GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Monday, 16 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 Eleven)

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

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

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

Transcript of the shorthand notes of Transcribe UK Ltd
Tel No: 01889 270708

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THE CHAIRMAN: Good morning, everyone. Just to remind you all again about maintaining the anonymity of the patients involved, should their names be mentioned in error, please do not refer to them outside of the room. We have the video link set and I think it is for you to continue, Mr Kark.

MR KARK: Before we start the video link, can I mention that one of the Panel members has just handed me two documents that were left on her desk. One is notes from Professor Weetman on Dr Hertoghe and one is a piece of research. They are my documents. I am afraid I have no idea how they ended up on Mrs Whitehill's desk. I am glad to report that Mrs Whitehill has reported that she has not read either of them, but I imagine that she has read the report in a different form. I have no idea how they got there. There may have been some shuffling over the weekend. I apologise for that having happened.

THE CHAIRMAN: Thank you. Dr Hertoghe, we will continue with the evidence and the questions from Mr Kark.

(*Via video link*)

THIERRY HERTOGHE, recalled
Cross-examined by MR KARK (continued)

Q Dr Hertoghe, can you hear me?
A Yes, I hear you clearly.

Q If at any stage you cannot hear me, obviously you will let us know.
A I will put my hand like *this* if I do not hear you clearly. Is that okay?

Q You can probably just tell us. I gather that there is something of a time delay, so I am going to speak slower and would you do the same?
A Can you speak also louder, please?

Q Can you hear me better now?
A I hear you better but it is still good if you could speak loud enough, please.

Q Dr Hertoghe, we were just finishing off on Friday in relation to Patient C. Do you remember?
A Yes.

Q I was asked by Mr Jenkins to deal with Armour thyroid. Can you hear me?
A I do not understand your question.

Q Do you still have the patient notes with you? Do you have a bundle with you?
A Yes, I have them above me here.

Q Can you turn to Dr Skinner's notes on Patient C and turn therefore behind tab 6?
A Which page, please?

Q It is file 1, tab 6, the very first page.

A That is Patient C?

Q Yes, that is right. You can see that there was a first consultation with Dr Skinner on 6 March - yes?
A Yes, the first note, yes.

B Q We know that the blood results following that consultation showed that her TSH – and you can see this at page 3, if you want to turn to page 3 of the same section…
A Yes, I have the lab tests.

Q Her TSH was 2.2 and her T4 was 11.6?
A Yes.

C Q We know that Dr Skinner started the patient on Thyroxine?
A Yes.

Q Go back to the first page and we see on 8 May that Dr Skinner saw her again?
A Yes.

Q She had put her dose up to 200mcg of Thyroxine per day?
D A Yes.

Q Dr Skinner prescribed, if you look at the bottom of that section of the note, 150mcg but added in Tertroxin, T3. Do you see that?
A Yes, I do.

E Q I am not going to go through it again but we know that there was no blood test before that change. Then the next meeting was on 7 August. There was a third consultation with Dr Skinner?
A Yes.

Q She was still on 150mcg of Thyroxine and 20mg of Tertroxin?
A Yes.

F Q He took blood on that occasion. There is no mention there, is there, that she had started to take Armour thyroid? The patient did not tell Dr Skinner that she was taking Armour thyroid at that time. Do you agree?
A Yes.

G Q The blood test following that consultation you will find at 6.10.
A Which page.

Q Sorry, tab 6, page 10. Do you have that page?
A Yes, I have it before me.

Q Her TSH was unrecordable effectively, and her T4 was 25.5, outside the reference range?
H A Yes.

Q On the blood tests, she was hyperthyroid, was she not?
A Again it is the same answer for all the other patients, that you cannot say because most probably the thyroid hormone was taken before the blood test, so in order to be sure about a patient being hyperthyroid I have to have the clinical systems also, and I do not have any evidence for this. It could be if she would have not taken the thyroid hormone before, but I have no information on this, and this is a difficult result. When a patient takes T3 and T4 medication before the blood test, that means in the five to eight hours before, she does have this sort of abnormality.

Q If we were to assume that Dr Skinner was competent when he took this blood test and understood that problem, and therefore the blood test was taken properly at an appropriate period after the taking of Thyroxine, then the blood test reveals that this patient was hyperthyroid, does it not?
A But not with a pulse of 64 per minute and a blood pressure at 86 …(*inaudible due to video link sound interference*)… I would say it is almost impossible this situation. If it were so that the patient had hyperthyroid symptoms and had this sort of blood test, then you are sure she is hyperthyroid, but here absolutely I must say not. We do not have this certainty.

Q If you assume that this blood test was right, you would have changed the prescription, would you not?
A If she had clinical signs and symptoms. Again you do have to have both. That is a certainty. I would say this sort of lab test, I generally do not have hypothyroid or …(*inaudible due to video link sound interference)*… I generally have hypothyroid symptoms I would say in 99 per cent of the cases, so this is again a picture that is most probably done with the blood test just before; also because the T3 is quite high, this is very difficult for a person taking T3 and T4 combination before the blood test.

Q Your evidence last week was that when you treated people with Thyroxine, your goal would be to keep them within the reference range. Do you agree still?
A Yes, it is, and I would specifically ask the patient not to take the thyroid hormone before, or, if it is necessary, I would ask for a supplementary blood test.

Q If this blood test is right, this patient is no longer within the reference range, is she?
A Again, but you do need to have hyperthyroid symptoms at clinical examination. It is very important here. This is the case, and for other cases, that patients need to be examined clinically in order to do a good medicine. I would say only relying on the blood test is not adequate to really follow up the patient.

Q Doctor, are you departing from your evidence that your goal would be to keep the patient within the reference range? Are you changing that?
A Yes, that is for, as I said, a small fraction of the patients do have lower receptors and lower other things that you might need higher doses, but it is a small fraction – exceptional patients.

Q What test would you do to find out if they had low receptors?
A There are several tests that you could do. The first, of course, is the clinical examination. The clinical symptoms and signs are the consequence of what happens in

A the cells. I would say it is almost the most reliable parameter. The second important parameter is checking enzymes and proteins in the blood. When a hormone comes inside the blood, the part itself, they usually stimulate enzyme systems. Some of those enzymes go in the blood like alcoholic(?) …(*inaudible due to video link sound interference*) … and other proteins like that is not an enzyme, six hormone … (*inaudible due to video link sound interference*) … they go quite a lot when the blood tests, when there is too much B thyroid hormone and quite reliably, if you combine it with clinical symptoms the third way to check what happens in the cells – am I going too fast?

Q You are slightly. I suspect you are, yes. Carry on. The third way of checking?
A The third way of checking is to have the metabolised thyroid hormones like when the de-iodosed downside or mono-iodosed, those have two or one so when the hormone T3 is used as a hormone it is changing the cells and one of the iodines disappears. You C have a lesser form. Those metabolised do give a good picture but we do not have this in standard tests in the laboratory. The fourth way to do it, but it is not sufficient on its own, as I showed, is to up the TSH. When the hormone is inside the pituitary itself, if there is too much thyroid hormone it does inhibit the TSH.

Q I am sorry. Can you just stop for a second. It does do what to the TSH, did you just say?
D A The TSH, the fourth, the less reliable of those four parameters is a suppressed TSH or a lower TSH. It decides that the hormones go in the pituitary itself. Again, I have to repeat the information I gave that the TSH is secreted by a very specific sort of cells and sometimes you have complete opposite reactions, what happens in the pituitary cells that secrete TSH and the other part itself of the body.

Q Would you advise a patient to start on Armour if this is what you thought was E happening, that the cells were not receiving the T3 appropriately? Would Armour make any difference?
A If a patient reacts well – not well on Thyroxine or on T4 and T3 medication my choice is to go over to Armour type, but only Armour type or other preparations. Armour is the only one I would trust. The others for dedicated thyroid I do not rely on. It has to be a slow conversion, a change from… You lower slightly the T4 and T3 preparation and then increase Armour thyroid. I would not join in general, except in exceptions, Armour F Thyroid with any other hormones. You could eventually add T3 if the patient on T3 or a little T4 if the patient needs proportionally more T4, but generally the patients do well with only Armour Thyroid.

Q We know that this patient by 31 August, so 20 days or so after the consultation, G was taking Armour Thyroid. We can see that there is a blood test on 24 September 2004 where here TSH is negligible and her T4 is 21.7. To what extent would you think the Armour Thyroid is going to affect the blood test?
A In order to answer correctly I need to have the T3, but generally if with Armour Thyroid you take the Armour Thyroid just before the blood test you do have a very high T3 and a slightly high T4, and the TSH that is generally suppressed if the doses are higher than the physiological dose. This is when Armour Thyroid is taken before the blood. If H you do not take the Armour Thyroid before what you have as a picture generally in a patient who is not over treated is a T4 within reference range and T3 within reference range and a TSH that could, if the person has a certain degree of central hypothyroidism,

A could be suppressed or could be lowered or could be normal. That depends on the patient and the health state of the pituitary gland of that patient. If the pituitary gland is already weaker because of aging, premature or not, or because of certain stress circumstances. That is a different topic which happens often and so I would say the T4 and T3 are generally within reference ranges if the treatment is not overdosed.

B Q That is exactly it, is it not? If the TSH and the T4 and the T3 are outside the reference range it is likely, is it not, that the patient is being, as you put it, overdosed?
A Only in this hypothetical situation, which in my experience is nothing changed. The patient also was hypothyroid and the patient had not taken the thyroid hormone before. Here I am 95 to 99% convinced that the patient took the Armour Thyroid or the thyroid hormones before the blood test, because this is typical with the clinical picture of normal to hypothyroid clinical signs and symptoms.

C Q This is on the basis that Dr Skinner was not competent when he took the blood test and the GP was not competent when he took the blood test. Is that right?
A I do not understand what you have said. Could you speak a little louder?

Q I will say it again. That is on the basis that Dr Skinner was not competent when he took the blood test and also the GP was not competent when he took the blood test – I
D should say she?
A I do not understand it when you say that Dr Skinner and the GP were – what?

Q Not competent, in other words doing it properly?
A Not competent?

