that a person's fitness to practise should be regarded as impaired for the purposes of the Act, by reason of a number of matters of which misconduct is one of them and it is misconduct that the case is put on that basis here.

Indicative Sanctions Guidance is the best available source of illumination of the meaning of impairment of fitness to practise and when looking at impairment you should look at the Indicative Sanctions Guidance. I can refer you to various passages, some of which you have been referred to already. Page S1-2, paragraph 11:

> "…the GMC's role in relation to fitness to practise is to consider concerns which are so serious as to raise the question whether the doctor concerned should continue to practise, either with restrictions on registration or at all."

There is a passage at paragraph 54, on page S3-13, which is probably less relevant, but it is there:

> "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."

Paragraph 57, on page S3-14, is a little bit more illuminating:

> "All human beings make mistakes from time to time. Doctors are no different. While occasional one off mistakes need to be thoroughly investigated by those immediately involved where the incident occurred and any harm put right, they are unlikely in themselves to indicate a fitness to practise problem. Good Medical Practice puts it this way:
>
> 'Serious or persistent failures to meet the standards in this booklet may put your registration at risk.'"

Pages S3-14 to 3-15, in paragraph 58, sets out a non-exhaustive list of circumstances in which the question of fitness to practise may arise and I would urge you to look at that particular section, paragraphs, and you should consider them.

It is for you to apply such standards as you consider to be appropriate to set for the profession. In doing so you may be assisted in some of the observations which are set out above and in the Indicative Sanctions Guidance. The general tenor of the guidance is that conduct should only be considered to impair a doctor's fitness to practise if it is regarded by you as bring a serious departure from the standards expected of a doctor with the status

and level of experience of the doctor in question.

As far as the Indicative Sanctions Guidance is concerned, in its earlier versions it has been approved by the High Court, the case of *Bevan v GMC [2005] EWHC 174 (Admin)* - I think that was the 2004 edition that was approved, but it was regarded as being helpful and sensible and there is no reason to suppose, it has not actually come up, that the current version that you are studying will be regarded in any different way.

Therefore, your task as a Panel is to set standards of fitness to practise which you consider to be appropriate in your professional judgment. In doing so you should have regard to the observations made in the Indicative Sanctions Guidance, as set out above.

However, you should also consider the matter in the light of the facts of this case. Can I turn to head of charge 33? That is the question of the refusal to carry out a performance assessment. In relation to that, Rule 17(8) says that that can be looked at, subject to paragraph 7, which actually does not apply in this case, where a practitioner has failed to submit to or comply with an assessment under schedule 1 or 2 and (a) there is credible evidence before the Fitness to Practise Panel that the practitioner's fitness to practise is impaired. That does not mean to say that you have a finding, merely that there is credible evidence that the fitness to practise is impaired. (b) a reasonable request has been made by the Registrar to the practitioner that he submit to or comply with the assessment and, (c), no reasonable excuse for such failure has been provided by the practitioner.

You have got three hurdles, you might say, to look at in relation to refusal to carry out a performance assessment: credible evidence, reasonable request, no reasonable excuse, but if those hurdles have been passed and you think that they have been passed in your professional judgment, then you may take such failure into account in determining the question of whether the practitioner's fitness to practise is impaired.

Now, those are all the matters on which I would advise the Panel. Does either party have anything to say about it?

MR KARK: Just one matter. This is a case in which the impairment is said to arise because of both misconduct and/or deficient professional performance. I think when he advised you, the Legal Assessor said that this is a case where misconduct is alleged. In fact both limbs are in your heads of charge. You do not have to find both, as it were, but you would have to find one of them, so it is an and/or, but you would have to consider both misconduct and/or deficient professional performance.

THE LEGAL ASSESSOR: Perfectly correct. Anything?

MR JENKINS: No, not as to the Legal Assessor's advice to you, but I will ask what may be an impossible question for the Panel. It is to do with housekeeping. I have a number of patients here who would like to give evidence. Depending upon your decision on impairment I may or may not want to call them. Obviously, you have to formulate reasons for whatever decision you reach on the question that you now have to consider, but I am just looking ahead as best I can to the position of those patients. Again, I will be asked, if I do not ask you now, "Why did you not ask the Panel how long they would take to make their decision?" and you cannot answer that, but I am just wondering whether,

realistically, if you were to find the case should go on, I will be calling patients tomorrow? It is a Sunday. I think it unlikely that the case will finish tomorrow on any view and in those circumstances it might be that we can grasp the nettle now and say, well, I can let those patients go because if they were to remain they will be sitting outside. Obviously there would be nothing more to do in public session for those patients.

THE CHAIRMAN: Mr Jenkins, as you know, the case has gone on and finding days can prove difficult. We have tomorrow booked and what I would say to you is that there will be no decision before lunch tomorrow, but there could be after lunch.

MR JENKINS: I am grateful. I know you cannot take it any further. That means that you will have to make a judgment, but thank you very much.

THE CHAIRMAN: Right. We will now go into *camera* to make the decision on whether the doctor's fitness to practise is impaired.

MR KARK: May the lawyers leave on the same terms as before? You have our contact numbers and we will be on a 30-minute call-back, as it were, if you are content with that. Otherwise, of course, we will remain.

THE CHAIRMAN: No, I think that is fine, thank you.

MR JENKINS: Can I leave a signed version of D21 just there, for the Panel secretary?

THE CHAIRMAN: Thank you.

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

(*The Panel later adjourned until 9.30 am on Sunday 9 September 2007*)