GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Monday, 9th July 2007

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

Case of:

GORDON ROBERT BRUCE SKINNER MB ChB 1965 Glasg SR
Registration No: 0726922
(Day 6)

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.

Monday, 9th July 2007

(9.30 am)

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

To maintain the anonymity of the patients involved in this case, should their names be mentioned in error, please do not refer to them outside of the room. Could you ensure that all mobiles are turned off, I am sure you probably have. Also just to remind you, if you need to talk to anyone, please do it outside of the room, it is quite distracting.

One other reminder, we are finishing at 3 o'clock today. Thank you.

Mr Kark?

MR JENKINS: Before Mr Kark begins, can I say I have Dr Hertoghe sitting next to me who is an expert.

THE CHAIRMAN: Thank you.

MR KARK: Could I call, please, Mr John Lynn.

Madam, I will be handing out copies of Mr Lynn's report, as we did with Professor Weetman.

THE CHAIRMAN: Thank you.

MR JOHN LYNN (sworn)

THE CHAIRMAN: Good morning, Mr Lynn. Do sit.

Thank you for coming to give evidence to this

Fitness to Practise Panel hearing enquiring into the allegation against Dr Skinner.

My name is Sandra Sturdy and I am chairing the Panel. The Panel members are made up of lay and medical members.

On my right we have Dr Margaret Elliot. On my left, we have Ms Kathryn Whitehill and Mr William Payne.

On my immediate right is the legal assessor who advises the Panel on matters of law, and on my left is the Panel secretary.

On your right is Mr Kark, the barrister who represents the GMC, and to your left is Dr Skinner's legal team led by his barrister, Mr Jenkins. To your immediate right is the shorthand writer, who takes notes on these proceedings.

Mr Kark will begin by asking you questions, following which Mr Jenkins may ask you questions on behalf of the doctor. Mr Kark can follow up and then there could be questions from the Panel.

Thank you, Mr Kark.

Examination-in-chief by MR KARK

MR KARK: May I begin, madam, please, by handing out copies of Mr Lynn's report.

THE CHAIRMAN: That would be C7?

MR KARK: I have not kept a note. Yes, C7.

Mr Lynn, so far as the microphones are in front of you, it is the one with the red light that works as far as you are concerned. Leave the other one alone, that is for the stenographers.

I want to ask you, please, a little bit about your experience and your clinical background. You know the Panel have heard already from Professor Anthony Weetman?

A. Yes.

Q. And you can take it that we know a certain amount about TSH levels, T4 and T3, but I am going to ask you, please, to assist the Panel from your experience. First of all, your present occupation is what?

A. I am retired from the Health Service, but in full time private practice in London at the Cromwell Hospital and other associated London hospitals.

Q. Practising as what?

A. As an endocrine surgeon with a special interest in thyroid disease. I must explain that endocrine surgery was a new development when I was appointed in about 1978 and was something which I had developed from America. Really, although it is very surgical, the emphasis is also very medical as well, and we have been training people with an interest in the endocrinology of thyroid disease and other hormonal diseases such as the adrenal and the parathyroid. So it is a very medically-based

system, and one really regards oneself as a physician who is able to operate on the patients that we diagnose.

Q. And I think you have rung that designated thyroid clinic or you ran it from 1978; is that right?

A. 1978 at the Royal Post Graduate Medical School until 2006.

Q. That was dealing with both benign and malignant thyroid disease, as well as, as you mentioned, surgery and medical aspects of thyroid disease?

A. That is correct.

Q. I think you have also lectured widely on the management of all forms of thyroid disease, and you also have a specific interest in the problems of replacement therapy with thyroxine.

A. Yes, because we operate on these patients we have to get their post-operative thyroid replacement correct, and we are dealing now with benign and malignant disease which we operate on. In addition, I have always been very interested in the problem of replacement with thyroxine, which has been, as we know only too well, extremely controversial.

Q. Can you give us an estimate, please, of the number of patients that you see on an annual basis?

A. At the moment, 3,000 a year. About 60 private patients a week, and in the past it would have been double that

amount.

Q. Are those all thyroid patients?

A. 90 per cent of them.

Q. I think you have examined the papers in this case, and I am going to go straight to paragraph 7 of your report because we have heard a lot about the possible symptoms and signs, as it were, of hypothyroidism, and I want to ask you about, again, your experience dealing with people who come to you with what may be or may not be symptoms of hypothyroidism.

You say in your report that patients vary and will have any number of symptoms, depending on the severity of the thyroid deficiency. What is the basic test that you do in order to find out what that problem, if any, is?

A. The basic investigation is biochemical, which is the TSH and the T3 and T4.

Q. I think we are going to hear in due course that to some extent, certainly, Dr Skinner eschews that. Why do you say the chemical test is so important?

A. Well, in my experience, it is the gold standard test. The problem is the range.

The range will vary from whether you're a night worker or a day worker. It will vary in different countries because of the iodine content. It will vary

when taken at the time of day.

So the problem has always been the range, and in the past we couldn't diagnose the lower range because the sensitivity of the test was so poor, we could only diagnose the upper range, but now because the test has become so sensitive due to changes in methodology, we are now able to look at both the lower and the upper range. But gold standard worldwide in accepted practice and in our practice is the TSH plus the T3 and T4.

Q. If you have a patient who comes to you with a number of symptoms and signs of what they think is hypothyroidism, but they fall within the reference range, what do you look at?

A. Clinically, do you mean?

Q. Yes.

A. I would examine them, and in my experience -- unlike Dr Skinner's -- patients whose thyroid function is within the normal range very rarely have anything to see or detect at all, they appear normal.

Q. We have at paragraph 6 of your report a list of common symptoms.

A. Yes.

Q. And those are common symptoms of hypothyroidism. Are they also symptoms potentially of other diagnostic diseases?

A. Absolutely. I may say many of these symptoms could be the diagnosis of primary hyperparathyroidism, which is excess calcium in your blood, fatigue, weakness, change in hair, constipation, depression. So there are lots of other conditions or several other conditions, and depression on its own may give similar symptoms, which will look just like this, which are not primary hypothyroidism.

Q. You say in your paragraph 8:

"... diagnosis of hypothyroidism is based exclusively on the measurement of the amount of thyroid hormone in the blood."

I just want you to clarify what you are saying there, are you saying you ignore all the symptoms?

A. Yes.

Q. Why do you say that?

A. I would look at the range very carefully, and we will discuss that if in a moment. I don't believe that a patient with a TSH of 2 has got primary hypothyroidism, full stop.

Q. And if they have symptoms such as those you have just discussed but they are at 2 or below 2, or in the region of 2, what else do you look for?

A. If they were below 2 or lower, one would wonder whether they were the opposite, whether they hyperthyroid. The

other thing which I think must be stressed is that if you have a doubtful case -- let us say it was at 4 for a moment -- one would examine them, check them, make sure that the TSH was repeated again before you embarked on thyroid therapy. After all if a woman is 25 years old and you are putting her on thyroid therapy, you may be putting her on thyroid therapy for 60 years, and nobody really knows the effect of that.

There are suggestions, as we will come to, about osteoporosis and suggestions of cardiovascular effects, but you are committing a patient -- it is very, very difficult to get patients off thyroxine once you have got them on it. So the trick is to say: look, your TSH is up a little, or is at the upper limits of a normal range or you have symptoms. Let us see you again in a month and repeat it, and let us make sure it is done at the right time of day. Let us make sure we repeat it. Because one of the best tests in medicine is looking at investigations which are separated by time.

Q. Once a patient has started, why do you say it is so difficult to get a patient off thyroxine, and have you had this experience yourself?

A. Yes. In two ways, once many year ago I was thyrotoxic, and when I was no longer toxic everybody else was happy --

Q. I didn't mean personally.
A. No, well, I can make the comment, everybody else was a lot happier than I was, and it takes time to get used to having a normal thyroid function. Patients, if they are on thyroxine, often want to stay on it because they feel good, and they will often be severely toxic, and we have great difficulty getting patients who are addicted to thyroxine -- thyroxine is almost an addictable drug. Once you go on it and you have got used it, it gives you a buzz feeling and you run all the risks of being unwell on long-term treatment.

So that is why it is difficult to get people off it, and we don't succeed. Many, many a time we advise our patients who take large doses of thyroxine often off the Internet to stop it, but they feel well on it, their TSHs are suppressed totally, their thyroid level are in the 40s often, T4s of 40, but can you get them off it? No.

Q. If the TSH is suppressed -- and we look at some notes here in this case -- really below a negligible reading, so it is below or at 0.01 TSH, what effect does that have on the thyroid gland?
A. If you are taking exogenous TSH, it will make the thyroid atrophy. When we explore patients for other reasons, when they have been on long-term thyroxine,

there is hardly any thyroid there.

If you ever get a thyroid cancer in a patient who for other reasons has been on thyroxine for years, there is hardly any thyroid there because in fact the exogenous thyroxine has suppressed the thyroid to such a state it almost atrophies. So that is the first thing.

Secondly, biochemically, if you are taking large doses of thyroxine, the thyroid is not contributing itself to any of other thyroid that is around. It is suppressed.

Q. And so the suggestion that you are treating a thyroid disease, which, when you start, had a within reference range of the TSH level, the suggestion you are treating some disease of the gland, what do you say about that? If you are putting T4 into the body what is the effect of that?

A. Well, the effect of that will suppress the thyroid long-term, and the only time one would consider that sort of -- let me just put it this way: the reason people may justify with a TSH at the upper end of the range is that we know that there is a small risk that they may get thyroid disease at a later date, true hypothyroidism, and you're only treating it then to prevent something later, while it is much better, in my view, to do what I suggest, to check their thyroid

function on a regular basis and then if there is thyroid failure, spontaneously, then to give them thyroid replacement.

Q. Are there good medical reasons on occasion for totally suppressing the thyroid?

A. Oh yes.

Q. Such as?

A. The important one is in the management of the rare condition of thyroid cancer, which is very rare. There are only 1,300 cases in this country every year.

There we know that TSH stimulates the growth of thyroid cancer. So when we have removed the thyroid cancer, we place these patients on -- in the past, we used to put them on large doses of thyroxine to suppress their TSH.

But now, because of concerns about osteoporosis, which have changed the -- the concerns have changed over the years, concerns of that, about that, we tend not to use such superlarge doses, we tend to use doses which keep the TSH at the lower end of the range, not totally suppressed.

Q. Can we deal with the potential problems that arise. You have mentioned osteoporosis. How rarely or how frequently is that thought to occur? What is the reading? What is the research on that?

A. I think it is very difficult to give a definite answer to that. Initially, it was thought to be very common.

The reason for that was a lot of the data was contaminated by the fact that there were, in the people studied, people who have thyrotoxicosis as well, because we know that primary thyrotoxicosis undoubtedly produces an incidence of loss of bone density, and in men in particular, fractures of bone, and the different studies you read tend to give you different information but the general view is that there is an increase in the risk of fracture in patients who are thyrotoxic and have TSH which is below the normal.

It is not the thyroid itself we think that is the problem, it is the suppression of the TSH. So if you oversuppress them, there is undoubtedly a risk of osteoporosis and there is this risk of fracture, which varies from study to study. The is big enough, even though it is doubtful, for one to say: why should we take the risk, maybe we are not sure; but if these patients don't need the thyroid replacement, why ever should they be taking a drug which has a risk, which at the moment we are not clear about?

Q. You mentioned men in particular.

A. Yes.

Q. Is there any danger to women?

A. In what?
Q. Of osteoporosis.
A. Yes.
Q. Again, any particular group of women who are thought to be --
A. Post menopausal. That is what the evidence shows, but one must make the point that if you put a 25-year-old woman on thyroxine unnecessarily, post menopausal women may already have problems with osteoporosis through other causes.

You may be putting somebody on, as I have already said, a drug for 40-odd years or maybe longer, and you still do not know its long-term effect.
Q. Apart from osteoporosis, what other problems are thought to arise?
A. Excessive -- there are cardiovascular problems. Atrial fibrillation in particular can occur with an excess of thyroxine, and this in itself is a complication which can lead to cardiac failure, et cetera, but this is fairly rare because it would be picked up fairly soon and would be more in the elderly where there are other factors.
Q. If you are having to put a patient on large doses of thyroxine, do you warn your patients about the possible side effects?

A. If you put patients on large doses of thyroxine, you have to have a cost-effective benefit why you are doing it, and you're doing it to stop them getting recurrence of their thyroid cancer, which is the main thing, and it is very effective in stopping the recurrence of thyroid cancer, but all these patients we watch very carefully. They have regular bone densities done to make sure they don't get into difficulty, and if they have difficulty, then we will add drugs which will help the problems of bone density, like calcium and also Pamidronate and other drugs.

Q. Are the patients made aware of those potential problems?

A. Absolutely.

Q. Can we turn to the reference range. Again we have heard quite a lot about the reference range, as you can imagine. I want to deal with two separate areas.

First of all, the reference range in patients who are not being treated for thyroid deficiency and then the reference range which is a goal once in treatment. Do you follow me?

A. Yes.

Q. They may be different, I expect.

The reference range as an accepted standard in the UK. Can you help us with that?

A. Yes. If you look at most labs, the upper limit of

normal is somewhere between 4.5 and 5 from various areas. So the upper limit of normal in this country is about 4.5 to 5.

The reference range, and it should be called the reference range, not the normal range, as we all know too well, will vary. In other countries it is quite high, it is up to 12 and 13 because of iodine deficiency. So there are lots of factors that affect the reference range, the time of day it is taken --

Q. Why the time of day it is taken?

A. Because it has this sort of modal secretion. I may say the secretion, if you do a TSH at 6 or 7 in the morning, it will be high. By 11 o'clock it will be much lower, and there may be as much as a 50 per cent change in the range. In the evening or late at night it will be high again.

So it is quite critical when you have the doubtful patient that you make sure when you've taken the TSH, and it is also critical when you do it spontaneously, when they are not on treatment and also when they are on treatment, because when they have taken their thyroxine will affect it. So it is not as clear cut. Just one test is no good, what you need is several tests going back to the concept of doing them in relation to time, maybe a month or three months apart, and doing them at

a set time in the day.

Q. What about the goal of treatment, once a person is on thyroxine?

A. Well, the reference range is quoted as up to 5 but from extraordinary reason because people don't want to undertreat, there is a general view that you should get their treatment range down to about 2.5. That is a bit illogical really when you think about it, because if the normal range is -- sorry, I apologise, the reference range is 1, why should you try and have a slightly different reference range when you treat them?

I think partly it is because people are keen to keep it down because patients don't always take their thyroxine. You only have one blood test and don't see them for three months, and there is an element of patients not taking their thyroxine regularly.

I think one of the reasons that people have tried to maybe overtreat them, maybe the wrong word, is to make sure they get adequate treatment and they know at 2.5 it is not a problem, it is not overtreating, it will make sure if they miss an odd dose, then maybe in the situation practically where it does not matter. I think that is the logic of it, as a practical person.

Q. You say in paragraph 10:

"In recent years there has been considerable

pressure to reduce the normal TSH to a lower level, but there is no evidence at the moment that this is justified, and any patient with a TSH below 5 would be considered not to have either asymptomatic or symptomatic hypothyroidism."

Your reference for that is the Yearbook of Endocrinology 2006. Is that a reference range relevant to the UK?

A. Yes, I believe so, yes.

Q. And you say at the bottom of that page:

"In summary, patients with a TSH of less than 5 mIU/L do not have either overt or subclinical hypothyroidism and do not need thyroid replacement."

I'm not going to ask you about the various preparations, or not in any great detail, because again, we have heard a good deal of evidence about the use of thyroxine, the combinations that there are. I do just want you to assist us with T3 and the use specifically of either T3, itself or Armour Thyroid, which apparently contains a greater amount of T3 as a ratio to T4?