Q Yes?
E A Or did not say to the patient, "Take your thyroid hormones after the blood test", simply that. It does not mean that they are incompetent, because this problem is with the GP and with endocrinologists. I think it is an educational problem here in the United States – in the United Kingdom. How to do the blood test is not well informed at the university, I suppose.

F Q Let us move on to Patient D. Her notes you will find at tabs 7 and 8. We know that when Patient D was seeing her GP she actually had a variable TSH. Her TSH was measured in January 2003 and you can find the note at tab 7, page 5?
A Yes.

Q We cannot see the exact date, but do you see three entries up from the bottom,
G January 2003 thyroid function test TSH 1.1?
A Yes.

Q If you go to page 81 of the same section?
A Which page please.

Q Page 81?
H A Yes.

Q You will see that her TSH on 19 November 2003 was again 1.1?

A Yes.

Q Then I am afraid you have got to go back to page 6 again?
A Yes.

Q To find that on 12 July her TSH was 0.67?
A Yes, I see this.

Q Those TSH levels were all before the patient went to see Dr Skinner?
A Yes, I see.

Q The patient then goes to see Dr Skinner and she takes with her those blood tests or a report of them. If we turn over to Dr Skinner's notes we will find at page 10 the document that the patient took with her.

THE CHAIRMAN: That is tab 8.

MR KARK: Page 10?
A These are the records of the GP, I believe. No?

Q No. These are the records of Dr Skinner. This is a document that the patient took with her to Dr Skinner. Do you see that it starts off with those TSH tests?
A I have probably got the wrong page

Q Page 10 of tab 8?
A Okay. Yes, I have this page.

Q We know that when this patient walked into Dr Skinner's surgery she seems to have taken with her, her history which had at the top of it those TSH results?
A If I well understood we are talking that the patient took this document to Dr Skinner and Dr Skinner took the document.

Q Whether he took the document or not, it appears that he did because it has ended up on his notes, so we know that the patient had it with her and it ended up on Dr Skinner's notes?
A I am sorry. I do not hear you clearly. Could you talk a little slower?

Q We know that Dr Skinner had this document?
A Okay, yes.

Q Dr Skinner started this patient on Thyroxine?
A Yes.

Q He took his own blood tests, the results of which we have at page 16?
A Of?

Q Tab 8, the same tab. Go to page 16?
A Yes, I see.

Q Would you agree that those tests are not abnormal in any way?
A I would agree that the tests could be normal, but the clinical picture shows clearly quite hypothyroid symptoms and signs.

Q I will ask the question again. This blood test does not demonstrate that the TSH or the T4 were abnormal in any way?
A I disagree with this statement. You cannot interpret a blood test without the clinical picture. With the clinical picture this could be hypothyroid. It could be "per" thyroid. You cannot interpret the blood test. I showed you that there should be a sort of grey zone within the reference range where people, where the judgment of hypothyroidism should rely on a combination of the test and the clinical picture.

Q Dr Hertoghe, applying European standards, American standards or even your own standard of the level of TSH being 2 as the upper level, this level is below all of those standards, including your own, is it not?
A Mr Kark, what I have said and what I have shown was when lipids were in the lower half of the T4 there could be the D (?) factor, which is the case. Also, with the TSH there are certain studies that show above the 1.5 or above the 0.9 or above the 0.4 when there could be the D fact. This patient has an enlarged thyroid so is more susceptible to make nodules, so more susceptible to make (*inaudible due to the video link sound interference*). There are many. What I think has moved Dr Skinner to give the treatment is the patient was suffering too much and has clear clinical signs and symptoms of deficiency, so he decided to have a thyroid test which is the thing that I personally do also when the patient suffers too much and there is a great insistence of the patient to be treated. I then try on very small doses of thyroid hormone and this is a practice I know many physicians do.

Q In the face of this blood test, would you have reconsidered your diagnosis?
A I would agree to give the treatment with this blood test later on if the treatment worked. If the treatment does not work, I would stop the treatment.

Q You would not describe this thyroid chemistry as being abnormal in any way, would you? You would not describe the chemistry as being abnormal. You may have clinical signs, but you would not describe the clinical chemistry as being abnormal in any way, would you?
A In any way … *(inaudible due to the video link sound interference)* … I would say this. I disagree with what you have said. I would describe that this blood test has to be absolutely interpreted in the light of the clinical signs and symptoms to give a definite and good answer.

Q Right. What happens was that the patient went back to see Dr Skinner on 18 November 2004 and you have the notes of that at page 24 of the same tab if you want to have reference to them.

THE CHAIRMAN: Mr Kark, is that 04 or 05, November?

MR KARK: 04. It is top of the page.

THE CHAIRMAN: Thank you.

THE WITNESS: Page 24, is that the clinical examination notes?

MR KARK: *(To the witness)* Yes.
A Of Dr Skinner?

Q That is right. At the top of the page, do see the date 18 November 2004?
A Yes.

Q The patient was apparently looking better but crying still. Her memory and her concentration was better. Her aches and pains were better. Her weight was the same. She had fewer side vision hallucinations. She was hawking less, but chocolate digestives still gave her bowel aches. Which of those signs do you say are signs of hypothyroidism? It will help you perhaps to go back to the beginning of this section and look at Dr Skinner's notes.
A I have little a difficult reading clearly, "All resumed," in the beginning of tab 8 in printed letters.

Q Yes, if you go right to the beginning of tab 8 you will find a typewritten document and two-thirds of the way down the page you will see 18 November 2004.
A Okay. This is a typical …

Q Go on.
A This is a typical improvement of a patient who is on thyroid hormones and who has hypothyroidism. No sleeping during the day, that means that there was sleeping in the day before. Some … *(Inaudible due to video link sound interference)* ... main symptom of hypothyroidism. Sleeping satisfactory at night, I suppose the patient was sleeping better, typical thyroid treatment improves the deep sleep stages three and four so they have deeper sleep which are compatible with their waking earlier and it is typical. The patient who has hypothyroidism has difficulties of waking up in the morning and when you give thyroid hormones they wake up much … they wake earlier, but they also wake much fresher. Mentally better. Typically when you have a low thyroid blood circulation in the brain it is low and they think poorly and they are like a sort of fatigue in the brain.

Q You are saying that ---
A One has … losing weight means that the weight is excessive, it is not only caused by low thyroid function because it is massive obesity, but still losing weight thyroid hormones may help in losing weight, but the weight side is lost, it is loss of myxoedema not so much the fat. Lipids are improved that is not a symptom of hypothyroidism classically. Although thyroid hormones can improve … *(inaudible due to video link sound interference)* … function so it is compatible with an improvement thanks to thyroid hormone. Not so as … *(inaudible due to video link sound interference)* … gone, I stand by the facts the clinical signs and symptoms coming out of the letter, then you see that psychosis is one of the main symptoms that he puts on. Not … *(inaudible due to video link sound interference)* … that is not specifically a good health, it is not specifically a sign of hypothyroidism, it could be an indirect sign because people are slow and cannot really get into contact with … *(inaudible due to video link sound interference)* … any more. So I would say it is a typical improvement thanks to thyroid hormone, but it could be. Another examination "more cheery," so I suppose more colour also when you have

nothing but thyroidism you look ill and have a yellowish tint of the skin. So if they have better colour that could be. "Temperature 36.8 C" is a typical temperature for … *(inaudible due to video link sound interference)* … thyroidism. It means that there was not too much or not too low. The temperature is between 36.6 and 36.8.

Q Where are you reading from? Hold on, where are you reading this from, this temperature?
A The second page of the notes, the clinical examination where it says the wrong page.

Q What date?
A The first page and there is a little section above.

Q So 36.8 you are on the third page, are you?
A Third page, yes.

Q That is 18 November 2005, that is a year later.
A It should be … well it is just … it follows.

Q It might follow, but it is a year later.
A *(inaudible due to video link sound interference)*

THE CHAIRMAN: Mr Kark, could I just interrupt for one second. If you could just wait one moment, Dr Hertoghe. It has been questioned ...

THE WITNESS: Can you speak louder, please, near the microphone?

THE CHAIRMAN: It has been questioned whether the link is sufficient. *(To the Shorthand writer)* Are you finding it difficult to follow? There is the option ---

THE WITNESS: I have a … *(inaudible due to video link sound interference)* … that I did not change anything in it with …

THE CHAIRMAN: Dr Hertoghe, could you ---

THE WITNESS: … notes of Dr Skinner on patient B and I have three pages of that.

THE CHAIRMAN: Dr Hertoghe, could you stop for one moment, please, I am just questioning the difficulties that some people might be having with the link. So if you could just go quiet for a second, we will just sort it out at this end.

Is anyone in particular having difficulty with this link?

MR KARK: It is whether it is the link or the way that the evidence is being given, with respect. I do not mean to be rude to Dr Hertoghe. We did have this problem last week anyway when he was here.

THE CHAIRMAN: First of all, I am actually asking the transcriber. Are you having difficulty?

THE SHORTHAND WRITER: Yes.

THE CHAIRMAN: Is it because of his speech or is it because of the actual ability to hear? It is a bit foggy.

THE SHORTHAND WRITER: It is both.

THE CHAIRMAN: Shall we make one further attempt to ask the witness to speak more slowly and more clearly and if you are still having difficulty then we will have to think again? It is just that if you take the link down, it might not work again. All right, so we will work with what we have got.

Dr Hertoghe, back to you. We wonder, please, could you speak as loudly as you can and as slowly as you can. There was a bit of fogginess in the link.

THE WITNESS: Okay, I understand.

THE CHAIRMAN: Thank you.

MR KARK: Dr Hertoghe, we were back on page 1, all right, of the typewritten document. Are you there?

A Can you repeat, please?

Q We are back on page 1 of the typewritten document at the beginning of tab 8.

A Yes.

Q Now I just want to go back to an answer you were just giving us. It was a very long answer. Were you saying that people who find it difficult to get up in the morning and do not spring out of bed that that is a sign of hypothyroidism?

A Yes, this is typical for low thyroid function because the blood flow in the brain is lower. There is also less blood flow and things function less well. When they move they feel better and better.