A. I most likely use more T3 than anybody because in fact I'm using it for thyroid cancers, and we have a considerable number of thyroid cancers. T3 has a short half-life, maybe about 8 hours, is rapidly absorbed and should be given -- synthetic T3 -- three

times a day.

So there is no logic, in my view, of just giving a single dose of T3 with T4 because it is not going to have an effect throughout the day. You are just going to have an effect for a couple of hours.

I have not used Armour thyroxine at all. I see many patients with it, who are on it, and usually I persuade them to come off it because I find it very difficult to control them and sort out, to be frank with you, their biochemistry when they're on it.

The argument about the T3 in Armour is, against it in part it is of a different percentage of T3 to T4. The argument in its favour for the T3 is there is a suggestion, as it is a dessicated extract, that T3 is bound to a thyroglobulin or bound to local proteins, and as a result this means that the absorption is much smoother over the day, but I have no experience of that.

Q. All right. You deal at the bottom of page 7 with patients that come to you having had access to the Internet, as I suppose all patients now have, and looking up the symptoms of hypothyroidism which are protean, and feel they are hypothyroid.

I don't want to go back to the list of symptoms, but the list of symptoms is very long indeed.

A. Yes.

Q. Can we turn then to page 8, and we are about to turn to Patient A.

You will find, if you need to have reference to it -- just let me introduce you to the bundle to your left. There is a thick bundle of papers there. You will find, if we need to have reference to it, that the GP notes in relation to Patient A appear at tab 1.

Dr Skinner's notes appear behind tab 2, and then the same for tab 3 is Patient B, GP notes, and tab 4 is Dr Skinner's notes.

At the moment, again, because the Panel are I think really quite well acquainted with the patient notes, I am not going to turn up the note each time. You've referred to them in your report, and I can give references on each occasion, I hope, if we need to have a look at them.

Patient A, we know, was referred to Dr Skinner by Dr Cook, and she had had a history of postnatal depression. The thyroid function test, which was done on 9th April 1999, so that is a very early one, showed a TSH of 1.5.

We know also that in July of 2001 her TSH was, as you described, normal, at 1.49. Do you mean within the reference range?

A. Yes, sorry, I apologise. Yes.

Q. I am in your paragraph 14 at the moment.
A. Yes.
Q. Subsequently, on 13th May, her TSH was 1.45. You have also noted that she had had a slight heart problem during her pregnancy.
A. Yes.
Q. I want to ask you the relevance of that if you're putting someone on thyroxine?
A. It was not clear from the notes what exactly it was. I suspect it was a non-significant murmur of the heart. Often during pregnant you either get a flow murmur -- I doubt if it was anything more sinister than that.
Q. All right. We know that Patient A had received advice from a Dr Veitch, back in October 2002, telling her she was clinically euthyroid, and then she goes on to a consultation with Dr Skinner on 16th January 2003 where he made a diagnosis of hypothyroidism. He was particularly interested in the lack of hair on her eyebrows.

Is that something you come across in hypothyroidism?
A. Well, one sees it in very severe hypothyroidism, patients with TSHs in the 60, 70s and 100s, but I have not seen it in an instance where somebody's TSH was 1.49, which although well within the reference range, is right low down in the reference range and really would

exclude, in my view, biochemically any suggestion whatsoever that this patient had hypothyroidism.

Q. He took a blood test but started Patient A on thyroxine, and he subsequently received the test, which we have at page 216, if anybody wants to check it, and again the TSH then was 1.4. So in July of 2001 it was 1.49.

In May of 2002 it was 1.45, and in January of 2003 it was 1.4.

When he received that test back, there certainly doesn't seem to be any indication that that changed his view, he still regarded this patient as hypothyroid. In your view, on that test, was she?

A. In my view on that test, she was in the lower reference range of the TSH and she was distinctly, in my view, not hypothyroid.

Q. You deal with the fact that she developed severe headaches and felt emotionally tense. You take the view, I think, that that's very unlikely to have been caused by the thyroxine.

A. Yes, I don't think this is related at all to it.

Q. Why not?

A. We're always putting people -- I have not seen that clinically myself, people going on thyroxine getting headaches like that. It could be a case, but I haven't seen it.

Q. We know that the patient took herself back to her GP and was eventually sent to Professor Franklyn. Professor Franklyn's view was that her TSH, I think to quote her, "was extremely normal". She was confident that Patient A did not have hypothyroidism, but it seems that thereafter this patient has kept on thyroxine and you deal with that at paragraph 21.

We haven't had the advantage of hearing from Professor Franklyn, but have you been in this sort of position yourself before where a patient has come to you on thyroxine and you don't think there is any need for it?

A. Absolutely, and then you do all you can to try and persuade them to stop it, and you're not always successful. You say there are risks, albeit very small, and I think Professor Franklyn's sort of management looks a bit odd to start with, because if the patient didn't have hypothyroidism, why not stop all the thyroxine completely, why make the suggestion she made?

I think that Professor Franklyn most likely felt that she wouldn't stop some form of thyroxine, and she was most likely better off, on the worst of two evils, to stay on the synthetic drug, and that's why she did it. It doesn't quite make sense because you would have thought she would have said: look, stop it completely.

She may have said that to start with and then felt that it was not possible to --

Q. Certainly that would be your aim. Whether it was her aim or not, we do not know.

A. Yes, my aim would be to stop it.

Q. You have said -- and we're going to come to this with other patients as well -- that it is very difficult to get patients off thyroxine once they have started. Is there any understanding as to why patients like it so much? If we were all in this room given a good dose for a couple of weeks of thyroxine, what would it do to us?

A. Well, I think it has a feel good factor. There is no question at all -- if I can go back, if I may, to the patient who said thyrotoxicosis and has then been treated and then is biochemically normal and feels well, but they don't feel as good as they did before they had their thyrotoxicosis, and it is a common complaint for the patient to say: I felt better when I was -- and I mean overtly thyrotoxic -- than I do now.

Q. So you're pleased with yourself, as it were, to have cured the thyrotoxicity --

A. Yes, you have got me, and then gradually it settles over a period of months. It is very, very common when we operate on patients with thyrotoxicosis and put them on adequate replacement and most likely, bringing their TSH

down to about 2.5 because of this concept of them keeping on their tablets, these patients then slowly, slowly they will say: gosh I feel better, and we get them into a normal stable state.

Q. You say at paragraph 23 in your comment on Patient A that in your view she was unnecessarily placed on thyroxine and with a clinical diagnosis of hypothyroidism which was not justified by the thyroid function.

You say:

"If anything [she] was at the lower end of the range."

You also deal, over the page, with the differential diagnosis. What do you think was -- you haven't seen her, you have seen her notes.

A. Well, she had already been on Prozac, so there was an element. That doesn't mean an awful lot because it is used a lot, but there had been an element of depression, and I suspect that there were other causes for this lady's symptomatology which were totally unrelated. I don't believe this lady had hypothyroidism, full stop.

Q. Paragraph 24 halfway down the page, at the top of page 12, so if the Panel read this they understand the context in which you mean it:

"The prescription of thyroxine was completely contra

indicated in my view and contra to the accepted practice of thyroid replacement in the [UK]."

When you said contra indicated, in what sense? Why was it contra indicated?

A. Because it wasn't necessary.

Q. And paragraph 26, you deal with the rather odd consultation which Patient A detailed in a letter to Dr Skinner, effectively a letter of complaint, but although it is unusual, I don't think you have great concerns about that, but you do appear to take the view that it was inappropriate to place her on thyroxine, it was unnecessary.

You say:

"It was likely to place her at harm and fell below acceptable practice."

Again, I will not go through this with each patient, but why do you say --

A. She is a relatively young woman, she's going to be on thyroxine for life, and it is known from studies in America that people on thyroxine the dosage is often not correct. She doesn't need to be on it. There is a risk possibly of osteopenia, osteoporosis, the risk of fracture is most likely minimal, but this is not in her best interests.

Q. Can we turn please to Patient B.

This lady saw her general practitioner on 28th January 2003. She undertook a Beck Depression Inventory Scale evaluation, and it demonstrated that her depression was in the moderate to severe area. Her thyroid function showed that her T4 level was 16.8 and TSH level was 2, 4 which you describe as absolutely normal in the sense that that's what you regularly see --

A. Yes.

Q. -- and within the reference range.

Previous thyroid function tests you set out at the bottom of paragraph 27, and I will not go through those, but we know that on 26th March 2003, when the patient had seen Dr Skinner on 20th March, he wrote to Dr Blair that she was -- in fact his expression was classically, I think, hypothyroid. What do you say about that?

A. I think that's wrong.

Q. He was aware that the biochemistry was normal but felt that she was hypothyroid from her symptoms, and he put her on thyroxine. She then went off to see Dr Blair in May. She had stopped her anti-depressants and started on thyroxine, and Dr Blair seems to have been trying to stop her. Would you have taken the same course as he did?

A. Absolutely. Can I make the comment that the thyroxine

was 225 micrograms a day, which is a considerable amount of thyroxine.

Q. And we can see that the effect of that in December of 2003, by then, she had been on thyroxine for some nine months. I think there may be an error in your report actually, which I hadn't spotted before. You say the TSH was less than 1. If we have a look at tab 4, page 8, I think it was actually less than 0.1.

A. I apologise, but it is still less than 1.

Q. It is. It is accurate, but it was 0.1. Perhaps I can ask the Panel to correct that.

We see the comment by the lab suggests slightly overreplaced with thyroxine.

A. I thought that was outrageous, I must say. Here is a T4 of 39 and I apologise for the mistake in my less than 0.01. This woman, if she walked through the door and was shaking a bit, you would say she had severe thyrotoxicosis and in fact had iatrogenic thyrotoxicosis, and was grossly overtreated for a condition she never had.

Q. When you see your thyrotoxic patients and they are demonstrated to be thyrotoxic by the blood results, how often do you see or do you necessarily see symptoms of thyrotoxicosis?

A. Usually they presented to you because they have either

got weight loss or are feeling unwell, so they usually present with some symptoms, otherwise they wouldn't come to the clinic. But we do see patients, particularly in patients who have simple goitres, the elderly, patients who are thyrotoxic, which is subclinical, and we're surprised that we pick them up, but this is particularly true in the elderly, the multi-nodular goitre.

Of course, the other way that thyrotoxics will present is with this atrial fibrillation in an elderly patient they just not just lose wait, they may just come to you, and say: I have got a little bit of an irregular heart, and thyrotoxicosis is one of the commonest causes of atrial fibrillation, but the young tend to come with loss of weight, and Graves' Disease, and sweaty, maybe eye disease. The elderly tend to come in a more less obvious way. I hope that answers the question.

Q. You have just mentioned Graves' Disease. Could you remind us what Graves' Disease is?

A. Graves' Disease is an autoimmune disease named after the famous Irish physician, Graves, and it is attack by antibodies of your thyroid which interferes with the thyroid in such a way that the thyroid produces too much hormone in the form of, usually, T4 with, of course, T3 as well, and sometimes it can produce pure T3, although that is unusual.

It is a very classic disease because it is associated with eye signs, and you have poppy eyes, and most of us have seen somebody who has had thyrotoxicosis. The most famous example, of course, is Marty Feldman, whose eyes were due to thyrotoxicosis.

The eye signs and the thyroid disease don't always relate very well, you can treat the eye disease -- correction, I apologise. You can treat the thyroid disease and the eye disease's progress is unpredictable. But Graves' Disease is this disease of young women, loss of weight, anxiety, sweating, with rather poppy eyes and anxiety.

It is a diffuse disease of the thyroid.

Q. If you see a raised T4 and a normal or diminished TSH, is Graves' Disease something that one should be looking out for?

A. Absolutely.

Q. We know that other doctors got involved here. We know Dr Liz Jordan became involved. We know that on the next appointment with Dr Skinner, which was 21st January, the patient complained of an incident of heart palpitations.

I can take you to the notes, but actually the easiest place to go is right at the beginning of tab 4. You will have Dr Skinner's note, typed note.

The entry in the middle, we're still on

20th January, so it is the entry in the middle of that page: do you see marked "Second consultation"?

A. Yes.

Q. And do you see:

"Taking reduced dose of 200 micrograms thyroxine on account of palpitations."

A. For one month, yes.

Q. In fact we see what happened on that occasion was that the thyroxine itself was reduced and she was put on Tertroxin. So T3.

A. Mm-hm.

Q. Again, I don't want to spend too much time on this, but was there any basis, in your view, upon which she should have taken that course?

A. None at all, but I wouldn't have had her on thyroxine at all.

MR JENKINS: Can I interrupt for a moment. I think the evidence the Panel are going to here is that it wasn't palpitations for a month, it was on one occasion.

MR KARK: I said, "an incident".

MR JENKINS: I understand.

MR KARK: But that was the complaint that I think she made on 20th -- it should have been, I think, 21st January 2003.

She was seen again, we know, on 18th March 2004, as

you describe in your report at paragraph 31. Again she was given a prescription of thyroxine and also T3. You've already stated in your view there was no need for her to be on thyroxine in the first place. Mr Lynn?

A. Sorry, absolutely, yes.

Q. She is seen again -- no, she is not seen again. There is a letter from Dr Skinner to Dr Blair and we have that at tab 4, page 11.

I just want to ask you about one matter that he mentions. He says:

"A note on [patient B] who has noticed some improvements on thyroid replacement but it is clearly still hypothyroid notwithstanding highish FT4 reading."

I do not think you need to comment on that.

But he says:

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

First of all, the last blood test that was done that we can see was back on 5th December 2003, which we have at page 8, where I think there is no T3 reading at all. Indeed we don't have any T3 readings for this patient in any of her blood tests, back in January of 2003 or August of 2003.

What do you say about Dr Skinner's comment about back stacking?

A. He's hypothesising that the conversion of T4 to T3 is inadequate within the cells. I find that very difficult.

We know that there are rare genetic entities which you do special tests for, but those run in families, and you will get conversion problems in patients who are very sick in hospital for other reasons, but in a fit woman, a relatively fit woman, I just say this is not something which has been within my -- I have seen myself under these circumstances, and I think it is an explanation for the levels and the misinterpreted clinical features to fit everything together. I don't think it is correct.

Q. What about that diagnosis of failing to back stack -- or she is back stacking therefore failing to convert in the absence of a test of the T3 levels?

A. Yes, that is another point as well, but I think the point is the whole concept, I think, in this situation, is erroneous, it is something which occurs in specific families. It occurs -- there is a lot of discussion about it, it is not something I've seen in my own practice. I do not believe it is the case in this entity but that's my personal view.

Q. Then we know that in March of 2004 she saw Dr Skinner again, and again she had a further period -- it is

described in his notes -- as three-quarters of hour heart beating during alcohol, with excessive alcohol during the evening.

Can excessive alcohol exacerbate the situation?

A. Yes, I'm sure it could, but I haven't got any hard evidence for it. Excessive alcohol can do lots of things.

Q. You deal with really your conclusion in relation to Patient B, that the lady has been treated unnecessarily with thyroxine by Dr Skinner. She was correctly advised by her GP, and you say:

"She did not need thyroid replacement and [she] was placed on a large dose of [T4] ... T3, which were in my view totally inappropriate, unnecessary, and not in [her] best interests, and likely to place her at harm."

Again, your explanation for that you have already given, once a patient is on T4 and, in this case, T3, it is difficult to get them off it?

A. That is correct.

Q. Can we turn to Patient C. You make a declaration, I think, that you share the same medical practice. I don't think that is going to cause us any difficulty.