Q All right. Could I ask you, Dr Hertoghe, to keep your answers as short as you feel you can and I think that will help us. All right? I have no criticism of your last answer at all, but could you just try and keep your answers as short as you feel you properly can?

Now at this second consultation Dr Skinner increased the dosage. From your answers last Friday can we take it that you would have wanted to do a blood test first?

A In order to increase the dose, in my experience it is not absolutely necessary to have blood test between a suboptimal dose and optimal dose trial but a slight increase of thyroid hormone would be acceptable without the blood test, but I do find that you do need a regular blood test, let us say every six months or so.

Q The next consultation with Dr Skinner was on 23 February 2005, all right?

A Yes.

Q So that is six months after the last blood test, yes?

A So I have page 2, the second page of the transcription notes and he did a blood test at that moment. Is that what you are saying?

Q No, he did not.
A Okay.

B Q On 23 February, it is the third consultation, the second follow-up, but it is the third consultation. It is six months after he has first seen the patient and it is six months since he saw a blood test. He altered the dosage again. Do you say that was acceptable without a blood test?
A I do not have enough clinical signs and symptoms on the paper. I find a lot of things are better. It depends on how much did he increase the dose. How much did he increase.

C Q I thought you just told us a few seconds ago that you should do a blood test every six months.
A Yes, I think it is useful to do every six months a blood test, especially every nine months.

Q If you are increasing ---
D A I would do a blood test every second consultation.

Q If you are increasing the dosage, you need to know what is happening in the blood do you not?
A You need to know exactly what happens to the clinical picture first and if there were signs of low thyroid function you could increase by small doses. In order to increase with larger doses and the clinical picture is not very clear, you need a blood test. In this
E case, I do not have enough information written down to know how and when the clinical examination to be a judge of it.

Q On 16 August 2005, the patient saw Dr Skinner again and you have the notes halfway down the second typed page. Do you want to find that; 16 August 2005?
A Yes, I have the transcription notes.

F Q Right.

"Present dosage 150 micrograms thyroxine per day.

Complaints:
Feeling well, feeling good
G Weight increased by 2 stones to 16 stones but eating chocolate, cakes, bread and potatoes
Knees and ankles are better
Memory and concentration is better and libido better."

She is smoking ten cigarettes a day still.

H "Pulse 70 a minute. Temperature 37º Celsius. Tongue still big-ish. Thyroid +."

A

The treatment was to increase the thyroxine for six weeks up to 175mcg and then to increase it again to 200mcg. Would you have done a blood test?

A So this is common practice in endocrinology. It is when you examine the patient, the patient has symptoms and signs of deficiency because things are better but they are not disappeared, so there are still problems going on, which is tongue still big-ish and things like that. It is common practice to first increase the dose and then do a blood test in order not to have two blood tests.

B

Q Do you remember ---
A If I understand, blood tests should be done in three months. This is common practice, yes.

C

Q Dr Hertoghe, this is the fourth consultation with Dr Skinner and he has still not done a blood test. Are you saying that that is acceptable?
A That is, I would say, not good. You should do at least every six or nine months a blood test, but what I mean, when you have this sort of physical examination and clinical picture that shows that there are still hypothyroid symptoms because things are better but not perfect, in place of doing two blood tests because it is a wrench for a patient, you do first increase lightly the doses and then check the dose if it is okay.

D

Q Is that what you are looking for, Dr Hertoghe – perfection by way of Thyroxine? Is that your answer?
A My answer is that you need to check regularly the blood tests – number one – every six or nine months. That is an important thing, but at each consultation the fact of increasing the dose should be afterwards certainly checked, but you can increase the dose before doing a lab test and then check the lab test about three months or… It depends how slow the increase is. Often it is two or three months check the blood test.

E

Q If we turn to page 38 of this section, we will see a prescription dated 16 November 2005?
A Yes.

F

Q That is two days before the consultation. If that prescription was written in advance of the consultation, do you agree that that would be wholly unacceptable?
A I do not understand, because actually the dose that the patient should have is 200mcg and this is just a prescription for the 200mcg, so I would say in that context it is acceptable because the patient was maybe running out of the medication. I do not know what happened. I do not know they are told the conversation.

G

Q I just want to understand this. You would have no difficulty about a doctor writing out a prescription two days in advance of a consultation for 200mcg of Thyroxine before he has seen the patient. Is that right?
A I do not know how the agenda worked, but we do have patients who one week or two weeks before the consultation they say their box, package, is

H

finished and "we do need urgently to have a package before the consultation", so I do not know why it was off et cetera. What I suppose is that there were two possibilities: either the patient had a late consultation on the 18th and had to go to the pharmacy first; either the patient was running out of medication just before and need a prescription. So, I would not say this is a problem because there was a check also on the 18th, which would have corrected the information.

Q Let us have a look at 18 November. This is the fourth follow up, the fifth consultation. We go back to the beginning of the bundle and the second page in on the typewritten notes:

> "Present dosage 200mcg a day. Feeling quite well. Improved on thyroid replacement. No sleeping during the day but sleeping satisfactorily at night and awakening earlier. Mentally better. Lost half a stone in weight. Libido improved. Not so asocial and hallucinations still gone. More cheery. Temperature 36.8, pulse 74. Tongue still enlarged but smaller. Goiter smaller. Blood pressure 120/60."

You would have wanted to check her blood, would you not?
A Well, basically I would do it every six months, yes, six to nine months.

Q On this occasion we do have a blood test, and you will find it at page 42 of the same section.
A Yes, I have it.

Q It shows that her TSH is unrecordable?
A Yes.

Q Her T4 is 27.2, outside the reference range?
A Yes.

Q In those circumstances, what would you have done?
A First, I would interview the patient if she took the thyroid hormone before or not. She probably would have said "Yes, I have taken the thyroid hormone before" and I would say, "Next time do not do that". So, if there was no clinical sign of hypothyroidism and an explanation of thyroid hormones before, which is the case, I really think – this is really honestly and everything – I would do the blood test at the next consultation, before the next consultation.

Q Let us imagine just for a moment that Dr Skinner new of the problem about taking Thyroxine just before a blood test and did it properly and left the right amount of time, so let us just imagine that he was competent taking his blood test, and you get a blood test back which shows that the TSH is negligible, or unrecordable, and that the T4 is 27.2 and the T3, which I think we on page 44 – it is the same test but then we get the T3 back – is also outside the reference range, although only just, 7.7. Let us just presume that that blood test is correct. What would you have done?
A Again I have to say that this is not relevant because it is most probably because the blood tests have been taken before because also the high T3, but I would certainly check

again, done the blood tests if I am sure, I am absolutely sure, that the patient took the thyroid hormone before, which I think is not the case here.

Q So you get it back and it shows the same results. What do you do?
A If I get such a result back, then I would see back the patient and try to find how this could be with… but normally when you have an overdose, an over-medication, you also have the clinical signs and symptoms, so I would recheck the clinical signs. I might have been I would say ... (*inaudible due to video link sound interference*) ... but there is no real sign that this would be the case.

Q Would you abandon your goal of trying to keep this patient within the reference range? Would you just forget about it and carry on?
A Certainly for the thyroid hormones, if the blood test is taken adequately, I would try to keep the lab tests of the T4 and the T3 within reference ranges.

Q Let me move on to ---
A Except maybe in the one patient in thousands where the situation could be different, but not on a classical case.

Q I want to turn, finally, to a different topic, that is, the kind of research that you rely on. Let me just put some documents away; give me a moment. You do not need *that* big bundle any more for the moment. You will remember that Professor Weetman produced, in relation to treating sub-clinical hypothyroidism and the definition of the upper limit of the TSH, his Appendix 2. I am not going to ask us all to go back to Appendix 2, but it was a report published in the European Journal of Endocrinology. Do you remember it? We can go back to it if you want. This is Appendix 2 of Professor Weetman's report. We have looked at it on a number of occasions. It was a study to which he had contributed and it included observations from Germany, Italy, Poland, Denmark, the Netherlands, Hungary, and it was a wide study that was peer reviewed. Do you remember that?
A Yes, I have it before me. I have it with Professor Weetman's curriculum vitae.

Q You will see in the abstract – and I have read the whole of the report – just dealing with the abstract for the moment, the last five lines:

> "When summarising the available evidence for the lowered upper TSH cut off values and the potential therapeutic implications, there is presently insufficient justification to lower the upper normal limit of TSH and for practical purposes it is still recommended to maintain the TSH reference level of 0.4 to 4. Classifying subjects for the TSH value between 2 and 4 as abnormal, as well as intervening with Thyroxine treatment in such subjects, is probably doing more harm than good."

You do not think that that report was right, do you?
A I think there is a debate. Like I told to yourself, there is a grey zone where people can be or cannot be treated within the reference range because they have clinical signs or symptoms or not of hypothyroidism. So I think this report, everything is still controversial, what I really think is the truth.

Q Dr Hertoghe, you have produced a report that we received on Friday and ---

MR JENKINS: The Panel have not had it.

MR KARK: Have you got it?

MR JENKINS: Yes.

MR KARK: I did not know whether Mr Jenkins was intending to hand this in anyway. I think he was.

MR JENKINS: Yes.

MR KARK: Then can we have it now, please? (*Same handed*)

THE CHAIRMAN: This will be D19.

MR KARK: I am just going to hold it up to you, Dr Hertoghe. Do you remember *this* report? It is Dr Hotze's report.
A Yes.

MR KARK: Is there another copy?

MRS WHITEHILL: Shall I share with Mr Payne?

THE CHAIRMAN: For the moment, but obviously you should have your own copy.

MR JENKINS: We only have eight in total. The Panel have five, Dr Hertoghe has one and Mr Kark and I each have one. We can certainly copy it.

MR KARK: Dr Hertoghe, this is a report that you are relying on by a Dr Steven Hotze?
A This is a report where the consensus number 9 was not relied on, but there was an ask to many doctors to provide evidence in their own consultations. This is one of the first studies coming in and it has not yet been approved for publication.

Q Were you intending to rely on it or not?
A Rely on what?

Q On this report. I thought that is why we were being given it?
A This is just to show that other physicians in other countries do treat patients within the reference range and it shows that those patients, not all, do improve with treatment and gives you a sort of classical picture.