She was seen, we know, by Dr Skinner on 6th March 2004. We know that he thought her to be hypothyroid. He took a blood test, and you say in your

report:

"Thyroid function test done at this ... time was absolutely normal [but] specifically the TSH was 2.2 and her T4 was 11.6."

On the basis of those tests was there any basis to treat her as being hypothyroid?

A. Not in my view.

Q. He nevertheless placed her on thyroxine, although there is no note, I do not think, of how much thyroxine he gave her. Then he saw her again in May, and on this occasion he put her up to whatever the earlier dosage had been, he put her up to 200 micrograms a day.

Is that a reasonable dose, a high dose or --

A. That's a large dose of thyroxine. I don't know her body weight, but you reckon 1.6 micrograms per kilogram of body weight. That is a large dose of thyroxine.

Q. Again, he writes this to Dr Summers, and we have this -- if we turn to tab 6, page 6:

"A note on C who I think is already improving on thyroid replacement, though she's recently, and off her own bat, put her dose up to 200 micrograms [he says] with curiously no thyrotoxicity, which made me wonder if perhaps there is some conversion problem."

Can you see upon what basis he's claiming there was no thyrotoxicity?

A. The only explanation is that in a normal patient, given that dose, the patient would have the signs of thyrotoxicosis and he was surprised that she didn't.

Q. But no blood test?

A. No blood test.

Q. And he says:

"I thought we need to rationalise and stabilise the situation and add in [as he puts it] some T3 if there is a conversion problem."

Again, your comments in relation to the conversion of T4 to T3 apply to this patient as before.

A. Yes, and it would seem more logical to give the T3 in a smaller dose three times a day because it is only lasting, if the concept were correct, for four to eight hours.

Q. Just coming back to that for a moment, if you give a patient T3, how do you say it should be given?

A. It should be given, as near as possible, eight-hourly. The other problem with it, which I did not emphasise, is you can get tremendous rises with the T3 absorbed -- synthetic T3, and you may get bouts of palpitations, and we do have that problem with our patients who have been treated with T3 for thyrotoxicosis. So I cannot see the logic of giving a single dose of T3 whatsoever.

Q. The basic premise with this patient is she shouldn't

have been on any of it?

A. No. Absolutely.

Q. Dr Skinner saw the patient again in August. I am turning to paragraph 39 of your report. Again, he provided her with a prescription.

In August he did another blood test and on this occasion -- we have it at page 10 of tab 6 -- the T4 level is at 25.5, so outside the reference range, and the TSH level is down at 0.1 or less than 0.1, which means presumably --

A. Undetectable.

Q. You've spoken about thyrotoxicosis, and we have heard quite a lot about it, is there any definition of thyrotoxicosis, when does a patient become thyrotoxic?

A. I suppose a clinical diagnosis of thyrotoxicosis would be the combination of the clinical signs of rapid pulse, possible atrial fibrillation, loss of weight, anxiety, with the biochemical evidence of the thyroid function tests, the TSH being suppressed or low, and the T3 and T4 being outside the range. The definition would be a combination of clinical and biochemical tests.

Q. In September, Dr Skinner wrote that the patient, again describing those levels we have just looked at, as "a little on high side". What do you say about that?

A. He's absolute right, they're very much on the high side,

they're inappropriate.

Q. We know that there was correspondence from Dr Ince when she wrote to Dr Skinner asking him to confirm what the symptoms were and what caused him to diagnose hypothyroidism. We know that doctors from that practice then were concerned about what was happening, and we know that Dr Cundy referred the matter to the GMC.

The patient was seen by Dr Andrew Rodin on 7th March 2005, and her present TSH by then was normal, but we know from the evidence that we've heard that in about October 2004, she had actually taken herself off thyroxine.

If all is well, how quickly do the levels --

A. I would have thought about four weeks.

Q. -- will come back to normal?

A. I'm just giving that as a game park figure. I would have said about four weeks.

Q. Again, your comments which you set out at page 20, paragraph 47, apply that in your view the prescription for this patient of thyroxine in the first place, let alone when the TSH levels were later established, was inappropriate, unnecessary and not in her best interests.

You say:

"... [likely] to place her at risk of cardiovascular

complications, osteopenia and possible osteoporosis."

For the non-medical members of the Panel and indeed myself, what is osteopenia?

A. It is just lower. While osteoporosis is -- penia means that it is outside the normal range, while --

Q. Of what, sorry?

A. Of the density range.

Q. Bone density, thank you.

A. While osteoporosis means actual loss of bone. The two overlap, really.

Q. Can we then turn, please, to Patient D. We know that this patient went to see Dr Stewart in July 2004. She had a strong family history of Hashimoto thyroiditis.

Again, can you give us a thumbnail picture to remind us of Hashimoto's thyroiditis?

A. Hashimoto was a Japanese pathologist who only described two patients and is now world famous, and basically he described the entity of antibodies to your own thyroid destroying it, this can be associated with adrenal abnormalities, and these antibodies destroy your own thyroid, and as a result you may on occasions become -- the initial destruction may cause a rise in the level of thyroxine, so you may get a mild transient hyperthyroidism, but then at a later date it then settles into hypothyroidism with a raised TSH, what are

called positive antibodies and low T3 and T4, and it is one of the commonest causes of everyday hypothyroidism that we see in a thyroid clinic.

Q. I just want to understand how it works. It is the structure of the thyroid gland that is being attacked --

A. By cells of the own body, that's the best way of looking at it.

Q. As it effectively disintegrates, it is obviously releasing for T3 and T4 into the system.

A. That is right. It doesn't always happen that way but the initial destruction will give a transient -- as the cells break down out comes the T3 and T4 from the thyroid --

Q. At which point presumably the TSH is markedly suppressed?

A. Will be suppressed, not often markedly, may be suppressed, and it then drops down. As that phenomenon settles you then get the phenomenon of being low hypothyroidism with a raised TSH and low T3 and T4, and it is associated with positive antibodies. Having said that, a significant number of the normal population who don't have Hashimoto's thyroiditis do have positive thyroid antibodies, but the diagnosis is clinched on the biochemistry plus the thyroid antibodies.

Q. I was just about to ask you, how do you diagnose it, by

a blood test?

A. By a blood test, yes.

Q. So if you have a patient with either high T4 and low TSH, or very low T4, is that something you would be looking out for?

A. No, you will have to say that again, sorry.

Q. If you have a patient coming into your clinic with a high T4 and a low TSH, or a low T4, is that something you would be looking out for?

A. If I could explain it again. Often the transient hyperthyroidism occurs before the patient gets to see you. In other words, they tend to get to see you when they have got the hypothyroidism.

The transient hyperthyroidism is often short lived, and quite extraordinarily, every now and again you can be hypo and then spontaneously become hyper again, but the classic presentation is that of possible previous hyper, which is mild, followed by significantly progressive hypo, which can be severe.

Q. We know that the GP was unhappy referring her, and indeed he didn't, but Patient D took herself off to see Dr Skinner in August, 24th August. T4 and TSH blood tests revealed that her TSH was at 1.9 and her T4 was at 14.2.

Again, in your view, for this patient to be

prescribed thyroxine, was it appropriate and necessary or not?

A. I would feel this was totally inappropriate.

Q. This is a patient who, having been put on thyroxine, has stayed on it.

A. Yes.

Q. I haven't dwelt it, but you commented in your report on the risk of harm to the earlier patients, and you don't think there is a risk of harm in relation to them.

A. No.

Q. Because effectively they come off it or they are at a low dose. What about this patient?

A. This patient is out of medical control, isn't she, in that she is self-medicating and no longer seeing any --

Q. She's seeing a doctor but not for her thyroid.

A. Not for her thyroid, and she buys her drugs, I understand, on the Internet.

I think as a basic principle this is grossly unsatisfactory that nobody should have treatment without supervision by a doctor.

Secondly, as I've said before, there is this tendency of patients who take thyroxine to want to take more and more and take large doses of it, with suppressed TSH, maybe below the low end of the reference

level, with the possible risks of osteopenia, osteoporosis, and atrial fibrillation. These risks admittedly are small, but the risks are there. If she's a young woman who is going to spend the rest of her life taking unnecessary thyroxine, there must be concerns about the risks to her general health.

Q. The patient saw Dr Skinner again on 18th November, and we know that he gave her a further prescription of thyroxine at 125 micrograms and then upping it to 150 micrograms, and then up to 175 micrograms.

Again, in your view, was there any basis upon which those prescriptions were appropriate?

A. None whatsoever.

Q. That is in November.

The last TSH we saw was back in August of 2004 when her TSH was at 1.9. We know on 23rd February that there was a further alteration of dosage at the third consultation. If you're altering a patient's dose of thyroxine, is there any necessity to do blood tests or is it something that can be done by eye, as it were?

A. If you're going to alter the level of thyroxine in any situation, you should take blood at the time of altering it and wait about four to six weeks and then take blood again. You have no idea of what you're doing unless you do that.

Q. You say finally this:

"[This patient] was inappropriately given thyroxine. There [was] no suggestion at any stage that she had any signs or symptoms related to hypothyroidism."

Can we just have a look at tab 8 and the very first page, which I hope are Dr Skinner's typewritten notes.

A. Yes, first consultation.

Q. She was saying she had been ill since her last baby. She was tired, but she had a good appetite, her weight had gone up, she ached all over, especially her lower back, she had poor concentration and memory, and she was very upset and crying. Arms and legs paraesthesia, side visions off wiggly lines.

First of all, are those symptoms and signs of hypothyroidism that you come across?

A. These symptoms could be for almost any condition, depression -- I do not understand what side vision hallucinations are, but these tests should be taken into account that at the time the TSH was only 1.9, which, even with the strict American criteria, is well within the lower end of the reference range -- sorry, apologies, within the reference range, and in my view this patient did not have hypothyroidism.

Q. Two final matters.

We often see this in Dr Skinner's notes of side

vision hallucinations, either something being seen out of the corner of one's eye, or shadows or wiggly lines. You deal with some 3,000 patients a year, how often have you come across these symptoms?

A. I don't know what he's talking about. It is my ignorance, I'm afraid.

Q. You haven't come across it?

A. No.

Q. Finally this: we have spoken about the levels in the UK, and there is, I think, certainly a move, I think the American Thyroid Association are suggesting an upper limit of TSH at the point of which treatment begins, presumably, of either 2.5 or 3.

Can you help us with that? Why is there a difference between the two countries, first of all?

A. Well, I think it is a matter of -- there are lots of reasons. I think it is a medicolegal reason.

There is a suggestion that these patients, by some people, who may be hypothyroid, we don't believe they are. We would only treat them in this country to prevent them -- the Wickham study, remember -- I'm sure you have been told about the Wickham study extensively -- shows that a TSH of 2 and above that there was a risk of hypothyroidism, but this was an immensely small risk and it meant they would not get

hypothyroidism in 20 years.

So maybe the Americans are being preventative. I think the majority of endocrinologists and people dealing with thyroid disease in this country would suggest that at a level of 2.5 or 3 they would not treat the patients. If they would, as I have suggested, repeat the thyroid function tests regularly, and if there is a progression or if there is positive antibodies, and if they want to treat the patient prophylactically, preventatively well and good, but I think most people will not treat these patients at these levels of TSH in the United Kingdom.

Q. Even applying the American levels, which we don't, but even applying the American levels, would any of these patients have been treated?

A. I don't think these patients would have been treated in the United States of America because their levels are such that it is within the reference range.

Q. Finally, we heard quite a lot from Professor Weetman, but I just want your assistance with this: I think you deal with it, in part at least, in your paragraph 61.

Apart from the dangers that you've outlined of suppressing the TSH over a long period, is there a danger in relation to differential diagnosis with these patients? If you simply start them on thyroxine

what's the danger?

A. First of all, these patients, remember, are unwell and, in my view, they have not been treated properly. They may need no treatment at all and reassurance, or they may need some form of psychiatric help.

The problem therefore is if they think that all their problems have been due to their thyroid, there is a tendency, I've seen it once or twice -- and this is anecdotal -- that these patients will increase their thyroxine more and more, and then definitely make themselves iatrogenically thyrotoxic.

I think these people are unwell and need help. I don't think just because we say they haven't got hypothyroidism one should discard them, and I would, unlike Dr Skinner, have done lots of -- looked at other things in this these patients.

I would have made sure that if he's concerned about the pituitary aspect that the pituitary is looked at. I would have looked at their calcium and other aspects, because these women were unwell, there is no question about that, otherwise they wouldn't have gone to a doctor, but I do not believe that the diagnosis of hypothyroidism was right in any of them.

Q. In your view, would any reasonable doctor have prescribed thyroxine to any of these patients?

A. I don't believe any reasonable doctor would have prescribed thyroxine for these patients.

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

MR JENKINS: Madam, I'm going to ask you if I could have some time to talk to Dr Skinner and the expert sitting beside me before I ask any questions of Mr Lynn. The usual coffee break will suffice, I'm sure.

THE CHAIRMAN: That is fine. Let's break then. Ten past, does that give you enough time?

MR JENKINS: Quarter past would be very kind, thank you.

(10.55 am)

(A short break)

(11.15 am)

THE CHAIRMAN: Mr Kark, ready to resume?

MR KARK: Yes, thank you.

THE CHAIRMAN: Mr Jenkins, sorry.

Cross-examination by MR JENKINS

MR JENKINS: Mr Lynn, I wonder if you could tell us how patients come to you.

A. Referred by general practitioners, other physicians, other surgeons, and in the private sector there is now an element of self-referral because of the Internet.

Q. I understand.

A. And we always then write to the general practitioner saying we have seen them.

Q. You raise that point, it is something you deal with in your report, the fact that Dr Skinner is regularly communicating with the GPs. That is an appropriate way for doctors to behave, clearly, if they are seeing patients and there are other doctors involved in an patient's care.

A. Yes.

Q. You have no criticism at all I think of Dr Skinner's communication with GPs.

A. No, not at all. I may say times have changed, and my own view of good medical practice from this point of view is that as long as we inform the general practitioner by letter on a regular basis.

Many patients come to us saying that they don't want their GP informed. This is a difficult situation and usually I will say that I would not -- I would rather -- usually I am able to persuade them to let me let their GP be informed.

Q. It is not a problem I think we have met in this case but, again, you have no criticism of Dr Skinner's communication with the GP, telling them what's going on and what he's doing?

A. No.

Q. Let us come back to your practice, if we may.

You told us patients can be referred by other

doctors or nowadays, given your purely private practice, some patients can come directly to you. What sort of patients do you see? Are they patients who have usually already had a blood test?

A. No, they come in all shapes and sizes really, because we run -- traditionally, before I left the Health Service, we worked with endocrinologists all the time. These clinics were joint clinics and we set up long before the so-called MDT, which means multi-disciplinary team, we were practising at the Hammersmith, even before I was appointed, way back in 1978, everybody was sort of discussed and seen by the whole team, so there was very much a team approach, which was developed by the Hammersmith as a concept of dealing with patients and, of course, this is now normal, to have an MDT, but when we did it, it was abnormal.

So many patients would come for a view, to the endocrinologist, and I would see them, or they would come directly from GPs, or because I'm surgically bent would come from -- for difficult, complicated cases, surgically, obviously, but also patients who were -- we were conscious of patients who thought they were hypothyroid or -- we saw those sort of patients. I can't give the exact numbers but they were sprinkled among our practice on a regular basis.

Q. The generality of your patients, would they be patients where a blood test had already been done and they fell outside the reference range?
A. No, they would come on their own, but usually if referred by the GP, they would come with a letter and they would be outside the reference range or within the range, and they are concerned by the GP because there was symptomatology.
Q. So there were GPs sending patients to you where patients had signs and symptoms but their blood test result was within the reference range?
A. Yes.
Q. And what would you do with such patients?
A. I would do as I said, I would check their thyroid function regularly. I wouldn't take one TSH, I would see how they went. I would check their antibodies. If there was any hint of any other pathology, I would investigate them fully, and these patients did not get put on thyroxine.
Q. So you can't tell us whether a trial of thyroxine for a patient who had signs and symptoms which may be consistent with hypothyroidism, but who had chemistry within the reference range, you can't tell us whether that was successful or not because you have never done it?

A. I haven't done that but these patients have been followed up, some of them for 20 years. This is an ongoing -- I'm not a doctor who discharges patients and sees them once, and I have not had in this instance problems.

Once they went outside the range -- I have been practising there for almost 30 years, so I have got patients who have been seen five, ten years later, who then developed hypothyroidism, and may well have needed to be treated, but I do not know of any instances where I think I have misdiagnosed a patient because of the thyroid function test.

Q. All right. But the issue I want to ask you about is your experience of treating patients who may have signs and symptoms but normal chemistry.

A. I have none because it is an entity which doesn't exist.

Q. Right. So if I produced a patient to you with signs and symptoms with chemistry within the reference range, you would say that is not a hypothyroid patient?

A. I would say it is not a hypothyroid patient but this patient must be watched and regular TSHs done, make sure there are no other problems and follow them. I would not discharge them, they have come to me because they are unwell.

Q. So you start off by saying there are other reasons for

the signs and symptoms, it is nothing to do with hypothyroidism?

A. Yes.

Q. Can we come back to the reference range. What does it actually show?

A. Sorry?

Q. The reference range, what does it actually refer to?

A. It refers to a population of people who are being -- it depends what the population is, it depends where it was done, and it will give you a range of values which are expected of that population. Some 95 per cent of them would be expected to be within that range.

Q. If you had a group of people who were healthy, in whom there was no family history, in whom there were no symptoms, and there was no reason to suspect problems with the thyroid under or overactive, would some of those patients, just looking at the chemistry, fall outside the reference range?

A. Yes, a small number of them.

Q. What are we to say about those patients who have abnormal chemistry? By definition they are healthy. Would you treat them?

A. No, I would follow them up and watch them, and if the changes became significant, I would then consider treatment.

Q. Why are they falling outside what you've called in your report the normal range?
A. Reference range.
Q. You call it the normal range again and again. In your evidence you have said reference.
A. Yes, and I apologise, it is misuse of term. It is a reference range.
Q. There is a misuse of terms inasmuch as one can start thinking of it as normal, whereas in fact it is not normal at all, is it?
A. No, it is a range of -- 95 per cent of the patients who are going to be within that range.
Q. What are we to say about those who fall outside of that range?
A. If they fall outside that range, we will -- let's say it is high, the TSH is high, and they have no symptoms, I would follow them up, and if they then became unwell, I would in fact treat them. I have a safety mechanism for it because in fact we look at them very carefully and we follow them up. I'm not making a decision on a single TSH which could vary from day to day, hour to hour.
Q. Subclinical hypothyroidism is the small group of patients -- if you look at the chart to your left, I hope it makes sense to you, it is not one that I drew,

it is intended to show the reference range charting a percentage of patients as against TSH levels. Are you able to understand it?

A. It is a bit of a scribble.

Q. It was drawn by a professor, and we will just have to deal with it, I am afraid. There is a small body of patients right by the Y axis, which is intended to show those patients who fall below the reference range.

A. Below, you mean their TSH is below the reference range.

Q. Yes, I am sorry, and there will be another group outside but beyond the reference range.

A. Yes.

Q. The subclinical hypothyroid patients are those who show no signs and symptoms, is this right?

A. Mm-hm.

Q. But whose chemistry falls below the reference range.

A. Subclinical hypothyroid, their reference falls above the reference range.

Q. I am sorry.

A. It is important to get it right.

Q. It is, and thank you for helping me. So the hyperthyroid, the subclinical hyperthyroid patients will be those next to the Y axis?

A. Yes. These going up there, yes.

Q. Part of the debate, I think, in endocrinology now is

whether subclinical hyper or hypothyroid patients should be treated?

A. Yes, and traditionally that is from a TSH of 5 up to 10, that's what the range was in the old tradition. My attitude to that is that if they have negative antibodies, one can watch them. The only reason for giving them thyroxine is to prevent them getting hypothyroidism at a later date.

In my view, there is no evidence that treating those patients has any beneficial effect, and after all, you have named it, subclinical, which means there are no clinical signs.

Q. Quite. With Dr Skinner, the patients A to D that you have been asked to consider, all of those fall within the 95 per cent of the reference range.

A. Yes.

Q. So they are not subclinical hypothyroid patients because they do have signs and symptoms?

A. That is a matter of Dr Skinner's opinion.

Q. It is indeed.

You have not seen any of these patients, you have not examined any of them.

A. No.

Q. I think you would accept, you are not in a position to offer any view as to the correctness or otherwise of the

signs and symptoms the patients reported, what they put on questionnaires, and what they may have said to Dr Skinner as to their own symptoms, and you're not in any position to comment on what Dr Skinner has recorded --

A. Absolutely.

Q. -- as any signs.

A. Absolutely.

Q. But you start from this proposition, is this right: whatever signs and symptoms were seen or complained of, if the blood results fall within the reference range, they cannot be signs and symptoms of hypothyroidism --

A. That is my experience.

Q. It does not exist?

A. Yes.

Q. That is your experience.

A. Yes.

Q. Your definition then of hypothyroidism is based entirely on a blood result. Is that right?

A. In the milder forms, yes. I may say, patients can be diagnosed as hypothyroidism, they can be unconscious, they can be -- there are lots of other ways they may present, but in the milder forms of hypothyroidism, the diagnosis is made in relationship to the reference

range.

Q. Can I suggest that there may well be patients and indeed there are patients suffering from hypothyroidism but whose blood chemistry may fall within the reference range?

A. Yes, but they would be of no clinical significance.

Q. What does that mean?

A. They have no symptoms. If you've got patients outside the reference range or falling subclinical, they have got higher TSHs, you cannot really expect with no symptoms whatsoever. I don't believe a lower TSH within the reference range you can have symptoms.

Q. I am suggesting there are patients who do have signs and symptoms which are consistent with hypothyroidism. That is a condition from which they suffer, but their chemistry falls within the reference range.

A. I don't agree, sir.

Q. Can you give me a working definition of "health"?

A. Being mentally ... Definition of health?

Q. I've thrown a bouncer at you.

A. That's quite all right. Having mental and physical wellbeing and feeling well, being able to undergo normal activities for your age and weight and size.

Q. If you now were to give me a definition of "health" in terms of thyroid functions, does how the patient feel

play any part in that?
A. I am sorry, I cannot hear you.
Q. If you were to give me a working definition of "health" with reference to thyroid function, does how the patient feels have any part of in that definition?
A. Of course it does, but I do not find in my own experience that they have complaints of lack of health with TSHs which are below 10.
Q. Well, can I suggest that the experience of others may be markedly different from yours.
A. You are quite entitled to say that, sir.
Q. Can I go on through your report -- well, I should say, your definition of thyrotoxicosis involves reference to chemical results.
A. Yes.
Q. And signs and symptoms.
A. Yes.
Q. But your definition of hypothyroidism does not involve reference to how the patient feels or any symptoms.
A. That's quite logical, because overactivity produces a much more specific set of signs and symptoms than underactivity.
Q. What are the signs and symptoms of underactivity? You have set them out in your report, haven't you?
A. Yes, but they are vague and you will -- they are vague,

while the signs of hyperthyroidism are in fact very specific. Rapid pulse, sweating, much more obvious.

Q. Dealing with patients who are thyrotoxic, with what level of frequency would one expect to see rapid pulse, sweating, palpitations?

A. In the majority of them.

Q. The majority?

A. Yes.

Q. Can we come on to Patient A.

A. Yes, of course.

Q. I am going to deal her very briefly. We know that she was investigated by a couple of other doctors, Dr Smith and Dr Veitch.

She was referred to Dr Skinner and he made a diagnosis, which led to a trial of thyroxine for that patient. She reported having headaches, which you say are extremely unlikely to have been due to the thyroxine she was put on.

A. Yes.

Q. The reports that we have and her medical records suggest that she felt better, that her symptoms were reduced, and that she was doing well on the replacement therapy. What's your comment on how that might have come about?

A. I think my comment is, one, I don't believe she was ever hypothyroid, that her TSHs were at the lower limit of

normal. Even for any range TSH of 1.5, I don't believe any, in my view, competent endocrinologist would give her thyroxine.

Q. Well, I've heard that. You've said that --

A. If I may continue, sir?

Q. Please do, yes.

A. And I believe that -- she may have felt better on the thyroxine but it wasn't -- it is a feel good factor, I don't believe it had anything to do with her underlying condition. I do not believe she was hypothyroid and I believe the thyroxine replacement was inappropriate.

Q. What should the Panel receive as your view as to why her symptoms were reducing?

A. There may be many factors. There may be a placebo effect, the fact that she has gone to see a doctor who is presumably quite charismatic, who is taking care, who has thought about the problem, one accepts all of that, but I do not believe her improvement of symptoms had anything to do with her thyroxine replacement.

Q. On your reading of the documents, did Patient A get on well with Dr Skinner?

A. I thought, yes. I presume so.

Q. Yes. What we know is that Dr Skinner stopped treating her in February of 2003 and wrote a letter to the GP,

and that subsequently her prescription was increased by the GP to 75 milliunits of thyroxine a day. Are you able to tell us whether that was good treatment by the GP or not?

A. I don't think that was good treatment, I think it was inappropriate.

Q. We know that Professor Jane Franklyn was involved and at that time the treatment was increased to 100 milliunits of thyroxine a day.

A. Not by Professor Franklyn.

Q. No, but she was involved. You have drawn an inference about what you think Professor Franklyn's attitude would have been that she would have been reluctant for this patient to continue on thyroxine at all.

A. Mm-hm.

Q. Can you tell us whether she indicates that?

A. There is a letter?

Q. It is tab 1 of the large bundle, page 55, I think. 56. 55 is the invitation from Professor Franklyn to express a view.

Page 55 is the request from Dr Cook, the GP, to review the patient. Page 56 is the response. (Pause).

A. She says:

"I did explain that given her extremely normal TSH, one can be confident about ruling out the diagnosis of

hypothyroidism."

Q. But she goes on to talk about bowel symptoms. We know that this lady had earlier complained of constipation, which was alleviated by the prescribing that was done for her?

A. She continues:

"I explained there is no specific indication as driven by her thyroid function test for this to be continued or indeed expected to be helpful."

Q. Do you infer from that that Professor Franklyn is saying to the patient: you should stop it? Or is she saying, as she says to the GP, effectively it is for the patient to choose?

A. I think what she's saying, reading between the lines, if I'm allowed to, that she doesn't need thyroid replacement, I think she makes that absolutely clear, but she feels that she will not spontaneously stop the thyroxine and thought it was better if should would be on the synthetic thyroxine than the Armour preparation. Basically I think that she should have stopped the thyroxine there and then.

Q. She does not quite say that, does she?

A. She says, you know -- she says:

"I [have] ... explained there is no specific indication as driven by her thyroid function for this to

be continued."

She says exactly that.

Q. She is not saying: I have told her that she should not take it.

A. You are splitting words, sir.

Q. Or that it is bad for her.

A. That's ridiculous.

Q. Is it ridiculous --

A. If I say to a patient: listen, there is no specific indication for you to continue your treatment for -- let us say you are a mild diabetic with loss of weight, you have been able to reduce weight. The patient to take the advice? I don't agree.

Q. Can I turn to the Armour Thyroid. You deal with it at paragraph 12 of your report on page 6.

I think Armour Thyroid is regulated, as are all medications in the United States, by the Food and Drugs Agency, the FDA.

A. Absolutely, yes.

Q. It is approved for use in the United States.

A. Yes.

Q. They are not known as a lax regime, the regulation authorities, the FDA in the United States.

A. Absolutely.

Q. One can draw the inference safely, I suggest, that it is

a form of medicine that's been considered and approved for use by the FDA.

A. In the United States.

Q. It can be used in this country as well, can it not?

A. Yes.

Q. You have told us you have seen patients who have been prescribed it.

A. Yes.

Q. Is that prescribed in this country?

A. Usually the patients -- there are general practitioners -- there is a pharmacy, I do not know where it is in the United Kingdom that will supply Armour to patients, but it is very, very rare to ever get a referral from a GP, I can't remember when I've had one, who in fact have started or have suggested Armour, in this country.

Q. You do not use Armour yourself?

A. No.

Q. Can you tell us why you don't? Do you only use thyroxine to replace T4?

A. I only use thyroxine.

Q. Do you use any medication which would be equivalent to T3, Tertroxin?

A. Yes, I use it for thyroid cancer patients.

Q. Absent thyroid cancer patients, do you use T3 and T4

together?

A. No.

Q. Why not?

A. I find it very difficult to control.

Let me start again. I do not use it because (a) I cannot see the logic on it, because I do not see patients who are unable to convert T4 to T3. I do not think it is an entity which occurs in the general run of thyroid patients, and also, if one's going to use it, it is very, very -- we have problems -- I know you do not want me to discuss the thyroid cancer patients, but in fact they can get tachycardias, arrythmias, excess of absorption, it is rapidly absorbed, it is not bound to anything and it is, therefore, difficult to control, and I see no use for it when I've got a very satisfactory substance, T4, which will replace the patient -- and gives a steady level, you get a study level with it.

Q. What proportion of your patients are thyroid cancer patients, roughly?

A. A 100 a year new ones. I was seeing one in 15 of the cancers in the country. Oh, but you see they go on forever, I would say in the clinic of 50 patients there would be 10 thyroid cancer patients.

Q. Are you able to tell us, what view is there taken benefit medical practitioners as to the levels of

hypothyroidism in the population?

A. I think people realise it is very common.

Q. We are talking about 1 per cent of the population, or 10 per cent, 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 to 5 per cent of a raised TSH.

Q. What about hyperthyroid patients?

A. Most likely the same sort of percentage. Many of them are --

Q. So we are 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 of millions of people and 5 per cent 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 because they fall outside the reference range does not mean they need any treatment.

Q. I agree that is the question for debate. You use the reference range to say whether they may need treatment or not. What I have suggested to you is there may be people within the reference range where there are signs and symptoms which are in fact hypothyroidism?

A. I would re-emphasise, I have not seen patients with TSHs below 10 with significant symptoms, and asymptomatic hypothyroidism, the top end of the range is 10 by definition, not by me but by general consensus.

Q. You talk about a TSH range of, did you say 11 or 12 in some countries?

A. Yes.

Q. Which countries are we talking about?

A. The Scandinavian countries where there is iodine deficiency. I apologise, in one Scandinavian country where there is iodine excess where they are very replete with iodine.

Q. What about other countries in Europe, do you know what their reference ranges are?

A. No. I understand in Germany that it is quite low, they have taken it down to about 2.5.

Q. I think you have seen Dr Hertoghe's report?
A. Yes.
Q. Which includes a number of laboratory results for patients in Germany where the TSH range is exactly that. What about in the United States, are you able to help us what the reference range is now?
A. They are trying to reduce the reference range to about 2.5 because of the large study.
Q. When you say they are trying to, what does that mean?
A. That is what has been suggested, but not everybody has accepted it. After all, you say there is a reference range, not everybody is going to follow the reference range in different parts of the country.

In Colorado, the reference range on young adults when they checked their thyroid function was up to 5, so it varies, it varies from place to place.

Q. You refer, it is page 5 of your report, paragraph 10, to the Yearbook of Endocrinology 2006, and you give that reference after this sentence:

"In recent years there has been considerable pressure to reduce the normal TSH to a lower level, but there is no evidence at the moment that this is justified, and any patient with a TSH below 5 milliunits per litre would be considered not to have either asymptomatic or symptomatic hypothyroidism."