Q Are you relying on this as a serious piece of research?
A I am relying on the studies I showed you previously that have been published in peer review journals. This is just to show that other doctors are doing treatment within the reference range in other countries.

Q There may be other ---

A It is the first… What?

Q There may be other doctors in other countries doing what Dr ---
A There are certainly other doctors. This is the first… We launched – how do you call them? – a demand to doctors to bring evidence in on treating patients within the reference range. This is not a study where what I say is sustained on or supported by. This is just one of the studies that we still have to analyse to see if it is okay for publication and it has also to be written differently.

Q So are you saying that you would not rely on it as a piece of published research?
A On its own, it is not enough to rely on it. It is just one education(*sic*). The purpose was not to prove that it works. The purpose was to show that other doctors were doing this sort of treatment.

Q Dr Hotze has got himself into a lot of trouble, has he not, with the American Association of Clinical Endocrinologists in the States? Do you know about that? He appeared on television and ---
A No, I do not know about it. I know that he is a leading figure in the fact that the reference range is not adequate.

Q Well, almost not relevant. He is of the Dr Broder Barnes school, is he not?
A I would not say it is not relevant because he does produce a blood test, so I would disagree with what you have just said.

Q He does produce a blood test, but let us just look at what he does with it. This is not particularly easy to follow, but if we look at the bottom right-hand corner of page 1, do you see the box headed "TSH before Treatment"?
A Yes.

Q There are some people with a TSH of just over 4.5 and some people – patient number 10 by way of example – who have a negligible TSH - yes?
A There is one patient where the TSH is very low.

Q He gives them all – Armour Thyroid and ---
A More than four.

Q He gives everybody Armour Thyroid, does he not?
A This is typically patients within the reference range of TSH, except the one on the bottom cannot be included because it is under the reference range. This study has already one little flaw. One patient should certainly not be logged with the group.

Q This is a retrospective study, is it not?
A Yes, so if they have less quality to a double blind placebo control.

Q I was just about to ask you that. I am glad you came out with it.
A Can you repeat the information you just said please?

Q Compared to a double blind placebo with a control group research this is very, very much weaker, is it not?

A I would not say very, very weaker because the evidence was quite clear here that there was major improvement, but I would say still we should rely more on double blind placebo controlled studies. There only problem is there is only one real double blind placebo controlled study, so it is not sufficient to make a conclusion.

Q Which one was that?
A The Pollock study in the British Medical Journal and it was also a small study. A retrospective study does have more value when the kind of improvement is important. Here the degree of improvement was quite important.

Q This was one doctor retrospectively looking back at 39 of his own patients?
A Yes.

Q It is a doctor who is very much involved in this particular debate, is he not?
A Yes, I think so, like Dr Weetman is also very involved, I would say, in this sort of argumentation.

Q He, with respect, at least has the qualifications as an endocrinologist, does he not?
A Yes, but you saw his curriculum vitae, almost a pure general practitioner education which is not sufficient, I would say, to be an adequate doctor. It is mainly general practitioner education of what I have read from the curriculum vitae. You saw it yourself.

Q When you finish this case and you carry on with your practice over the course of the next week or so, are you going back to your anti-ageing medicine practice?
A I did not well understand. What is the link between anti-ageing medicine?

Q I just want to know. When you have finished giving evidence about thyroid treatment in this case and you go back to your normal run of patients, what proportion of them will be coming to you for anti-ageing medicine?
A In a sense I have no patient who comes for anti-ageing medicine, a very small fraction. What I have is patients who suffer and that I do have to improve. Many of those patients have hormonal deficiencies or hormonal problems, sometimes hormonal excesses.

Q When you say a tiny fraction, are you going to treat the majority of your patients with Thyroxine?
A The majority would be too much, but many of those patients are patients who have gone through a long history of medical problems. Many of those are hypothyroid. I cannot say that they are 90% patients, certainly not. That is too much of a figure, but probably certainly more than 50%. Those patients are very much your patients. They have gone through a long history of medical problems. That is the majority of my patients.

Q Do you regard most of those as having thyroid problems or simply generally hormone problems?
A Thyroid problems and I only give thyroid hormones when there is deficiency in the hormone.

Q You are now the President of the World Hormone Society?

A The International Hormone Society.

Q Are you planning to get a leading endocrinologist on to the board of that society with you?
A Yes. I think this is a good way to progress.

B Q You do not have one at the moment, do you?
A Yes. We do have Professor Bowyer. Professor Beaulieu is the highest authority in France scientifically, Emile Beaulieu, in all our directory of companies. In France the highest post in science is being President of the Academy of Science. He has this title three years ago, during two years the presidency. He is considered as a major figure in endocrinology, Professor Etienne-Emile Beaulieu.

C Q Are you saying he is on the board?
A He is also prefaced two of my books on medicine for the general public.

Q Are you saying he is on the board or one of the governors of the International Hormone Society?
A He is in the World Society of Ante-Ageing Medicine and he accepts to go in other committees. There is another one who accepted to be a lecturer at our international… I
D am just talking about the major personalities. Professor Russ Reiter (?) from Dallas Texas. He has published more than 1100 studies on the midline data bank. He is a very famous professor.

Q You keep coming out with these figures of 1100 studies and in your report you cite many, many studies, but your evidence earlier this morning is that there is only one double blind cross-over trial and that does not support the contention…
E A No.

Q …that people within the reference range, in other words that sub-clinically hypothyroid should be treated, does it? It does not support that contention?
A That is correct, but giving with Thyroxine only medication.

Q Thank you?
F A Can I just comment? You have said that headaches were in the textbook on endocrinology. This is the most important textbook of endocrinology, the Williams Textbook of Endocrinology. On page 463 in the bottom of the first column it is written that in hypothyroidism headaches are frequent. To my knowledge this is the most known textbook on endocrinology. I did fax to the Secretary the copy of the papers.

G Q We have not seen that, I do no think.

MR JENKINS: I have it.

MR KARK: Can I see it please? (*Same handed*) (*Pause*) Dr Hertoghe, when did you come across this? Dr Hertoghe, when did you come across this?
H A This weekend. When I came home I went to see the textbooks. The first textbook I opened was this one and this is already sufficient for me, because this corresponds because what we feel is practice.

Q I am afraid I have not had an opportunity of looking at this. You accept, I think, having looked at again, that headaches do not appear, for what it is worth, in the Werner and Ingbar book as a clinical sign of hypothyroidism…
A Yes, but…

Q …except in cases of pituitary cancer?
A But that is a very technical book. You do not really learn how to treat patients there.

Q I see. Thank you. There is another text here about the TSH controversy, an article published in the more important journal, the Journal of Endocrinology and Metabolism that shows that evidence for zero TSH are (*inaudible).*

THE SHORTHAND WRITER: I am sorry. I cannot hear.

THE WITNESS: I think it is a good answer to the article produced by Professor Weetman.

THE CHAIRMAN: Dr Hertoghe, they were having a bit of difficulty hearing that last one, but I think now we will hand questions over to Mr Jenkins.

Re-examined by MR JENKINS

Q You have sent through some documents, including the page that you have referred to in Williams Textbook of Endocrinology. I am going to ask for the Panel to see that. You have also attached to it an article by Wartofsky and another author. Would you like the Panel to see that? You have said that is an answer to the article that Professor Weetman produced?
A Yes. Wartofsky is a more important authority on endocrinology.

THE LEGAL ASSESSOR: Excuse me.

THE WITNESS: I think it is worth reading the article.

THE CHAIRMAN: Dr Hertoghe, could you wait one second? The Legal Assessor would like to comment.

THE LEGAL ASSESSOR: Can I remember please? Dr Hertoghe is a witness. He may be an expert witness, but he is still nevertheless a witness. When he retired on Friday night, of course he was not going to have communication with anybody concerning his evidence. Perhaps you would care to explain, Mr Jenkins, quite how much communication has taken place and quite what papers it is now proposed that this witness is going to put before the Panel or perhaps you would like to have a little think about the position.

MR JENKINS: I have had no communication with Dr Hertoghe, nor have my solicitors. I know that he sent through to my solicitor's secretary copies of these documents. That is what has happened.

THE LEGAL ASSESSOR: It may be that the doctor himself does not quite understand his position as a witness and his position of what he should or should not have done while he was still in the witness box.

MR JENKINS: Can I correct myself? I am told the documents were sent through to the Panel Secretary, not to Dr Skinner's solicitor. We have not spoken to him. We have just been given copies of these documents. That is what has happened. He has sent them through to the GMC. I see a nod from behind you from the Panel Secretary. There has been no communication with Dr Hertoghe until he felt that these documents are relevant based on the evidence that he gave last week.

(*To the witness)* Is that right? Can you hear me Dr Hertoghe?

A I did not hear you too clearly, but when I came home, like always, I get to search the information. I had no contact whatsoever with Mr Jenkins. I sent to the Secretary, Judith, this morning text and I asked her to make 15 copies of each note. I was a little surprised that later on I hear that Mr Jenkins has this information. It was only meant for the Secretary and to be distributed to all participants. I think this evidence is important. That is why it is sent. Was there any mistake? I do not understand.

Q I do not know that anything improper has happened. I certainly have not done anything improper. It is not unusual for someone giving evidence as an expert to think that there may be more material that the Panel should see. As I understand it, that is exactly what has happened.

MR KARK: I do not have any criticism in fact of what has happened, given that explanation. Of course I accept from Mr Jenkins that he has had no contact with the witness.

THE CHAIRMAN: Thank you. We will call this D20.

MR KARK: What I am concerned about is that this was never put to Professor Weetman. He has never had an opportunity of dealing with and, frankly, nor have I. I now do not have an expert with me. We will see how we have to take that forward.

MR JENKINS: I am going to ask that you see this. Can I ask if it has been distributed?

THE CHAIRMAN: Yes.

MR JENKINS: (*To the witness*) The front page is a rather larger copy which is reproduced on the second page. I think, Dr Hertoghe, you have underlined the part of the text where it says "Headaches are frequent"?

A Can you speak closer to the microphone?

Q I will. Is it your underlining of the passage "Headaches are frequent"? Did you underline it?

A Yes, I underlined it.