Do you have that page or a copy of the book?

A. I have it here, yes.

Q. I am assuming it is a big book.

A. No, it is a little book actually.

Q. Oh good.

A. I marked it for you.

Q. 222 to 223.

Can I just have a brief look at it?

A. Of course you can. (Handed).

There is a comment by Mazzaferi at the bottom.

(Pause).

Q. I am going to ask that we could hang onto it for a moment and photocopy some pages from it. Is that all right?

A. Yes.

Q. You have made reference on page 7 to, is it Bunevicus?

A. Yes.

Q. If Mr Kark just looks at the references.

MR KARK: I think the witness will want to have it.

MR JENKINS: If you look at reference number 1 on page 223 that you are now looking at, Mr Lynn, is it Bunevicus, is it I-U-S or just U-S, the first reference.

A. B-U-N-E-V-I-C-I-U-S.

Q. I-U-S?

A. Yes.

Q. It is not correctly spelt in your report.

I think that Bunevicius paper suggested that patients did well on T3 and T4 together. Yes?

A. Yes, in the short-term I understand, but that was just one study and there were many other studies, several other studies, that in fact didn't confirm this.

Mazzaferi's comment:

"For now there is insufficient evidence to recommend T3/T4 therapy for hypothyroid patients."

But he does make the comment, which I would agree with you that:

"Yet why so many patients seem dissatisfied with thyroid hormone replacement therapy remains a major clinical conundrum of our time."

Q. Yes. The aim of treatment is to improve how the patients feel, as well as, you would say, maintain their blood chemistry within appropriate levels. Surely practitioners should be exploring different forms of therapy, T3 and T4?

A. Absolutely, but it has not been my experience that that has been the case, that we had very satisfactory results of putting patients on T4.

Q. You do not put patients on T3.

A. I did not say I did, I said on T4.

Q. How can you say that -- well, forgive me, you are not

suggesting it is wrong to put patients on T3 and T4?

A. I am not suggesting for any moment it is wrong putting patients on T3/4. I said I do not do it and I think it is difficult to control.

Q. But if patients are finding benefit on it, you wouldn't criticise a practitioner who prescribed in that way?

A. As long as it was given to a patient whose TSH was not so low in the normal range that they did not need it at all.

Q. Armour Thyroid is a form of T3 and T4 therapy.

A. It has, of course, the advantage, as I said earlier, that the T3 may be slowly released, so you don't have the problem with synthetic T3, and I accept that.

Q. I am grateful.

We were told by Professor Weetman that in 1996 there were guidelines which dealt with the question of the aim of treatment, and that the aim of treatment, according to these guidelines, was to alleviate patients' symptoms.

A. Yes.

Q. Are you familiar with those guidelines, the 1996 guidelines?

A. Am I allowed to open my own documents?

Q. Yes, please do. Look at any document you need to.

A. This is a study from Birmingham with Professor Franklyn,

is it not?

Q. The Panel have it in Professor Weetman's report, page 6. It is the UK consensus statement that Professor Weetman talked of.

A. BMJ 1996 "Consensus statement for good practice and audit measures and the management of hypothyroidisms and hyperthyroidism".

Q. That is right. What we have told about it was that a correct dose was one which relieved symptoms and would in most patients result in a "normal or raised serum thyroxine concentration, that's T4, a normal tri-iodothyronine concentration, that is T3, and a normal or below normal serum thyroid stimulating thyroid concentration.

Can I paraphrase that: the correct dose was one which are relieved symptoms and would in most patients result in a normal or raised T4, a normal T3, and a normal or below normal TSH concentration.

A. Absolutely.

MR KARK: Professor Weetman did go on after that to say that thoughts about that had moved on.

MR JENKINS: He did, in 2004 and 2005, are the references he gave, and we are dealing with patients in 2002, 2003, 2004 and then 2005.

MR KARK: I have not got the transcript in front of me but

I thought he said where there was a gradual progression and it did not just suddenly happen in 2004. I am just keen that the witness -- and I do not mean this pejoratively -- is not misled into thinking that is where Professor Weetman stopped, he didn't.

MR JENKINS: I am not suggesting that is where he stopped, I am just looking at the consensus statement which may still have been thought to be current at the time when Dr Skinner was treating these patients.

A. Absolutely. May I make the comment that the consensus statement for good practice and audit measures for the management of hypothyroidism, none of these patients had hypothyroidism, so this consensus statement is of no consequence.

Q. It depends how you define hypothyroidism, let us agree on that. You defined it in one way, and I have suggested there is another way of looking at it --

A. I do not think --

Q. -- looking at the signs and symptoms that the patients may have.

A. I do not believe that the consensus statement defined it the same way as it is been described by Dr Skinner.

Q. Well, there we are.

Just dealing with Armour Thyroid then, T3 and T4, you would not criticise a doctor who treated patients in

a way that you do not, if patients obtained a benefit from it?

A. If they had hypothyroidism.

Q. Well, I think you want to state at the start of almost every response: yes, but I would not have treated these patients.

A. Yes.

Q. That is understood?

A. Yes.

Q. But on the basis that they are being treated for hypothyroidism, you would not treat -- if they were correctly treated for hypothyroidism, if they were --

A. I do not think it is ideal, but I do not think it would be a source of comment for a committee like this.

Q. What, T3 and T4?

A. T4. In other words, it would not be something which would be unacceptable practice.

Q. Fine. You would not criticise a doctor who was treating chemically hypothyroid patients with T3 and T4?

A. No.

Q. Armour Thyroid, again, you would not criticise, it is something which is approved of in the United States --

A. Not at all.

Q. -- perfectly lawful to do if over here. If patients were obtaining benefit, good, you would applaud it.

Patient B --

A. Could you just give me a minute, I have got little space here.

Q. I am not going to take you through the detail of Patient B.

Patient B was someone who came to Dr Skinner, her doctor, Dr Blair did not want her to come, but the only reports we have of how she was doing once she was prescribed thyroxine are that she was doing well.

A. Mm-hm.

Q. Again, you are bound to say, because you don't accept she was ever hypothyroid, if she was doing well, if she was improving, it could not be because of the treatment she was receiving.

A. Absolutely.

Q. Because it was the wrong treatment.

A. Yes.

Q. Can you tell us then why she was improving?

A. Because I think that she had -- there may have been other reasons. She had been very extensively investigated -- she had depression. She had been treated for depression. Her depression was quite severe on the Beck scale, and it may be that her depression -- depression is a cyclical thing -- may have improved, but I do not believe she improved because of the thyroxine

she was given.

Q. So you have to assume that other things were going on, you have to infer that other things were going on because it does not fit the conclusion that you want to reach?

A. No, not at all. I do not think she was ever hypothyroid and therefore, giving her thyroxine is inappropriate.

Q. Do you accept that there is a debate -- you are very much to one side of it, but there is a debate as to whether it is ever appropriate to prescribe thyroid replacement therapy for patients who have sign or symptoms?

A. I accept there is a debate, but all these TSHs are very, very low in the United Kingdom level, and they are just about within the range of the United States of America level. Now, if you had said, if Dr Skinner had given these patients with a TSH of between 5 and 10 thyroxine, I would accept that there is a debate, but I do not think there is any debate about giving patients who have low TSHs in this low range thyroxine. I just do not agree.

Q. Would you agree that in medicine generally sometimes a doctor will think: I am not sure of what the diagnosis is but we can commence a trial of this type of medication?

A. Absolutely.
Q. If it achieves therapeutic benefit, then that will help us with the diagnosis.
A. Yes, I accept that.
Q. If the treatment that is provided on the basis of a tentative diagnosis, if the treatment works, it tends to confirm that the diagnosis was correct.
A. I am not sure that is true.
Q. I did not say it did prove it, I said it tends to prove it. It is evidence that must tend to confirm --
A. Yes, if you get better on something, you relate the two together.
Q. If the symptoms that the patients were complaining of and the signs that Dr Skinner noted were actually there -- and, again, you are in no position to contradict that they were -- what do you say of a practitioner who starts a trial of thyroid replacement therapy for such a patient?
A. I think in this instant it is wrong because of the TSH.
Q. Can I suggest it would be not unreasonable to start a trial and see whether the symptoms are alleviated?
A. I think it would be much better to not start a trial, to do several TSHs, see what happens, and then decide what to do. I do not believe a trial should be done using a single TSH.

Q. Let me come to Patient D, I do not need to deal with them all, but Patient D is perhaps the most vivid of all the four patients. You will recall that she was a lady who had been feeling pretty poorly for five or six years, since the birth of her third child. We have been dealing with the cases all week. You have to refresh your memory, I know, do, if you want to --

A. I can remember.

Q. All right. What we know is that for a period of time, since the birth of her last child, she was treated with an antidepressant for about a year I think, Fluoxetine, she stopped that because it was making her feel like a zombie, but the evidence we have heard was she was sleeping for considerable portions of the day, and had a variety of other symptoms and signs as well that are recorded in the notes and that we examined when she gave evidence, and that her life was completely turned around -- my words not hers, but I hope I'm not overemphasising the tenor of her evidence. Her life was completely turned around once she started treatment with Dr Skinner on thyroid replacement therapy. Are you able to say why that might be?

A. I think it is certainly not due to her thyroid disease. She initially had a TSH of 0.67 which is low. She had a history of depression. Her TSHs were low, she was on

large doses of thyroxine, and there is no question, as I've said, with patients who we have with thyroid cancer, that they feel very, very good on large doses of thyroxine, and I believe it is an addictable drug in these circumstances. I think the treatment was inappropriate, and I do not believe that the thyroxine has resulted in her feeling better, I think it is due to other factors.

Q. Do you anticipate that the state of medical knowledge will move on significantly?

A. Absolutely.

Q. Over the next, 10/20, however many decades into the future?

A. Yes.

Q. Do you think there may be many aspects of patients who may feel no drive, they feel depressed, may feel the sort of cluster of symptoms that we've seen in these patients, that there may be fuller explanations in due course as to why they feel the way they do?

A. Absolutely.

Q. Or do you think it is all due to depression, which can be treated --

A. No, I do not think it is due to depression, there may be other aspects of it, but I do not believe in this instance it is due to lack of thyroid.

Q. Can we talk about risk. What are the risks to which many or all of these patients are exposed?

Let us deal with D first. D is the one who's continuing to take medication. She sees her GP, Dr Stewart, but doesn't see him for any thyroid problem that she may have. She's continuing on thyroxine, which she gets through the Internet, and she has no medical follow-up in relation to that at all.

Let us agree that is wholly undesirable?

A. I am glad you agree that is undesirable.

Q. No, take it from me, Dr Skinner would wish that she is followed up, but for reasons that the Panel is well aware of, she's not.

Let us deal with patients who are being followed up by Dr Skinner. What risks are patients being exposed to? You've told us of the risk of atrial fibrillation. You have told us about palpitations, sweating, if they are thyrotoxic.

A. Mm-hm.

Q. Patients will very easily be able to recognise those signs or symptoms if they should occur.

A. Yes.

Q. And those can be dealt with in various ways.

A. By reducing the dose.

Q. That's one way.

On the basis that there is some continuing follow-up of patients, what long-term risk are those patients being exposed to, if any?

A. Initially I think the risks were over exaggerated. I think that the risks of osteoporosis and fracture were considered to be quite severe.

Q. Can I ask what you mean by initially?

A. 10/15 years ago.

Q. Right.

A. Sorry, that's initially for me. I apologise.

Q. No, that's all right, I just want to understand what you mean.

A. The reason for that was that when people looked at studies, patients on thyroxine, a lot of them had in that group patients who undoubtedly were thyrotoxic. I think you have to separate the problems of thyrotoxicosis giving bone problems from the giving thyroid itself.

I think the view now is that -- or my view now is, looking at the literature, that there is a risk of osteopenia, that means prior to osteoporosis, there is a risk of osteoporosis, but in women, particularly in post menopausal women -- the reasons for that is that they are already at risk anyway because of lack of ovarian function and many of them won't be on HRT.

I think these risks are small, but still real.

Q. Yes? Can those risks --

A. In men, there is a risk of hip fracture but there are articles scattered among the literature, and this is things that everybody argues about, that say there is in fact a risk of fracture even in women on patients on thyroxine. So one's attitude must therefore be: if the patient doesn't need the drug, why subject them to something which there may be a risk, albeit it may not be real?

Q. I understand. Is there a way of treating patients so as to minimise the risk?

A. Yes.

Q. If they are on thyroxine?

A. We would follow all our patients with thyroxine, we would have regular -- if they will fund it -- two to three-yearly bone densities, and if there is any suggestion of any drop in bone -- and I can't give you numbers -- one would then consider giving Pamidronate and other agents which in fact re-mineralise the bone. So if these patients were going to be on thyroxine for a long period of time, they should in fact be followed up very, very carefully.

Q. I understand. But there are ways of addressing the --

A. The small risk.

Q. -- the small risks they are exposed to?
A. Yes.
Q. Would you agree there are other studies that suggests there is no risk to hypothyroidism patients?
A. Yes, I agree. Hyper we're talking about?
Q. Hypo. Hypothyroidism patients who are given replacement therapy.
A. Yes. I agree.
Q. Are there any studies?
A. There are other studies that say there are no risks but there are studies that say some risks and if you're practising safe medicine, you have to practice the risk factor, not the non-risk factor.
Q. I understand. Can we break it down. There are studies that deal with thyrotoxic patients?
A. Yes.
Q. Hyperthyroid patients.
A. Yes.
Q. Studies that suggest patients are at risk to osteopenia?
A. Minimal, and they're only really at risk if their TSH is significantly suppressed down to about less than 1.
Q. These are patients with thyroid disease?
A. Thyroid -- and on thyroxine.
Q. Are there studies that deal with patients who are on replacement therapy?

A. Yes, there are studies. I think some of them are sort of patients with thyroid cancer, who are replaced with thyroxine, and I don't know the results of those.
Q. Are there studies that might be directly relevant to the patients that we're looking at here, patients who are thought to be hypothyroid who are given replacement therapy, the studies as to --
A. I can't answer that question, sorry.
Q. So you say it is a theoretical risk.
A. Yes -- no, I say that some studies say that you can have fractures, some studies say that you can't, and therefore as a matter of responsibility we shouldn't use a drug which may have a risk.
Q. I understand. I think most drugs would carry some risk of some kind.
A. Yes, but only if you need to give the drug for a therapeutic effect, not if you have to give it to somebody who doesn't have a condition.
Q. I agree, and that is the underlying question, but most drugs carry the risk of side effects.
A. Yes.
Q. Some of them potentially serious.
A. Yes.
Q. The issue is: what's the degree of risk that the patient might be being exposed to? Are they aware? Is it

explained to them that there is some degree of risk?

Secondly, what's the benefit to balance against the degree of risk and the patient agreeing --

A. Yes, absolutely.

Q. -- to accept that risk?

A. Absolutely.

Q. Those are questions for almost any kind of medical intervention, whether it be a surgical procedure that you might undertake or for prescribing.

A. Mm-hm.

Q. And so far as atrial fibrillation is concerned, again, there are ways of minimising any risk to patients and it is a risk that's very small anyway.

A. Yes, I accept that.

MR JENKINS: Thank you very much, Mr Lynn.

Re-examination by MR KARK

MR KARK: In relation to that last topic, as I understand it, you are saying that if there is a risk it increases as the TSH reduces.

A. Yes.

Q. In your practice, do you check bone density?

A. Yes, we would check bone density every two years. We would do that if a woman came to our clinic anyway. Let's be honest, women should have their bone density done every two years anyway because osteoporosis is

a chronic, devastating disease, which can produce problems, vague problems as well. So it is unfair, to me, to say to you: look, we do a bone density for the thyroid. We will do it because we think there is this risk, but we will be doing it anyway. Any patient in an endocrine clinic would have a bone density done every couple of years. Females, that is.

Q. In your practice, do you come across patients where their bones do appear to have been affected?

A. Yes, but we do that with patients who it is difficult to tell whether it is the thyroxine or whether in fact it is just spontaneous over a period of years.

Q. How often are you able to say -- and I appreciate you're dealing with patients generally who are on thyroxine.

A. Yes.

Q. But how often do you come across patients, what percentage of your patients?

A. I couldn't tell you, but it would be one or two patients at clinic, one would be concerned about their bone density, or discuss it, or say: look, it is dropping off a little, let's make sure we recheck it in a year or so.

Q. Sorry, one or two patients a clinic; how many in a clinic?

A. Let us say there are 30 patients in a clinic. It usually raises its head every clinic. It is very

difficult for me to give numbers. It would be inappropriate for me to put a number.

Q. All right. It was put to you really as a statement that you are on one far side of the debate in relation to the treatment of patients whose TSH levels are, I think, within or at the edge of the reference range.

A. I don't think that's correct. Any doubtful TSH, what I do is I follow them up very regularly, they're not allowed out of the clinic, I am just meticulously careful, and if patients' TSH then went up to what I felt was an inappropriate range, then we would, of course, consider treating with thyroxine.

As I said before, a one-off test is of no value, you need several tests and you need to make sure when they were taken and whether they were taking any thyroxine at the time. Time in medicine, looking at results in relation to time, is the best test of all, because it gives you an idea of how things are progressing.

I don't believe that somebody will suffer in any way at all by waiting a month or three months with these sort of symptoms. Otherwise, you may put them on a treatment which I think is totally and utterly inappropriate, and once you place them on that treatment, you are committed for life, because it is very, very difficult to get patients off, and it is

quite difficult test them.

What do you do? You say: oh, you've been hypothyroid, shall we stop you at two years for three months, or five years, or 10 years. You are committed to a lifetime of taking tablets.

Q. You were asked about advances in medical science, but let's just deal for the moment with the here and now, or even the 2002 and the 2003, and the 2004. Was there ever a point in that period at which, in your view, a responsible practitioner could effectively ditch the concept of blood tests?

A. No.

Q. Or now?

A. No.

Q. You were asked about the incidence of hypothyroidism and you were telling the Panel how relatively common it was, and I just want to clarify your evidence because the figure of 5 per cent was repeated to you by Mr Jenkins, but my note of your evidence was that in 60-year-old patients or older --

A. Yes.

Q. -- the incidence is in the region of 3 to 5 per cent. Can you help us?

A. I can't give you the exact figures. I can find you the figures because the epidemiology is all in the boxes

here, but I can't give you an exact figure. It is a significant figure and it would be wrong of me to -- I'm trying to give you a ballpark idea.

Q. Absolutely and I'm not suggesting you should minimise it, but the figure that you gave, I think --

A. This is checked by a chemical hypothyroidism. Overt hypothyroidism is very different.

Q. Sorry, overt hypothyroidism?

A. In other words, patients who have got -- I don't think for 5 per cent of the population who are over 55 or 60 have got overt hypothyroidism, and what is interesting, if you look at a study of geriatrics, lovely old people who had high TSHs in their 80s and 90s, they did better if they had a slightly high TSH, above 5, than patients who in fact had lower TSHs. So it is all a little bit of a difficult situation.

Q. Sorry, overt hypothyroidism?

A. Overt.

Q. Meaning what?

A. Overt means open, visible, clinical.

Q. Right.

Just going back to Professor Franklyn's letter, page 57, tab 1, and I think you were being criticised really for overstating it. But I don't think you were -- again, I don't mean this critically, but you

were not drawn down, I think, to the last few lines of that paragraph on page 57 where she says:

"The latter recommendation is based on extensive evidence that overtreatment with thyroid hormones is indicated by suppression of TSH is associated with long-term adverse effects specifically with development of atrial fibrillation and increased risk of osteoporosis."

That seems to have been her view then, and does that, in your view, reflect what the thinking was at that time?

A. Well, yes.

MR KARK: Thank you, would you wait there, please.

Questions from THE PANEL

THE CHAIRMAN: Are there Panel members who have any questions? Dr Elliot? Shall we begin with you?

DR ELLIOT: Good afternoon. I have some general questions which I would just like to ask you about, about what you said --

MR KARK: I don't think the witness can hear. I wonder if you can bring the microphone closer.

DR ELLIOT: Is that better?

A. Much better. Thank you so much.

DR ELLIOT: You told us about your experience treating people with thyroid cancer in whom you have to give

large doses of thyroxine in order to suppress the TSH levels. You said that the level of TSH had to be watched very carefully in those patients.

Could you give us an idea of what a large dose of thyroxine is in these cases, in patients with thyroid cancer?

A. Yes. I would regard a large dose of thyroxine, 200 micrograms. 200 micrograms would suppress almost everybody. We would normally for replacement doses, let's say, a 70 kilogram woman, 1.6 micrograms per kilogram body weight, so that's just under 100 micrograms. So 100 micrograms is, in my view, about the replacement dose for a patient to replace them.

We would give much higher doses for the cancer patient, up to 200, but that's changed because we've got concerned about cardiovascular effects and concerned about osteoporosis. Admittedly the concern was small, but we were using large doses, and in patients who had thyroid cancer, their risks vary enormously on the type and the grade. If they had a low grade thyroid cancer, we tended to not give them so much thyroxine, possibly given them 125, and keep their TSH in the lower half of the range, while for the aggressive thyroid cancer we would still give them doses which would totally suppress the TSH to become undetectable.

DR ELLIOT: So you would consider in that case 200 micrograms to be a large dose.

A. I would regard 200 micrograms an extremely large dose of thyroxine.

DR ELLIOT: Is it a large dose of thyroxine in the treatment of hypothyroidism?

A. Oh, I believe so.

DR ELLIOT: Okay. I want to ask you now about what I gather was your own personal experience of the effects of thyroxine and your observations on patients who take thyroxine replacement therapy. Thyroxine itself has a feel good factor.

A. Yes.

DR ELLIOT: How much research has been done on that? What's the reason for it?

A. I do not know, I can't your answer question, but I've been sitting in that clinic for years and, of course, this is anecdotal, and one must accept it as anecdote, but there is undoubtedly a feel good factor. The real problem is patients who, rather like the four patients of Dr Skinner, have gone on -- I am just using that as an example -- and, in my view, have been inappropriately treated for hypothyroidism, who take thyroxine, and then often gradually over the period of years increase the dose.

I've got one patient on 400 micrograms of thyroxine, he's a male, 400 micrograms of thyroxine, who obviously comes to see me regularly but, in fact, I can do absolutely nothing to get him down because he feels he feels good [sic] if he goes any lower.

His TSH is totally undetectable and his T4s run in the 50s with very high T3s as well, and it is a problem getting patients -- that is why I'm so anti putting people on them unless you're absolutely certain they need to be on the drug for the right reason.

DR ELLIOT: I understand, yes.

I think you said that it was addictive.

A. Yes. I'm using it in a loose way. These people are addicted to their thyroxine, full stop.

DR ELLIOT: But as far as you're aware, there is not any research into what the reason for that is.

A. No.

DR ELLIOT: Can I move on to the patients now. I want to ask you some things which counsel have not asked you about, but which are in the charges in relation to each patient. So I'm assuming that since you have seen the notes, they are --

A. I have the charges here.

DR ELLIOT: Have you seen the charges?

A. Somewhere.

DR ELLIOT: They're in a yellow sheet.

A. You may have to guide me. Is that all right?

DR ELLIOT: The charges we have are on a yellow sheet.

A. May I have a copy from someone? They have changed colour. (Handed).

I've obviously seen these before.

DR ELLIOT: If you look at page 2, this is in relation to Patient A.

This is in charge 3, 3A -- 3B and 3C:

"You took an inadequate history. You carried out an inadequate examination."

Now, you may be assisted by looking in the file behind tab 2. Those are Dr Skinner's notes on Patient A.

MR KARK: Sorry, before this line of questioning continues, I think we need to establish with the witness whether he has been in the position to give expert evidence about this aspect. We've heard from Professor Weetman, but this gentleman, as Mr Jenkins rather made clear, is a surgeon who will work on secondary or tertiary referrals. So I just wonder if it can be established with the witness that he can speak about, as it were, as an expert witness on the questions you're go about to ask him.

MR JENKINS: Forgive me, he did say that now he treats

patients privately and there are some patients who come directly to him. So I think it is within his experience.

A. Could I answer that question? I've always seen medical patients. It was designated as a thyroid clinic. I would see thyrotoxics from the general practitioners. So I've always dealt with the general run of the mill thyroid problems. Does that answer your question?

MR KARK: Yes, thank you.

THE CHAIRMAN: Can I also say, if I am right, we're talking about an inadequate history and an inadequate examination. Basically, it is a function of doctors is really what we are talking about, am I correct? Thank you.

DR ELLIOT: You may be assisted by -- behind tab 2, the first sheet is Dr Skinner's transcript.

A. Page 1?

DR ELLIOT: Yes. It is confusing because the next page is marked page 1 as well.

A. So you want me to comment on the examination?

DR ELLIOT: Let me just finish. On this page is a transcript of Dr Skinner's own transcript of his medical notes of that consultation, and you will find immediately behind page 1 are various letters and GP notes which Dr Skinner had before him when he saw the

patient, so he had that background information. Then following on from all those typewritten letters, which finish on page 11, the next pages are Dr Skinner's handwritten notes in doctor's handwriting.

A. Yes.

DR ELLIOT: Which is presumably why it has been transcribed. What I wanted to ask you about was there, in your opinion, as a doctor who sees many patients with thyroid and other disorders, do you feel that Dr Skinner's history taking was inadequate?

A. I think it is totally adequate. I would say -- it is at page -- it is dated -- is it 16/01/03? Is that right?

I may say he has made comments about the family history, he has taken the temperature and the blood pressure, he has examined the thyroid. I have no problem with that whatsoever.

DR ELLIOT: So some of the things you mentioned were actually examination as well. Do you feel his --

A. You can't really comment on somebody's examination except to say he has written down he did it.

DR ELLIOT: Yes, but are the notes on his examination --

A. Yes, they're very satisfactory, I have no problem with that whatsoever.

DR ELLIOT: Thank you. I would just like to take you on now

to charge 3H. In the light of your suspicion --

A. The B12 deficiency.

DR ELLIOT: "You failed to perform any investigation."

What you may find helpful in this context is a letter to the doctor, which you'll find behind tab 2 on page 15.

Do you think it is reasonable for someone in Dr Skinner's position simply to inform the GP of the suspicion of B12 deficiency, or do you think that is something he should have investigated himself?

A. Well, I think he says perhaps B12 deficient with yellow lemon tint in the skin. He has mentioned it and it would be ideal if he said: why don't you do a B12 test? Check the B12. But he's actually mentioned it and written back to the doctor. I think it is a moot point, but I don't really feel that it is inappropriate.

DR ELLIOT: Thank you.

A. I don't see why he didn't do it himself, of course.

DR ELLIOT: Yes --

A. But the obvious thing, if you think it is B12 deficient, you do a B12 -- after all, he thought she was thyroid deficient, so he has done --

DR ELLIOT: Yes. Can I take you now, again the same tab, to page 27. It is the second page of the letter.

A. Sorry, I can't hear you.

DR ELLIOT: Page 27 behind tab 2. It is the second page of another letter of Dr Skinner's to the GP.

This is a query I have in connection with charge 3I, which is:

"You suspected a diagnosis of secondary hypoadrenalism."

And charge J:

"In the light of your suspicion, you failed to refer Patient A to an endocrinologist or other relevant specialist for evaluation."

The part in the letter that I want to take you to is the second paragraph, which suggests it might be worth taking a blood sample for full blood count and serum cortisol just to put the possibility of --

A. I think this is very difficult because often doctors use these letters as an aide memoire to themselves when they look at the patient again. If he felt there was secondary hypoadrenalism, and I'm not sure whether he meant of the -- I presume he meant a low cortisol, then it would be appropriate to do a 24 urinary cortisol and also to do the serum cortisol and what's called an ACTH.

If he put it as an aide memoire, it is not very clear that when he saw the patient again, then he might think: well, it may be that. I'm sorry to be vague, but ...

But basically, if he felt that she had either of these conditions, you really should investigate them. If you think there is a condition you should investigate it.

DR ELLIOT: Yes. Should he have referred the patient to a relevant specialist for evaluation?

A. I think that's hard. I think that he could organise 24-hour urinary cortisols, he could organise the ACTH, they are only blood tests, and if they were normal, it would stop the necessity for a referral. I wouldn't be critical of that, but ideally those tests should have been done, or else it may have been using the aide memoire for him at a later date to think about it.

DR ELLIOT: The next question I want to ask you about, still about Patient A, is on page 3 of the charges. It is charge 7 I'm going to ask you about.

Just to remind you, this was the patient who had been prescribed a small dose of thyroxine, 25 micrograms, and in fact she said in her evidence immediately she developed severe headache and tension --

A. That is right, yes.

Q. -- and phoned or tried to phone Dr Skinner about this within four to seven days of starting the medication. You said in your evidence that you thought it was very unlikely that this symptom was due to the thyroxine, in

your experience you had not encountered this as an effect of thyroxine.

The charge is that although the patient had told Dr Skinner of this symptom, he hadn't made any record in the medical notes and had failed to assess her himself or to arrange for her to be assessed by a general practitioner. I just want to ask you if you feel that it was appropriate that that patient in the light of those symptoms should have been reassessed.

A. I think it is appropriate, even though I think the symptoms were obviously self-limiting and thank goodness not serious. In fairness, about telephone conversations and patients, it is good practice to write down what you've said, but many of us have so many telephone conversations with patients that it would be -- I would be totally dishonest if I didn't say that I have done similar things and dealt with it on the phone and made arrangements with a GP but I've often not put it in a note because I've been on the phone somewhere away from the notes, and that is not good practice but I think is very common practice.

DR ELLIOT: Yes. If someone does have a symptom, which you believe to be entirely unrelated to something which you have prescribed, do you think it is reasonable to adopt a waiting brief and give it a short time to --

A. No, I think if somebody says they have a severe headache, the answer is either to ring NHS Direct now, which they all can do if they can't get their GP, or speak to the GP, or make sure some action is taken. No harm came to this being left, but it would have been ideal for some comment to have been made to some doctor over it.

DR ELLIOT: Thank you.

With regard to the other three patients, B, C and D, I just wanted to ask you, in each of these patients whether you felt the history taking and examination was adequate. In order to do that, you need to look behind the various tabs which refer to Dr Skinner's notes.

A. Are you able to help me with those?

DR ELLIOT: I am, yes. For Patient B, that would be tab 4.

Again, it is the same pattern. Dr Skinner's own transcript is on the very first page, any results which were to hand follow, and then Dr Skinner's own notes in this case start on page 4.

A. I regard those notes as perfectly adequate.

DR ELLIOT: So the note of the history and the note of the examination, in your view, were adequate --

A. It is perfectly adequate. He has taken the complaint, he has done the examination, he has done the blood pressure, he has made his points.

DR ELLIOT: Again, for Patient C, those would be behind tab 6, and on this occasion Dr Skinner's notes follow immediately behind his transcript so it is easier to find.

A. You know, this is perfectly satisfactory.

DR ELLIOT: Finally for Patient D, they are behind tab 8.

A. Is there a written note?

DR ELLIOT: Yes, it is further on. This is all stuff the patient brought with her, you see. It starts on page 11 the written note.