Q Do you have the page in front of you, 463?

A Yes, I do.

Q Can I take you on to the next column?
A Yes.

Q If you go down about ten lines does it say this:

B

"Thick, slurred speech and hoarseness are due to myxedematous infiltration of the tongue and larynx, respectively."

A Yes, I see this.

Q It goes on:

C

"Body movements are slow and clumsy… Numbness and tingling of the extremities are frequent;"

A Yes.

Q There is mention of carpal tunnel syndrome. The tendon reflexes are slow, especially during the relaxation stage?
D
A Yes.

Q If we turn to the third page, have you shown us the front of the book "Williams Textbook of Endocrinology, 9th Edition"?
A Yes.

E Q This is the book from which the passage we have just read has come?
A Yes. It is to my knowledge the most important endocrine book, the most known endocrine book on endocrinology.

THE CHAIRMAN: Could we ask the date of publication of the book please?

MR JENKINS: Do you know when the book was published? If you have it in front of you, you should be able to tell us very quickly?
F
A I think an old edition is the one I have here. Saunders is a big company, but let me see. 1998, this edition. Normally Dr Weetman has this book.

Q If we go to the next page you have included an article by Wartofsky. That deals with the suggestion that the range for TSH, the reference range, should be narrowed?
G
A Yes.

Q Is there anything in particular you want us to look at in that article?
A It has a lot of different information, also the average value of healthy people is around 1.5 and so it makes us think a lot that many patients within the reference range could be hypothyroid. Actually it is full of very interesting references. I would point out one thing. It is interesting to know that we have this sort of article published in the more important journal.
H

Q Can I take you to the fourth page of the article, please, in the right-hand column about 15 lines up from the bottom?
A Are you on the first page of the article or which page?

Q The fourth page.

THE CHAIRMAN: You are on the first page of the Wartofsky article?

MR JENKINS: No, I am on the fourth page of the Wartofsky article. I am sorry. It does have (iv) and it has figure one at the bottom.

(To the witness) I just want to ask you about a passage in the right-hand column about 15 lines up from the bottom where they say, "In the final analysis." Do you have that passage?
A Fifteen.

Q I think it is 13 lines up from the bottom, in fact.
A Okay, I have it.

Q

> "In the final analysis, we aim to employ our best clinical judgement and do what is optimal for our patients. Given the wealth of data on the abnormalities present in untreated sub-clinical hypothyroidism or hyperthyroidism and the demonstrated benefits of therapy to date, we are not disposed to have our hands tied by the deficiencies inherent in analyses of this issue by evidence-based medicine and allow our patients to continue to be at risk as a consequence. Clearly, one thing that all parties to this controversy can agree upon is the need for large-scale, carefully constructed and performed studies."

Over the page at the end of the article the authors say:

> "Assessment could include a review of their personal and family medical history and serum cholesterol and thyroid antibody levels and the decision as to whether to initiate a trial of levothyroxine therapy is based more upon the 'art of medicine' at this time than the science."

Without going ---

MR KARK: I am sorry to interrupt, but I am slightly troubled about this. This article was not written until 2006.

MR JENKINS: Fine.

MR KARK: Well I am looking at whether it is 2005 or ---

MR JENKINS: It was received on March 1, 2005 from the fifth page, just under "acknowledgements".

MR KARK: Sorry, I am looking at the first page of the article which has the heading

"Controversy in Clinical Endocrinology. Department of Medicine," and then it ends with the ---

MR JENKINS: I think this is a zip code.

MR KARK: A zip code.

MR JENKINS: If one looks to the top of that page in small prints we have, "Copyright 2005 by the Endocrine Society." Does that help? If one turns back to the fifth page of the article under "acknowledgements," we see it was received 1 March 2005 and accepted on 29 June 2005.

(To the witness) Going back to the passage I read to you, the two passages about clinicians not wanting to have their hands tied by evidence-based medicine and assessment being based more upon the art of medicine at this time than the science. Do you agree with those sentiments?
A Yes, I agree totally. You also have to know that Professor Wartofsky is the official endocrine representative of the Endocrine Society when they have to negotiate with American Parliament. So he is really an authority there.

Q Have you then attached three pages from another text book?
A Yes.

Q The last page of the bundle of materials sent through, is that the front page of the text book?
A Yes.

Q Dealing with the endocrine system and selected metabolic diseases. Thank you, you are holding up the book for us. Can you tell us when it was published?
A It is a very old book because an American … *(inaudible due to video link sound interference)* … years ago but it was very famous in medicine the … *(inaudible due to video link sound interference)* … he made drawings of patients with all sorts of pathology. This is his book on endocrinology and it is taken out and it is a very clinical book but it takes the most important clinical signs of each deficiency in hormone and … *(inaudible due to video link sound interference)* … I have taken.

Q I see that it is a book of medical illustrations and it may be that conditions have not changed, but just tell us the date of the book if you can find it?
A 1965.

Q I understand. The two pages which you have included with illustrations, have you included those?
A These pages?

Q I see. You are showing us what it looks like. It has not come through terribly well on the photocopier, but you are showing us the page that has been copied?
A So what it looks like, I do not know if you can see ---

Q We can.

A You can see a drawing of the patient and all the different figures and, for instance, the … *(inaudible due to video link sound interference)* … that we saw in the clinical examination with dental impression, typical signs of low thyroid function. Also the dry skin that is coughed up and also the puffiness of the eyes. So it is like when I look at … when I looked at these like Dr Skinner in his report had read this book before.

Q Yes, thank you.
A Also signs and ---

Q I do not think I need ask you any more questions. Thank you very much, Dr Hertoghe.

THE CHAIRMAN: Thank you. Dr Hertoghe, we will take a break now for 20 minutes so that will be about ten to twelve we will commence again. Can you hear? Is that all right?

THE WITNESS: It is all right for me.

THE CHAIRMAN: Thank you.

THE WITNESS: I will be waiting then.

MR KARK: Madam, I obviously do not want this to go on for ever, but just having received this report, I may have a few questions to ask about it. I have not seen it before.

MR JENKINS: Of course, I would have no objections to that.

MR KARK: Thank you.

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Kark, are you ready?

MR KARK: I am sorry, yes, I am and I have just got Dr Hertgohe ---

THE CHAIRMAN: Sorry, we have just lost the doctor.

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

Q Are you back with us, doctor?
A Can you hear me or not?

Q Yes, can you hear me?
A Yes, I can.

Q I just wanted to ask you one matter in relation to this article by, is it, Professor Wartofsky? Could you go to the same passage that was read to you by Mr Jenkins at (iv)? Are you there?
A On page 4, is that the one you want?

Q That is. Right-hand column, four lines up.

"Clearly, one thing that all parties to this controversy can agree upon is the need for large-scale, carefully constructed and performed studies."

Do you see that?
A Yes.

Q Reading on:

"Until those data become available, a more precisely determined reference range for TSH of 0.3-2.5 will permit detection of individuals at risk of overt thyroid disease and should prompt their additional follow-up to confirm progression into thyroid dysfunction and thereby justify initiation of therapy."

Can we just pause there for a moment to try and understand what that means? First of all, they are suggesting a more precisely determined reference range of 0.3 to 2.5. Yes? Is that right, doctor?
A Was that a question?

Q Yes.
A So ---

Q Can you confirm ---
A What he is proposing is … *(inaudible due to video link sound interference)* … a new reference range between 0.5 and 2.5 until we get more information.

Q Well I think it is 0.3 to 2.5, is it not?
A Yes.

Q Right. What it is suggesting, as I understand it, but please help us, is that if you have a reference range at that level with an upper limit of 2.5, it will permit detection of individuals at risk of overt thyroid disease. In other words, those people over 2.5. Yes?
A Yes, that is right.

Q And should prompt, in relation to those people, their additional follow-up to confirm progression into thyroid dysfunction. In other words, if you have somebody who is over 2.5 you would want to test them again to see if there has been progression into thyroid dysfunction. Yes?
A Yes.

Q So you would want to check them to see if those levels were changing which would indicate thyroid disease.
A Yes.

Q It is not saying certainly in that paragraph (and forgive me but I still have not read the whole of it) that you should immediately treat those people over 2.5, is it? It is suggesting that you should check them.

A Actually he does say later on that when you have a clinical picture you probably should treat in that grey zone.

Q What, if you have clinical signs of hyperthyroidism at over 2.5 then you could treat them. Yes?
A Yes.

Q Okay. Just to continue to finish off this section:

> "We will probably never have an absolute cutoff value for TSH distinguishing normal from abnormal, but recognition that the mean of normal TSH values is only between 1.18 and 1.40 and that more than 95% of the normal population will have a TSH level less than 2.5 clearly imply that anyone with a higher value should be carefully assessed for early thyroid failure."

Yes?
A Yes.

Q

> "Thus, we believe that a TSH level between 5 and 10 deserves confirmation and, if confirmed, warrants treatment. More judgment is required until more definitive data are available for the management of those patients with TSH values between 2.5 and 5.0."

A Yes.

Q I am just going through it to try and understand what this article is actually saying. All right? On those values, applying the 2.5 as the upper limit of the reference range, none of these patients with whom this Panel are dealing fall outside that reference range, do they?
A Yes. None of those are above 2.5.

Q No. None of them would fall outside the reference range that Wartofsky is suggesting.
A But you have to know what Wartofsky is suggesting is that above 2.5 there is progression into overt hypothyroidism. The risk is much higher ---

Q I understand.
A He is not … that is just part of the topic. It does not approach the whole topic that says that with the studies that show this pathology under 2.5 … *(inaudible due to video link sound interference)* …and even under 2 in certain circumstances. And so the grey zone can be considered as marginal because he is just talking about one little section of medicine where you have the 2.5 and 5.0, a progression from an earlier failure to an over failure. The risk of this is very high. So we are … he is just talking about thyroidism and for that middle part he found that treatment could probably be instituted if there are also clinical signs and symptoms and a medical history.

Q You would reduce that even lower to 2?

A If the grey zone, like I said, where some people may or may not be treated and I would rather put it under … between 1 and 4, or 2 and 4 … 1.5 and 4 where patients have … *(inaudible due to video link sound interference)* … in the cells of hypothyroidism and it should be treated, but he is just talking about one little section. We need the whole section.