A. He's made very adequate comments in the notes. I have no problem with that whatsoever.

DR ELLIOT: Thank you very much indeed.

THE CHAIRMAN: Further questions? Mr Payne?

MR PAYNE: Good afternoon.

A. Good afternoon.

MR PAYNE: Can you hear me okay?

A. Yes, thank you very much.

MR PAYNE: You said to us that you've been working at this for around 30 years.

A. I'm so sorry, I am afraid you will have to have the microphone nearer.

MR PAYNE: You said your career has spanned approximately 30 years.

A. Since 1964 when I qualified.

MR PAYNE: I believe when you were giving your evidence you said that you've seen people over a period of many years.

A. Yes.

MR PAYNE: I also believe that you said that you've seen some people who didn't have a thyroid problem but developed in later time.

A. That is right.

MR PAYNE: Why did they come to you in the first place?

A. I can't answer that. Maybe they felt generally unwell, maybe they thought they needed to be viewed by a doctor, they may have had minor abnormalities of their thyroid function when I saw them, but I followed these patients up.

Unless it was equivocally nothing, if they were patients we had any concern about, they would be followed up, and in fact when I left the Health Service, the clinic, obviously for cost reasons, that stopped because these patients were all sent back to the general practitioner. But basically I was following up any doubtful thyroid problem since 1978 when I was appointed at the Hammersmith and any doubt at all about a patient, we kept them and I saw them myself.

MR PAYNE: Would it be fair to say that going back all those years, that those people were referred to you by their

GPs?
A. Yes.
MR PAYNE: So they would have visited their GP with certain signs and symptoms, and one would think they would have taken the relevant blood test.
A. Yes.
MR PAYNE: But they were referred to --
A. And sometimes they may have had a mildly raised blood test -- because my policy was not to treat them. Sometimes they were thought rather like Dr Skinner thought, with his patients, where I disagree with, that they were hypothyroid and would I see them, and then I didn't let them go, I kept them. Unfortunately one was so busy, one didn't have the time to document or put everything on computer because it was a different age, we do now, but no then.
MR PAYNE: I understand. I'm right in thinking that as far as your opinion is, the evidence you've given us, that the only true test is for the blood test to see --
A. Yes, I believe that to be so.
MR PAYNE: But these people were referred to you, couldn't -- it is impossible for the symptoms to start actually before the readings are outside the level?
A. In my view, I don't agree with Dr Skinner's view, I do not believe that patients whose bloods are within the

range, the reference range, or minimally outside even, have significant symptoms. Careful with the use of significant. I would say symptoms.

MR PAYNE: It was suggested to you that you are one side of a debate. Now, I'm a lay member, I'm not involved in the medical profession whatsoever, but is there a debate going on with regard to this particular aspect?

A. Well, I don't think among the people I meet every day there isn't --

MR PAYNE: So there's not two sides --

A. I don't meet people who say to me: oh, Mr Lynn, or John, I'm concerned about the range in these patients, I think most of us agree with what I've said, and I think the debate has been brought on by Dr Skinner and other people.

It has made us think, and there is no harm in that whatsoever, made us all think about what we are doing, and I've given it a lot of thought, but it has in no way made me change my practice, and I don't think it is fair to say I'm at one end of the range. I was always brought up never to be the last or first to do anything. Safety is my middle name. It sounds pompous, but I think one has to be very, very cautious and I'm very quick to take on new developments, but one has to be cautious. I certainly like to feel I'm in the middle of

the reference range.

MR PAYNE: Just one other question. Could I ask you to turn to page 22 of your report.

A. Yes, of course, sir.

MR PAYNE: At the bottom, it is for Patient D, I believe, it is "Comment with regard to Patient D".

A. And it says:

"Miss D was inappropriately given thyroxine. There was no suggestion of any stage she had signs or symptoms relating to hypothyroidism. Her biochemistry was absolutely ..."

"Normal" is the wrong word, it should be within the reference range. I accept that:

"... and Dr Skinner on the basis of subtle clinical signs suggested she needed treatment which I feel is inappropriate and such treatment falls outside good medical practice."

MR PAYNE: I just want to clarify this point, because, like I have said already, I'm not a medical member, I'm a lay member to the Panel, but she came to give evidence, did Patient D, and she gave the signs and symptoms that she had, and we've been given throughout the course of this hearing all the relevant signs and symptoms. Unfortunately for myself, from a personal aspect, my wife has suffered with thyroid problems, and it could

have been my wife speaking. She had all the symptoms that my wife had, and I find for you to say that she had any of the signs or symptoms is difficult for me to understand your comment there. I would like you to reflect -- amplify for me.

A. She at no stage had the biochemistry that suggested that the signs and symptoms which are suggestive of hypothyroidism were in fact due to hypothyroidism.

MR PAYNE: Okay. That's the blood test.

A. That's the blood test.

MR PAYNE: Thank you very much indeed.

MRS WHITEHILL: Good afternoon, Mr Lynn. Can you hear me clearly?

A. Yes, thank you.

MRS WHITEHILL: I too would like to ask some questions about Patient D. You gave an example earlier of a patient in your practice who has T4s in the 50s and he is on a very high level of thyroxine.

A. Yes.

MRS WHITEHILL: Patient D was also on a high level of thyroxine, 200 micrograms, I think, and accepting all you've said about the wellness feeling and the almost addictive nature of thyroxine, would you expect Patient D to suffer any symptoms of thyrotoxicosis on that dosage?

A. I think it varies considerably, but it is a dose which I think could induce thyrotoxicosis. Patients vary enormously, if I can say, when you give them thyroxine on their response, and I can't remember what her weight was, if she was particularly overweight.

MRS WHITEHILL: 16 stone.

A. Well, there must be -- I've forgotten about that. There are other reasons. She is going to feel unwell because of her weight, her movement. 16 stone is a heavy lady.

MRS WHITEHILL: But she actually felt very well and I accept the reasons. I'm more interested in why she didn't feel unwell on the large dose.

A. I think she had a very large body mass and for her it may not be such a large dose.

MRS WHITEHILL: Thank you.

My last question: do people who have hypothyroidism, where their TSH is outside the reference range, and they take a dose of thyroxine that's appropriate, do all those symptoms resolve?

A. Could you say -- patients who have?

MRS WHITEHILL: Hypothyroidism as defined by both the --

A. Yes, on the whole the symptoms will resolve and they should feel normal. They will get -- their hair will come back, the weight will go down, the horrible thickening of their face, the unpleasant feeling, their

loss of -- many of them with severe -- loss of dignity, I don't know quite the word, but I think you know what I mean, they look unpleasant, bless them, and in fact they go back to normal. If you have hypothyroidism which is genuine, it is a wonderful condition to treat because the results are fantastic.

MRS WHITEHILL: Thank you, Mr Lynn.

THE CHAIRMAN: I wonder if you could give me final guidance. We've talked about the feel good factor, one of the doctors referred to thyroxine had an amphetamine effect. We have all said that you feel this isn't good for the patient, causing thyrotoxicity, et cetera. How long can you go on being thyrotoxic?

A. Okay, well, first of all, most of us don't have much experience of people who are not treated for their thyrotoxicosis, but in the 1930s, before the drugs were available, there was somewhere in the region of 10 to 20 per cent mortality 18 months with untreated thyrotoxicosis. I'm only giving you figures off the top of my head, you know.

It was a killing disease until the anti-thyroid drugs came in. It was a very difficult disease to treat. A great percentage of thyrotoxics are self-limiting, about 50 per cent of patients with thyrotoxicosis, it get better on its own, but those

50 per cent who didn't get better on its own would get worse and worse and could really look like people out of a concentration camp, thin, starving, cokectic(?), and there was a significant mortality.

I can't quite answer your question in the modern era because it is very rare for people who are thyrotoxic not at some stage to be treated, although many of our patients plod on with rapid pulses and high TSHs, who are self-taking their thyroxine, and I must be frank with you, over the years I haven't had a death from one of those patients.

THE CHAIRMAN: Thank you. I was just a bit confused when you said about people who insist on taking thyroxine, you are really committing them to a lifetime of thyroxine. There are no withdrawal symptoms, if I'm correct, you basically mean people become psychologically dependent on thyroxine. Is that what you're saying?

A. Two things. First of all, if you decided to put them on thyroxine, you are committing yourself, your thyroid has failed. There is no suggestion the thyroid's going to get better. Therefore, you are committing thyroxine for life. You're not going to stop it at three months, suddenly stop it and see how your thyroid is.

So the minute you're put on -- and I'm sure

everybody will agree, the minute you're put on thyroxine, if it is put for a diagnosis of hypothyroidism, the hypothyroidism will not resolve, so logically you are going to take your tablets to your grave. Point number 1.

Point number 2, you have the feel good factor, if you're on them unnecessarily and you have the feel good factor, you're not going to want to stop them most likely because they kept your weight down, and in London they're used extensively, thyroid tablets are used in slimming clinics inappropriately to keep weight down and this sort of thing.

Does that answer your question, Madam Chairman?

THE CHAIRMAN: Yes, I think what I was really saying, the responsibility of doctors to intervene, if a patient requires a prescription, do you have to give it?

A. If a patient requires a prescription, do you have to give it, did you say?

MR KARK: If a patient requests.

THE CHAIRMAN: If a patient requests a prescription --

A. Absolutely not.

THE CHAIRMAN: Has his own choice.

A. You must do what you think is -- our general rule as doctors is to do what is in the patient's interest, not what the patient wants.

THE CHAIRMAN: Thank you, just one more. T3 and the Armour Thyroid. The ratio with Armour Thyroid T3 is 4 or 5 to 1.

A. That is right.

THE CHAIRMAN: T3 is slightly more unstable. You say you only give it in cancer patients, but for those who do give it to patients, be they either hypo or euthyroid, would you -- I think you might have stated this, but would it have a risk factor to it?

A. It would have exactly the same risk of overdosing somebody with T4.

THE CHAIRMAN: No greater risk, T3?

A. No, I would say after all T4 goes to T3 so I do not think there's any difference in the risk.

THE CHAIRMAN: Thank you very much.

MRS WHITEHILL: Excuse me, chairman, I have one more question. Sorry, Mr Lynn, I do have another question from the beginning of your evidence that the Chairman has sparked my memory on.

You said earlier that if patients are taking thyroxine that there is an atrophy of the thyroid gland.

A. Yes.

MRS WHITEHILL: If a patient were to stop taking the thyroxine, would the gland regenerate?

A. I don't think I can answer that question. I think if

they've taken it in the short-term for one or two years, possibly it would regenerate and you would stop -- but these glands -- and of course, physicians aren't inside the neck, they do not see.

These glands instead of being the normal weight would be minute and fibrosed and small, and therefore, it is possible, and I have no evidence except to say it is possible that long-term thyroxine replacement inappropriately would in the end produce hypothyroidism because if you stopped it, the thyroid would never recover.

MRS WHITEHILL: Thank you very much.

THE CHAIRMAN: Thank you. Any further questions?

Further re-examination by MR KARK

MR KARK: Just, I think, one.

You dealt very fairly with the notes, and you have no criticism in essence of the notes made by Dr Skinner. But the questions that were asked of you in general included also -- and I'm just looking at head of charge 8C and D -- carrying out an inadequate examination, and I just want to ask you about one aspect of that.

A. Can I just be referred to -- what is it?

Q. Sorry, in the heads of charge it is 8D.

A. I have that, I just want to see what he wrote.

Q. Let me take you, by way of example, to tab 4. I just want to ask about one specific aspect of this or two, perhaps. We see that part of this patient's problems were tinglings in feet and arms and then this:

"Side vision, hallucinations of lights."

We see comments in other patients, I'm not going to go through them, fairly frequent reference to problems with vision. If that's right and the patient was complaining of problems with vision, I want to ask this in as open a way as possible: what would you say, if anything, about the investigation which followed?

A. Well, first of all, I don't know what side vision, hallucination of lights mean. I have not a clue, I'm afraid, I'm just like a layperson over this, I have absolutely no idea what it means, but it occurs on several other bits of paper, and it may be a physical sign or a comment that Dr Skinner has found he thinks is appropriate to make the diagnosis, although I myself have never come across it or never seen it referenced or heard of it before.

Q. Would you expect there to be any further investigation if that's something that the patient was complaining of?

A. In fairness to him, if he actually believes that this is a symptom which he has seen of hypothyroidism, which I think he's wrong about, then I would have thought

there would be no point in looking elsewhere, and I suspect he does. Basically you're saying to me should the patient see an ophthalmologist, but if he feel that this is something he has seen and believes in it, then I think enough is enough.

Q. So if he is relating it to hypothyroidism and he thinks the cure is in thyroxine, you wouldn't expect him to go further?

A. No.

MR KARK: Very well, thank you.

THE CHAIRMAN: Mr Jenkins, any further questions?

MR JENKINS: No, I don't. If I had them, I would have asked them before Mr Kark. But thank you.

THE CHAIRMAN: Thank you, Mr Lynn, for attending today and giving your evidence. I think we are finished and you may leave. Thank you.

MR JENKINS: I think that's Mr Kark's case, subject to some documents.

MR KARK: Not quite. There are two statements of Ms Jordan and Ms Floyd which I can summarise, both of which relate to the performance appraisal, and then there are some documents which we are going to invite you very briefly to look through. That will then be the end of the GMC's case. I don't know if Mr Jenkins was then going to ask for further time in any event.

MR JENKINS: We are due to stop this case at 3.00 today, and if the lunch adjournment was the usual length of time, we have an hour in the afternoon to do obviously some work on Mr Kark's case, and then ordinarily I would start mine.

Once I do start, obviously I'm not able to talk to Dr Skinner during the course of his evidence overnight, and I know there are matters that he and I should properly discuss before I call him. I wonder if you would allow me this indulgence that I don't call him today and we start first thing in the morning.

There is one other outstanding matter about Dr Skinner's book, and you have seen reference to it, and you know Patient D read it, and it seems to me it might be useful for the Panel to have the opportunity to look at it. I don't require you to read it, but I think it is a document that will be referred to at later stages in the case, and it might be something that you can look at this afternoon during the rest of the time before we stop sitting at 3.00. I raise that for Mr Kark to consider because he may be content with that or he may have other views.

MR KARK: I think Mr Jenkins knows my attitude to the book. It is this: it is Dr Skinner's evidence, first of all, that counts, not anything that he has written

previously.

Secondly, I have had the opportunity to read the book and it does range very far and wide across a spectrum of subjects, as perhaps you'd expect. I certainly proposed to use some of it in order to base some of my questions of Dr Skinner, so I, in principle, have no difficulty in the document going before you.

I think depending on how much of it is put in in cross-examination, before you go into camera, I think it should be withdrawn, I don't think you should have that with you because there is a danger that then replaces the evidence that you hear orally. But in order to assist you to follow, perhaps examination-in-chief, it may well be that Mr Jenkins is going to refer to it, and in order to assist you to follow cross-examination, then I can see no difficulty about you having a copy of the document. I would not invite you, with respect, to read it through for the reason that I have stated.

THE CHAIRMAN: Thank you.

THE LEGAL ASSESSOR: I am asked if I have an opinion and I can't say, really, because I haven't seen the book. I do have a slight hesitation in the sense that of course it is an inquiry and once matters are put before a Panel, I have a slight hesitation at this stage of them being withdrawn from the Panel at a later stage.

They can be warned and they are appropriately warned that they may think that it is inappropriate to put too much weight as to certain documents or certain matters that they have before them, but they are not like a jury: you can't just put them before them and take them away, I think.