B Q I am sorry, Dr Hertoghe, I just want it to be clear. What are you saying should be the upper reference range?
A So what I say is that in the upper half, or upper two-thirds of the reference range, some patients who do, some patients who do not have to be treated, and how do you know? Well, you have to do a clinical picture and a clinical assessment. People who feel fine who have a TSH of 3.5 or 3.8 should not be treated. People who have a lot of symptoms that are typical of hypothyroidism above 1.5 or above 2 have to be treated
C because they are hypothyroid and the treatment will give a definitive answer, if it is adequate or not. If a person does not need thyroid hormones, he has clinical signs of overdoses when he is treated between the reference range.

Q I am sorry, Dr Hertoghe, from that answer I am trying to glean what you are saying about the range. Are you saying that anybody over 1.5, which you have just mentioned ---
A Okay, so ---
D
Q Hold on, hold on. Dr Hertoghe, the purpose of your evidence is to answer questions, so let me ask a question first. Are you saying ---
A I do not understand your question. Could you speak louder, please?

Q Are you saying that anyone over 1.5, which is a figure that you just gave, is in danger of developing hypothyroidism and therefore should be repeatedly monitored? Is
E that what you are saying?
A No. What I am saying is that people with a TSH above 1.5 or higher may have some kind of mild thyroid failure, of hypothyroidism. How do you know? Well, you go and examine the patient clinically and you eventually also enzymes in the blood, or whatever, and that gives you the whole clinical picture. If they have indeed those signs of similar hypothyroidism, they deserve to have a therapy trial.

F Q So what you are saying is that if a patient is anywhere over 1.5 ---
A Or 2; we are still in discussion about that.

Q 1.5 would cover approximately what, half the population? How many people in the population would ---
G A It can cover half of the population, but do not forget that the reference ranges are based on the patients who go to the laboratory. It is generally not optimally healthy patients.

Q I am sorry, I just want to know if you took the TSH values for 1,000 in London, how many of those ---
A Can you talk louder, please? I do not hear.

H Q If you took the TSH levels of 1,000 in a normal iodine efficient, not deficient, population, so they have sufficient iodine, how many of those would you think would

have a TSH of over 1.5 – what proportion?
A I think I understood. If you said that if you take a population that has no iodine deficiency and no thyroid pathology, that the TSH is what…?

Q Over 1.5. How many of the population does ---
A Well, it is about 1.5, but it is still not optimal condition, because again it is based on lab tests where they have not examined the patient clinically.
Q I will ask you one more time.
A It is not optimal ---

Q Can you just listen, please?
A What?

Q Can you just pause for a moment and listen to the question? Are you able to give us a percentage figure of how many people in the population would have a TSH of over 1.5?
A In classical studies like the lab tests are done for the moment, which is still not optimal, 50 per cent have a high level, but that does not mean that 50 per cent have to be treated. Fifty per cent may merit investigation to see if they have symptoms of thyroid deficiency or not, and also medical history.

Q So about half the population, you would think, would merit investigation for thyroid deficiency?
A Yes.

MR KARK: Thank you.

THE CHAIRMAN: Mr Jenkins, do you have any follow-up questions?

MR JENKINS: No.

Questioned by THE PANEL

DR ELLIOT: Dr Hertoghe, can you hear me?
A I hear you, but please speak loud, near the microphone.

Q I have now got two microphones. Does that help?
A Good, yes, that is better.

Q I want to ask you again about the reference range for TSH. You showed us a slide in your presentation on Friday, which is in our bundle D14 on page 47.
A *This* slide?

Q It was your slide. It was the bundle that we have labelled D14.
A *This*?

Q That looks like it. It is headed, "Reference values of thyroid tests" at the top.
A Yes, my slide.

Q You will see the reference range 0.3 to 2.5. You say that that is evaluated on persons without thyroid abnormalities?
A Yes.

Q Can you tell me the source of that particular graph? Where did those figures come from?
A What they have taken are patients that… This is a sample of patients who do not see any thyroid abnormality, no nodal or goitre, patients that ---
Q Yes, I understand that, but who did this study? From where did that reference range come?
A I do not remember the name. I can find it up quite easy. Let me see whether it is here. (*Short pause*) It is Appendix 17 in my file. Actually it is the following: it is three studies based on studies from Demers and Spencer in 'Clinical Endocrinology'. Spencer is a very famous physician. The ones she did the NSCP guidelines. She wrote the NSCP guidelines and then they were reviewed by others – Hollowell and Staehling in the Journal of Clinical Endocrinology and Metabolism 2002, and 2003 Balloch. Those individuals had no personal or family history of thyroid dysfunction, no physical or palpable goitre, were not taking any medication and did not have thyroid antibodies.

Q Do I understand then that that reference range was derived not from a group of patients, mainly sick persons who go to the laboratory, but from a group of people who had no history whatsoever of thyroid disease? Is that correct?
A People who had no thyroid disease, but we do not know if they had other diseases. They were considered as healthy.

Q In that group, the upper limit of the reference range was 2.5?
A Actually it is only for one study, Balloch, because the other two studies said it was from 0.4 to 2. The studies of Demers and Hollowell actually pointed out that the upper limit should be 2.

Q The next thing that I want to ask you about is something that you said this morning. You said that you often try a therapeutic trial of thyroid hormones in patients who are suffering symptoms. I just want to ask you how long you would continue a therapeutic trial, because you also then said that if the treatment does not work, you would stop it. How long would you continue a therapeutic trial of thyroid hormone in a patient who had symptoms which you considered could be due to hypothyroidism but whose tests were within the reference range?
A Well, the minimum time would be three months to four months. That would be a minimum time if there is no direct evidence of hypothyroidism or thyroid hormones that are not tolerated, but if it well tolerated, I would at least consider three or four months and make a good clinical evaluation. If the dose is too low, there will not be much improvement, you have to continue the trial until you get an optimal improvement and you have to do laboratory tests optimally, and a clinical evaluation has always to be done to be sure you are not doing something wrong.

Q How long would you continue a therapeutic ---
A Now if it works ---

Q How long would you continue a therapeutic trial?

A If it works…

Q It is not working.
A …it could become a lifelong treatment if the patient needs the therapy, because if the patient stops, they go back to ---

B Q Yes, I understand that, Dr Hertoghe, but what I am talking about is if the treatment does not work, how long would you continue a therapeutic trial?
A I think you would ---

Q Because we have agreed, I think, that there are other possible causes of some of the symptoms of hypothyroidism?
A Yes.

C Q You may be wrong in your diagnosis. How long would you continue a therapeutic trial?
A I would not continue longer than six or eight months personally, but often I have enough data to understand what is the problem before, if there is another part of the symptom.

D Q In someone who has hypothyroidism which has been confirmed by laboratory tests, or indeed in one of the classical forms of hypothyroidism which you showed us in your slides, how long would you expect replacement treatment with thyroid hormones to take before there is an observable clinical effect?
A You need a minimum time of two months before you have sufficient improvement, because it is also because you start on low doses, so you need two to two months and a half or three months to really have visible signs that are clear that it is
E improving.

Q I was struck by one of your clinical photographs, or perhaps it was one of your grandfather's photographs, in which a patient with myxoedema had clearly improved in a photograph two months later.
A I did not understand the last part of your…

F Q A patient who had clinical myxoedema in one of the photographs that you showed us had clearly improved from the photograph just two months after treatment started, and I believe you said that hypothyroidism was a very satisfying disease to treat because of the clinical response?
A Yes.

G Q What is the normal pace of a clinical response in someone who is suffering from hypothyroidism?
A Some patients can have already in the first week improvement. Those patients are the ones who will improve also the best and the quickest in general, but most of the patients will feel a difference from the second month on. One of the reasons that they had quicker improvement is that at all times they went also quicker, they went on higher
H doses, so the difference was quicker. Now we are more prudent because some patients may not tolerate the thyroid hormones so well, so the doses are much lower to start and more progressive, so the improvements are also lower.

Q If you are treating someone who has thyroid function tests outwith the reference range – in other words, someone who has biochemical as well as clinical hypothyroidism – do you start them on small doses of Thyroxine?
A Yes.

DR ELLIOT: Thank you.

THE CHAIRMAN: Dr Hertoghe, I know that it is a bit difficult with the time lag and everything, but I would just ask you, please, to slow down your speech, if you could, and keep your answers as concise as possible, and please try not to talk while the other person is talking. I know that it is difficult, but let us proceed.
A Thank you.

MRS WHITEHILL: No questions, thank you.

MR PAYNE: Dr Hertoghe, can you hear me okay?
A I hear you but it is better if you are closer to the microphone.

Q Can you hear me better now?
A Yes, better.

Q I do not have many questions for you. We have heard a lot about the reference range and other alternative measurements within that reference range and measurements that you think are the optimal figures for the reference range, but is there any measurement at all that you would not treat someone for a thyroid complaint, that you believed was a thyroid complaint?
A Sure. If the patient has values within the actual references ranges and feels perfect and has no physical signs of deficiency, I would not treat that patient.

Q Is there any measurement where, say, perhaps people do have those symptoms but are within a particular reference range that you find is acceptable but they have the symptoms? Would you treat those patients?
A I am not sure that I have understood your question fully. If what you mean is if I have a patient who is within the reference range and has a few signs, if I would treat them or not, or what is exactly the question? Can you repeat it?

Q I will try my best. We have talked about the differences in the reference range and what people think is the best place to be and the optimum position for reference, but is there anyone that you would not treat who has the signs and symptoms of a thyroid problem but falls within the optimum reference range? Is there anyone that you would not treat? Is there any range at all that you would not treat someone?
A A good question! I always do additional testing, so if all the other additional testing for other endocrine deficiencies and the medical history are completely positive – I mean are negative – I mean I find nothing – if I find no other cause, the patient is suffering, is within the reference range and has clinical signs and symptoms, I probably will treat that patient, but I will do additional testing for central hypothyroidism to see if it is not the brain that is weak and that is why the tests are good. In a certain sense we always have so many patients with clinical signs and symptoms that it is a very rare

situation where it is so clear that they have to be treated. I would treat a patient who had severe symptoms at least. If it is mild I probably will not treat, but if it is severe or moderate enough, strong enough, I would treat these patients.

Q I think you did say in your evidence that you gave on Friday that you would do periodic blood tests and you would do them before, on a regular interval, just to see what the blood test measurements were. Is that correct?
A Yes, before each consultation generally.

Q If, for instance, you felt it was necessary to adjust the amount of Thyroxine that you were going to give to someone you would want a blood test to at least have the readings in front of you?
A If I understood your question well, I would want to have a blood test always before, but I have patients who come in in emergencies where I do a clinical evaluation and I can adapt those following that even without a blood test.

Q In a situation where Dr Skinner is where it is not an emergency, he had one patient that he saw on three occasions and did not take a blood test. You are saying that that is not the optimum way forward then. You would have wanted a blood test for those?
A It is not the optimum, but it is a way that many physicians also who work in this field work like this. I would not say it is out of standard, but there is still improvement possible in his way of treating.

Q If you have not got one of these blood tests, how do you know the right amount to increase or decrease the medication?
A That is very easy. You examine the patient. There are physical signs, even listening to the heart, the way it bounces. You really have the idea of whether it is enough or not enough or too much. Then I also have specific questions about how the patient feels. It is so much difference between too much and too low. It is so clear. When you look to find the symptoms it becomes very easy, but you need a lot of time to do that. There are a lot of questions to ask and there is a lot to look at, physical examination. Just on one sign, on one symptom I would not adapt the dose.

THE CHAIRMAN: Dr Hertoghe, could I ask you to remind me again? You qualified as a medical doctor in 1986. Did you work then as, as we call it, a general practitioner? Did you work from then on in medicine?
A No. I did the first four months of psychiatry. I was officially accepted as psychiatry. Then when I saw that part of the treatments were not totally adequate I worked with my father in the endocrinology service. I actually only worked then mainly in endocrinology, in the hormone therapy. He was considered at the time a specialist. He had mainly thyroid patients, hypo and hyper.

Q From 1986 onwards you worked in this field and not as a general practitioner. I have got that. Could you fully explain to me please? You have an initial visit from a new patient. Can you give me total details of how you proceed with this patient, i.e. do you send them a questionnaire before they come to you etc., and I would like to know how you proceed, what examinations, what history and do you get any GP or doctors' notes? Thank you.
A Patients come to my place. They are only accepted if they have filled in an 18-

page questionnaire. Among the questions are two pages on thyroid function, especially hypo and some hyperthyroid complaints that patients can have. We check also the food. We do a medical history, which is the version that my father did in the beginning on the particular medical history for thyroid function. When they are accepted, because they have filled in their questionnaire, we give them an appointment. During one hour they are re-interviewed on the questions that seem not well answered or that need additional information. Then we proceed to a physical examination. That takes about 15 to 20 minutes and which is quite profound. Blood pressure is taken and the typical signs. We have a whole paper with physical signs of thyroid dysfunction where we fill in. There is also a paper for female hormone deficiency or male hormone deficiency, so there are a lot of other endocrine systems that are examined.

Also the food is examined, because some foods do lower the thyroid function. If you eat a lot of proteins you secrete the conversion of T4 or T3. You can have lower thyroid function. We try to give better advice so that before the next consultation, after tests have been done, the patients have already improved on the food.

After giving advice on the food we ask for lab tests in blood and 24-hour urine tests. Blood is just a snapshot, one moment at a time, so we do an additional 24-hour urine test also on T3 and T4 for the adrenal hormones. You get easier metabolised with the urines of 24 hours. You can get a good picture of 24 hours with urine tests. Then we see the patient back about one month later when all tests have come in. We tell them the blood tests and we prescribe the treatment to the patient and explain extensively. It takes another hour. We have papers that inform. If we treat the thyroid dysfunction we give a paper that gives an explanation on which points to watch out for. If you have too much, what happens? Please 'phone us or decrease the dose. We do a lot of teaching of our patients on how to do and how to contact us. We always say to the patient that it is better, if there are problems, to 'phone once too much. That is enough. Once too quickly, that is too late.

Q That was very full. Thank you very much. Without referring to tabs, you have fully looked at Dr Skinner's examinations, initial and follow up. Do you think the initial consultation provides sufficient information to then proceed with a diagnosis of hypothyroidism?

A Yes. Generally I found the questionnaires where patients put a mark or circle around the symptoms – it seemed to me adequate. We have more extensive questionnaires, but it seemed to me adequate. Physical examination is not as profound as we do, but it still seems adequate. He found a lot of signs in the later textbook of endocrinology, so I find that it was adequate to make a therapy trial.

Q I have heard what you have said about monitoring and the length between taking blood tests. Do you think that 13 months, whilst you are treating a patient and changing their dosages, between blood tests is too long? A simple question.

A It is because a number of my patients come once a year and they have indeed only once a year blood tests. Generally, when the treatment is well balanced some patients know so well how to lower the dose if ever there is a problem, how to recognise too much, that in some patients 12 months can be adequate, 13 or 12 months. I always to have one blood test at least every nine months or in some more difficult patients six months. In the long term I would say it can be adequate.

Q If one of those patients became clinically thyrotoxic within that time would you consider that 13 months was too long to follow up with a blood test?
A Certainly if a patient is quickly thyrotoxic those patients have to be monitored every six months. I did not really see a patient here, but certainly some patients are more sensitive. They need every six months. Some others know so well how to balance the treatment, they know how to decrease the dose that it can be safely done every 12 months.

THE CHAIRMAN: That is fine. Thank you very much. That is the end of questions from myself. Are there any further questions from Mr Jenkins or Mr Kark?

MR JENKINS: No, thank you.

MR KARK: No, thank you.

THE CHAIRMAN: That ends your evidence Dr Hertoghe. Thank you very much for participating. It has been a long and difficult morning, I know. That is the end of your evidence.

(*The witness withdrew*)

THE CHAIRMAN: Mr Jenkins.

MR JENKINS: I have got a witness I would like to call, Sue Conway. She has been here for a number of days. There is an objection to me calling her. For that reason I have to address you briefly as to the law.

Can I take you back to the notice of hearing please? Plainly there are many different factual allegations that you have to determine in this case, but they reduce to a similar allegation for all four of the patients. It is whether Dr Skinner was right to treat those patients at all. The allegation can be summed up under two of the headings, whether Dr Skinner's treatment or his prescribing for each of the patients was appropriate or responsible. The allegation plainly for each of the four is that his treatment of them was inappropriate and irresponsible. Plainly there are other allegations but that is the main thrust of the charge against him.

You have heard from two of the patients, A and D. You have heard from medical practitioners in respect of all of them. What I would like to do is to call another patient and to do so so that the patient's voice is heard more clearly in the evidence that you hear and that you consider, when deciding whether those allegations on Dr Skinner's treatment of A to D was inappropriate and irresponsible.

Evidence will be admissible, you can hear evidence if it is relevant to any question that you have to determine. If you are deciding whether a given factual allegation is proven or not, you are entitled to hear any evidence that may have a bearing on your determination of that issue. I can take you briefly to the rules. It will not take us long. Rule 34 of the 2004 Rules that govern proceedings at the Fitness to Practise Panels of the General Medical Council – I do not have a tab or a page.

THE CHAIRMAN: Tab D, page 35.

MR JENKINS: Rule 34(1) reads:

> **"Evidence**
> (**34.** - (1) Subject to paragraph (2), the Committee or a Panel may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.
>
> 2) Where evidence would not be admissible in criminal proceedings in England, the Committee or Panel shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable."

I say that evidence would be admissible in a court of law, but whether or not it is, plainly, under sub-rule (1), if your consider it fair and relevant to the case before you, you can hear Mrs Conway's evidence.

Can I give you some examples to illustrate where evidence from one patient may be relevant when you are considering allegations in respect other patients, because usually it would not be relevant. Can I give you an example of an allegation about a general practitioner who assessed a patient and missed a diagnosis. If there were concerns by experts that the general practitioners actions with respect to that patient were inappropriate and irresponsible in failing to make the diagnosis and to treat the patient appropriately, one can imagine that allegation being pursued at a Fitness to Practise Panel, that the doctor missed a diagnosis with respect to a given patient.

In those circumstances, the doctor and his lawyers may have other patients who were able to say, "He is a very good doctor." Is that relevant to whether that doctor's actions in missing a diagnosis and failing to treat appropriately were inappropriate and irresponsible? Plainly it is not relevant. It does not go to the issue of whether he missed the diagnosis or whether his actions were appropriate or not. If there were patients that the defence wanted to call to say that that doctor had previously made exactly the right diagnosis in similar circumstances. Is that relevant to whether this doctor's actions in respect of the one patient were appropriate or responsible? Again, the answer is no.

The testimonials about the patients, whether as to the doctor making the right diagnosis in similar circumstances or that generally he was a good doctor may be relevant to the question of impairment, whether his fitness to practise is impaired and they would certainly be relevant to any question of sanction. They are not relevant to the factual question of, in treating the patient as he did, missing the diagnosis and failing to institute proper treatment, were the doctor's actions inappropriate or irresponsible.

Can I take a different example, perhaps rather closer to this case? If a doctor undertook a surgical procedure on a patient and two experts were then to say that the doctor was irresponsible and inappropriate to undertake that surgical procedure on that patient, and the doctor faced a Fitness to Practise Panel hearing with exactly those allegations, this doctor undertaking that surgical procedure acted in a way that was irresponsible and

inappropriate, is it relevant to those allegations whether the doctor has ever done that surgical procedure before? I say it is. What if the facts were that the doctor had only tried that surgical procedure once before and it had been a dismal failure? Is that relevant to the question of whether he, in undertaking the surgical procedure on this patient, was acting in a way that was responsible or appropriate? I say it is plainly relevant.

What if, on the other hand, the doctor had done that form of surgical procedure on a thousand other patients before and had been remarkably successful? Does that have a bearing on whether the doctor's actions were irresponsible or inappropriate in treating the specific patient in the manner that he did? Of course, it does. Of course, it has a bearing on that. When you come to consider this case, the real issue is what would be and what would fall without appropriate treatment and that is the debate or part of it that we are engaged in.