MR JENKINS: If I can add to that, the Panel, at the time they consider the factual questions and deliberate on those, they will of course have a transcript of Dr Skinner's evidence and they can remind themselves that it is the transcript that they should focus on as the evidence in the case. But I wonder if I can give a copy of the book to your learned legal assessor so that he can have the chance to flick through it himself over the lunch adjournment and perhaps express a view having looked at it, at 2 o'clock or whenever we finish Mr Kark's evidence.

THE CHAIRMAN: We will proceed that way. Thank you. What we will do is have lunch until 2.00 and then proceed with Mr Kark's evidence. Thank you.

(1.05 pm)

(Lunch Adjournment)

(2.00 pm)

THE CHAIRMAN: The legal assessor has a point that he would like to bring up and then we will continue with Mr Kark.

THE LEGAL ASSESSOR: In the course of his questioning of Mr Lynn, Mr Payne referred to the fact of the symptoms being described in relation to a patient and comparing them to the symptoms of his own wife who had had problems of a thyroid nature.

The matter was raised during the luncheon adjournment by both counsel and they asked me to address the matter. I have spoken to Mr Payne about it. He has indicated that he has no objection to the hearing knowing that at some time, I think some four or five years ago, his wife suffered or had a problem with hyperthyroidism. She was treated conventionally with drugs. That went over a two year period and she was cured. He thought nothing of it, knew nothing indeed about the event particularly, not having spoken terribly much to his wife about the particular matters, apart from, I think, the fact that she was cured. He had never heard of Dr Skinner before this hearing and indeed had never heard of any other method of treatment apart from the conventional way in which his wife was cured and treated.

It was purely the fact that reading through the report of Mr Lynn and looking at that particular paragraph, he compared those symptoms that were described by the patient to those described by his wife,

and I think his words were: apart from the weight loss being different, i.e. losing weight or gaining weight, that being the only difference between the two patients as the symptoms described.

It seemed to him that the symptoms were identical to those that his wife had, and, using that knowledge, he wished to find out from Mr Lynn why were -- the symptoms in effect being the same as his wife's, how you were saying that those were not the symptoms? Of course Mr Lynn's reply being: the symptoms may have been the same, but the underlying cause of the symptoms may have been different. But that was the purpose of the question and on everything that I can find there is no underlying method, reason, or indication of the way in which Mr Payne is forming any view or has formed any view in this hearing.

MR KARK: First of all, thank you on behalf of the Bar for making the enquiry. Secondly, thank you to Mr Payne for being willing to reveal the background. Apologies, I suppose, if we're oversensitive, although, as one saw at the beginning of this hearing, one is sensitive about the possibility even of the Panel knowing anything outside the confines of the evidence. So thank you for making the enquiry. I have no application to make.

MR JENKINS: I agree with every part of that.

MR KARK: Then we can move on.

I am going to ask to be handed out to you the section that you are currently missing from tab 3 of file 2. So could I ask you to take up file 2, please. (Handed). Can I ask that you be given a small bundle of documents to insert into the empty tab 3 at the moment.

The statement that's relevant to these documents -- and I am not going to read it through unless I'm asked to do so because the purpose of the statement is really to produce documents that you have. But the statement maker is Ceri Fiona Floyd, who says:

"I make this statement in relation to the General Medical Council's investigation of Dr Skinner and I attach to my statement a bundle of documents from my file. This includes exchanges of correspondence with Dr Skinner relating to the complaints made against him."

And she produces the documents that you have therein. I am going to take you through them very briefly because you will find in here a number of documents that you have already seen, which were copied to Dr Skinner so he knew the nature of the complaint.

We start at page 2. You will see the exhibit label is CF1, Ceri Floyd 1, that is her documents, and the first document is the letter from Liz Jordan which you will already have seen, where she writes to raise

a concern about the prescribing habits of Dr Skinner, saying:

"I believe that there is enough evidence of a repeated departure from good professional practice that the case should be brought to your attention."

And she was writing in her capacity as the Medical Director of the NHS Argyll and Clyde relating to a concern raised by one of the local community pharmacists, and you will remember the Tesco refusal to issue T3.

Over the page is the letter from the GMC to Dr Skinner, informing him that the GMC had received information from Dr Jordan and inviting his comment and enclosing with that the letter from Dr Jordan and also a further copy of the prescription at page 8 with the Tesco's refusal to issue the T3.

Then a document at page 9 where Dr Skinner responds to the complaint and he writes:

"I was consulted by my patient [Patient B] on 28th January 2003 with symptoms which suggested a significant depressive condition."

Sorry, this is Dr Blair writing to Kerry Floyd at the GMC.

He describes how he previously prescribed anti-depressants for her and then, third paragraph down,

how he discussed with her her normal thyroid function tests in February of 2003, and then how in April 2003 he found that she had gone to Dr Skinner. He had a letter from a Dr Skinner and he says:

"I strongly advised her against taking thyroxine, as I felt there was no clinical indication for this."

And he says how he had spoken to Dr James Thomson, the local endocrinologist:

"His advice was that despite some trials which had been carried out in the States, further studies in Stobhill had shown that there was no scientific basis for such a prescription."

So that was bringing to the attention of the GMC Dr Blair's concerns and he attached to that letter the "doghouse" letter, which you have already seen, at page 11 elsewhere in bundle 1 and the prescription. Then could I ask you to go to page 14 of the bundle where we do have Dr Skinner's response to the complaint of Dr Jordan.

He says:

"I have taken the liberty of receiving advice in confidence from various respected colleagues who share my difficulty in identifying the precise nature of this complaint from Dr Jordan or indeed what shortfall in care is being alleged by the complainant.

"The patient was treated for hypothyroidism with a change in medication when it seemed she was not converting thyroxine to tri-iodothyronine."

He writes in the fourth paragraph:

"I hope you will not interpret my comments as dismissive. While I understand that the General Medical Council have a difficult job to do to separate the wheat from the worrisome chaff, there are issues of principle and it would surely be reasonable for the General Medical Council to at least request or engross in their guidelines that a potential complainant (unless it is a serious matter in the nature of murder, drug addiction etc) have at least one professional conversation with the subject of the complaint before writing to the General Medical Council."

He says:

"May I respectfully request that we have some precision in the nature of the complaint from Dr Jordan, the perceived shortfall in the prescription which the Tesco pharmacist deemed improper - and did not issue - for some unaccountable reason and perhaps from Dr Blair the Family Practitioner to establish if he has any difficulty with our shared care. He has certainly never expressed any concern to me.

"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 letter follows, thanking Dr Skinner for his communication.

Could I ask you to go to page 20 because the rest you have seen. This puts Dr Skinner on notice on 23rd July 2004, third paragraph down:

"The screener considers that an assessment of the standard of your professional performance needs to be carried out in the light of the information received from Dr Jordan, and in particular the information regarding: inappropriate/irresponsible prescribing, relations with colleagues, substandard treatment."

Then could I ask you to go on because there was some correspondence about whether he received that notice or not. Then at page 35 he asks for an extension of time and the extension is given to him at page 36.

At page 37 he writes:

"It is impossible for the MPS Solicitor with whom I have an appointment ... to provide optimal advice or indeed any sensible advice when the patients and indeed some of the complainants are anonymous although it is unclear to myself who is or was their carer why they

require to be anonymous."

To explain that, there was a letter relating to anonymous complaints, but it is the letter of Dr Jordan and Dr Blair upon which we rely at this stage.

At page 39 you can see:

"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 on the standard of your professional performance."

That's written on him on 28th September 2004.

On page 40 Dr Skinner writes back asking for deanonymisation by the GMC, saying:

"I believe that the screener may waive a requirement for performance assessment following review of the complete material."

At page 45 he agrees to a performance assessment. He says:

"... which I hope will at last stimulate evaluation of three of the outstanding problems in the diagnosis and management of hypothyroidism namely the criticality of clinical evaluation in diagnosis and management, the extent of dosage levels in management of hypothyroid patients and the usefulness of Armour Thyroid, which is a porcine thyroid extract."

If you go to page 48 and 49 you will find the forms

that he sent to the GMC as a precursor to the assessment. At page 49 you will see that he is described as a self-employed medical director of the Louise Lorne Clinic in Birmingham and Chief Executive Officer of Vaccine Research International plc, same address.

Over the page, director of HIV Inc, UK address as above, and at page 51 he says:

"I hereby accept the invitation of the screener, contained in the GMC's letter of 3rd November 2004 to undergo an assessment of the standard of my professional performance. I also confirm that the information given below is correct."

He gives his date of birth as 21st February 1942, making him now of course 65 years old.

"The speciality in which I most regularly practise is hypothyroidism and my sub-speciality is chronic fatigue syndrome. I also practise in the speciality of vaccine research."

Page 53, please. This is written by Radcliffes LeBrasseur, the solicitors who currently represent Dr Skinner:

"We write to advise 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 must now be convened to consider the question as to whether it is appropriate to make an order that an assessment should be carried out. It is Dr Skinner's contention that this is neither necessary nor appropriate."

On page 54 we have a letter directly from Dr Skinner, saying:

"I wonder if it is worth indicating to the GMC that this is not a blanket refusal to a performance assessment but that I am concerned that my agreement would - albeit not legally but certainly morally - constitute a tacit agreement that the three serious charges - and there is no doubt that these have been spelled out by the GMC ... have substance. The GMC are contending that there is prima facie evidence and it is surely reasonable to disclose this prima facie evidence to the practitioner under scrutiny prior to decision-making on performance evaluation or other procedural outcome.

"I know the Medical Protection Society have place an embargo on my eloquent arguments to the GMC but I think it would be appropriate to copy the GMC on this note to

indicate that I have not flippantly changed my mind on performance assessment but have come to this decision through genuine concern over the reasonableness of these procedures."

And finally, page 56, Dr Skinner is put on notice that having withdrawn his agreement to the assessment of his performance, the registrar has referred him to the Fitness to Practise Panel.

Can I then deal with the statement of Sam Jordan, who is a professional performance assessment officer of the GMC, and she produces various documents which can be found in SJ1. Again, I am not going to read through the rest of her statement, but you can see that we begin at page 2 with a letter to Dr Skinner back on 12th November 2004. This is over into tab 4 of the same file, writing to him:

"We are aware that your speciality is general practice and I enclose information describing the nature of the assessment processes for doctors in that speciality."

Inviting him to be accompanied by a supporter, et cetera, et cetera, and asking him to complete a portfolio by 26th November.

"The purpose of the portfolio is really for the Assessment Panel to provide information to them about

yourself and your practice."

If you go on in the bundle to page 11 you will see the beginning, the introduction to the portfolio:

"The purpose of the portfolio is to give the assessment team a clear picture of the following: your qualifications and experience."

You will see that he did in fact fill a portfolio in; I'm not going to go through it now, but it may be in due course you will wish to certainly cast your eye over it, starting at page 14.

Can I just draw your attention to a couple of pages. On page 15 he is asked:

"With regard to your qualifications and training, are there any comments, explanations, or additional information that you think may be relevant, which you wish to bring to the attention of the assessors. In conjunction with referring family practitioners and specialised colleagues I have been managing patients with mainly hypothyroidism for ten years."

Over the page he describes himself as from 1998 as the medical director, self-employed, three to four days a week, management and diagnosis of thyroid problems, restoration of health in a seriously neglected group of patients.

Again, I am being very selective and if Mr Jenkins

wants to draw anything else at this stage to your attention, I would have no objection.

At page 27, he says:

"I am not a general practitioner."

At page 38, paragraph 19, he says:

"Patients are seen by referral from their family practitioners. The majority have hypothyroidism."

Over the page:

"My practice is a secondary referral practice from which I make tertiary referral."

That is all that I am going to draw to your attention. As I say, it may become relevant later in the case.

Page 74 may be relevant to the issues that you've been considering. You will see about halfway down the page:

"Please comment here on any factors about you or your practice that make it difficult for you to reach these standards."

In other words, the standards in good medical practice.

He writes this:

"A number of colleagues in this field essentially disagree with my view that hypothyroidism should be diagnosed primarily on clinical evidence while taking

due cognisance of thyroid chemistry. It is regrettable that a small proportion of colleagues inexplicably decline discussion on the issue and indeed none of the complainants would attend a working seminar which I organised to investigate these issues."

That is all that I bring to your attention at this stage. That is the case of the General Medical Council.

THE CHAIRMAN: Thank you, Mr Kark.

Mr Jenkins, do you have anything further?

MR JENKINS: Madam, as I indicated before we broke for lunch, I am going to invite you effectively to adjourn hearing evidence now. I certainly will be calling Dr Skinner, but, if you permit it, I will call him first thing tomorrow morning. As I have indicated, I do have copies of Dr Skinner's report and I hope that your legal assessor has had a chance to flick through it, which may be sufficient for him to give any further advice, but I leave it to him.

I say it would be helpful for the Panel to see what Dr Skinner takes by way of an approach. It is a book written essentially for patients and it sets out his approach and why it is that he takes it. I anticipate that he may be cross-examined about sections of it. I think it would be useful, as I say, for the Panel to see his approach before he gives evidence and it should

shorten the process of giving evidence to some degree. Mr Kark certainly nodded to that last bit. So I would invite you to receive a copy of the book and flick through it.

Can I tell you, if you receive it, which passages you should perhaps concentrate on, but I will wait to see whether you will receive it.

MR KARK: As I said earlier, I have no objection to your receiving it, but the purpose of your receiving it is so it is better to follow examination-in-chief, if it is referred to, and cross-examination. You would not normally receive the proof of evidence of a defendant in these proceedings, and this is actually much more than a proof. As I say, I don't think Mr Jenkins would contend that it is all relevant, it isn't, and it does range far and wide.

So I have no objection to you receiving it, but please with that caveat that it is relevant to Dr Skinner's evidence which he will give on oath and will enable you better to follow the examination-in-chief and certainly the cross-examination. I'm not sure how relevant it is for you to read passages of it in advance, given that limited objective, but again you'll receive advice no doubt.

THE LEGAL ASSESSOR: Can I just clarify? It was my understanding originally, when the book was produced, that it was a document that was going to be used for the purposes of cross-examination quite extensively and, for obvious reasons, where a document is used extensively in cross-examination in many occasions it is almost inevitable that that document goes before the jury or in this case the Panel; quite rightly so.

I had not actually understood originally a request that the Panel be provided the book in advance of Dr Skinner's evidence, which might be a little difficult, because, after all, the book amounts to quite largely what his evidence may be. It may be argued to be self-serving in some respects. It is perfectly right and correct that he be asked about it during the course of his evidence. Do either counsel have anything to say really about it being given in advance? I query that.

MR JENKINS: Having invited you to rise half an hour early, I was anxious to find that there was something the Panel could usefully do. If you were going to read it at some stage, reading it now or flicking through it now would seem a suitable time. I have no strong views on it either way. If there are concerns that it is not appropriate for the Panel to see it in advance of hearing from Dr Skinner, I'm entirely comfortable with

that and we can provide with you a copy of it tomorrow morning when Dr Skinner gives his evidence.

MR KARK: I suspect there's quite enough for you to read in the portfolio that you have just been given and the enjoyment of reading the transcripts. With respect given the caution I have already indicated, I would not favour you receiving the book in advance for the very reason that we've indicated: it is primarily relevant so you can follow perhaps some parts of examination-in-chief, if it is referred to, and cross-examination. The danger is that if you receive it in advance, the temptation will be simply to read it and it becomes the evidence of Dr Skinner.

MR JENKINS: If Mr Kark has any concerns at all I won't encourage you to read it now and we'll deal with it tomorrow morning.

THE CHAIRMAN: Thank you, I think that's possibly the best way forward. We will adjourn now and meet tomorrow morning at 9.30. Thank you.

(2.30 pm)

(The hearing adjourned until 9.30 am
on Tuesday 10th July 2007)

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