Again, there are side issues about vitamin B12, side issues about the length of any trial, whether blood tests should be undertaken within the trial. As to the central question, was it ever appropriate for Dr Skinner to put patients with chemistry within the reference range but with apparent signs and symptoms of hypothyroidism, was it appropriate for those to be put on a trial of thyroid replacement therapy? I say it must be relevant for you to hear a patient's voice or what other patients were saying because if it be the case (and I do not pre-empt the evidence) that Dr Skinner has treated a number of patients highly successfully, that has to have a bearing on whether it is appropriate for him to undertake this form of treatment on these patients or not. That is the argument that I place before you.

You have, from much earlier in the case, eleven days ago on day one, you should have still somewhere in front of you three documents which we labelled D4(a), D4(b) and D4(c). These are letters written by Susan Conway to the GMC in 2004 … sorry, 2005, 2006 and 2007. I know you have read them, but I just draw your attention to them to remind you of their existence.

This is a lady who is able to say how she was treated by others. I do not require you to read them now but just as long as they are in front of you. This is a lady who is able to say that her health was poor, that she did not get good treatment before she saw Dr Skinner, and that when she came into his hands he treated her in a way that was very successful.

I say that having that information and being able to hear her give evidence in front of you is of relevance to the factual questions that you have to decide: was it responsible or appropriate for Dr Skinner to embark upon treatment of patients A, B, C and D? Plainly, I would like to call Mrs Conway as an example of other patients. Now, whether she thinks he is a nice man or not is not relevant; whether she thinks he is a sympathetic man or not is not relevant to the factual question that you have to determine, be it irresponsibility or inappropriateness of him in her treatment. I say you are entitled and indeed you should hear the evidence that she has to give.

Again, it comes back to what is the experience of the doctor in embarking on treatment which other doctors may say is not appropriate? If it is a doctor of some considerable experience in undertaking precisely that form of treatment, it is relevant for you to know

what level of success he has had in treating other patients before you come on to consider whether he is behaving irresponsibly or inappropriately. That is the submission that I make on the basis upon which I make them.

THE CHAIRMAN: Mr Kark.

MR KARK: I have asked my instructing solicitor to copy a case called *Campbell* which I think you have to consider as part of this application. I am afraid he is not back yet and I wonder in those circumstances if you might like to rise for lunch which we sometimes do early, come back early and by that time I will have Campbell copied and we can complete this argument.

THE CHAIRMAN: Fine. The Legal Assessor has a comment.

THE LEGAL ASSESSOR: I was just about to make a suggestion. Mr Jenkins, are you proposing to put before the Panel for their consideration the witness statement of Mrs Conway?

MR JENKINS: No.

THE LEGAL ASSESSOR: For, afterall, the Panel will have to consider what evidence she is going to give. They have got letters from Mrs Conway which were put forward in preliminary proceedings as to the recusal of the chairman, but they may not contain, of course, everything that she proposes to say.

MR JENKINS: I am content with those letters.

THE LEGAL ASSESSOR: So are you content that at this stage the Panel familiarise themselves with these letters and adopt that as the position of the evidence that she is about to give?

MR JENKINS: Yes.

THE CHAIRMAN: Mr Kark, you are content with that also?

MR KARK: Yes, of course, it will require slight mental gymnastics if the Panel decide not to hear the evidence. They will then have to put out of their mind what they have just read. Given the wealth of other evidence in this case, I do not suppose in this particular case that will be a problem.

THE CHAIRMAN: Thank you. So we will break for lunch until 1.30 then. Thank you. Is that long enough, Mr Kark?

MR KARK: No, I am sure that is quite enough. Thank you.

(The Panel adjourned for lunch)

THE CHAIRMAN: Mr Kark.

MR KARK: First of all, can we start by handing *Campbell* out, please?

THE CHAIRMAN: This will be C11 then.

MR KARK: It is not really an exhibit, it is a legal authority. I do not think it is necessary to give it a C number.

THE CHAIRMAN: All right. Thank you.

MR KARK: I will wait until everybody has it. *(Same handed)*

I know that this case will be familiar to many of you. This was a case under the old rules with the old panels where what had happened was that the defence had been allowed to produce what was essentially character evidence at a time prior to the Panel deciding the issue of serious professional misconduct. As a result of that they were taken to the High Court on appeal.

The summary appears towards the back of the bundle. Just before we go to the summary, could I take you to paragraph 26 just so that you understand the issue? Could you look at the part just above paragraph 26 from the top of the page? I am afraid the pages are not numbered. This is reflecting what happened in the committee. Do you see this three lines down:

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

So, first of all, I readily accept that the issue here was slightly different.

Can I take you to the summary. If we go to the top first of all. If you find paragraph 34, this is dealing with a report of Dame Janet Smith where she "expressed concerns," as we see at the top of the page,

> "which we share, that the Board required that the Committee considering

culpability should take account of material advanced in personal mitigation which was, 'as a matter of logic and principle, irrelevant' to the issue whether the doctor was guilty of serious professional misconduct. She acknowledged, as we do, that some evidence of potential mitigation might be relevant to the seriousness of the misconduct under examination. However she noted it was 'very common for the doctor to produce testimonials from patients and colleagues about his/her general abilities and character', potentially relevant to sanctions, but 'quite irrelevant' to serious professional misconduct. She observed:

> 'I have seen decisions in which it is apparent that, in deciding whether the doctor was guilty of serious professional misconduct, the Committee panel took into account purely personal mitigation from testimonials."

Well could we go to the conclusions starting at paragraph 46:

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

Well they decided ultimately that they being: Lord Justice Judge, Lord Justice Longmore and Lord Justice Jacob in the Court of Appeal, that (and this is at paragraph 58):

> "The Professional Conduct Committee erred in law in taking into account the personal mitigation advanced by Dr Birkin (namely, his 'unblemished medical practice' and personal testimonials) in deciding whether he was guilty of serious professional misconduct. That evidence was relevant only to the question of sanction, following a finding of serious professional misconduct."

Now that authority has a limited role here because obviously what the Court of Appeal was considering was different rules and different procedures, in particular the issue of SPM, but it does underline that you have to be very careful not to allow evidence to be given which is not relevant to the particular decision that you have to make at this stage of the proceedings.

The argument put forward by Mr Jenkins is this: you are considering the practice of this doctor and whether his prescribing (and head of charge 5 might be appropriate to take by way of example) to Mrs A was "inappropriate, unnecessary, irresponsible, not in the best interests of the patient and to place [the] patient at risk of harm."

First of all, you are dealing with four particular cases and you have all the records in relation to those particular cases and some of these cases you have heard from the patient and in two you have not, but you are concentrating on the particular four patients.

You are not in this case looking at the intention of Dr Skinner. His intention does not matter in our submission. He may have the very finest of intentions, but if what he is doing is medically wrong his good intention does not help him.

Let me just deal with the issue that Mr Jenkins made of the analogy that he used in relation to the surgical procedure. In other words, as I understood the argument, a surgical procedure out of the norm which two experts have said that was the wrong procedure by modern standards of medical practice that the doctors says, "Well I can call 1,000 upon whom I have performed this procedure and they are all very happy and walking about and comfortable." Would that be relevant?

If the evidence from the expert medical witnesses was, in the first place, that the surgery may well have been necessary, or that it was the wrong surgery to perform because in fact these patients may have been suffering from other problems in any event; and secondly, that even though the patients may feel fine for the moment, that sort of surgery will lead to long-term problems, then the fact that he has done it a thousand times in the past does not actually help him because on a medical evidence the surgery is still wrong.

When I, in due course, address you, I was going to make a suggestion. I was going to put it forward now as to how you should approach this case because it is on any anybody's view I think we can all accept that this is a case of some considerable complexity given the amount of material that has been foisted upon you and indeed upon the lawyers.

The first question I was going to suggest that you ask yourselves is this: Was it appropriate or not for Dr Skinner to prescribe thyroid treatment in the circumstances of each of these individual patients? The way that you would need to approach that question is to ask this question first: Was it within the bounds of acceptable medical practice at the time to prescribe thyroid treatment to any of these patients looked at individually? I will

just repeat that if it is helpful: Was it within the bounds of acceptable medical practice at the time to prescribed thyroid treatment to any of these patients looked at individually?

If, first of all, that test is the right one as the starting point, as it were, if you were to find that it was within the bounds of acceptable medical practice to treat these patients individually with Thyroxine, then it is very unlikely frankly that you would be able to find any of the heads of charges to suggest that his practice was irresponsible, inappropriate, et cetera, proved.

If, on the other hand, your view on the evidence that you have heard is that it was not within the bounds of acceptable medical practice at the time to prescribe thyroid treatment, then you would go on to consider the individual heads of charge but you may then find, having made that decision, that your decision thereafter is rather easier.

If that is the right test that ultimately you are going to be asked to consider, then step back a moment and look at this argument now. If the test is going to be whether it was within the bounds of acceptable medical practice, hearing from one patient or five patients or 20 patients "I was treated by Dr Skinner and I felt much better afterwards" is not going to help you to resolve the question whether it was acceptable medical practice or not. That question has to be answered by those who are learned, as it were, in medical practice; and I do not just mean the experts. I include the various doctors – Dr Prentice, Dr Ince, Dr Stewart and Dr Cook.

I understand that there is not just one patient but I expect hundreds of patients who would be itching to give the kind of evidence that Mr Jenkins would like to call, but we can accept for the moment that there may be many patients who are grateful to Dr Skinner – and I think I opened it in this way – who think that their lot has been improved by Dr Skinner, but, considering these heads of charge as to whether or not it was proper medical practice, hearing from them or from one of them will not help you.

It is therefore my submission that you should not receive this evidence from this individual patient.

MR JENKINS: Can I respond to that very briefly? I am not interested in Dr Skinner's intention, whether or not he is well intentioned. Plainly, he is well intentioned and wants the best interests of his patient, but that is not why I want to call the evidence. I want you to hear the evidence because I say that it is relevant to your consideration of whether his actions are irresponsible or inappropriate to know that he has considerable experience in treating patients in this way.

To come back to an allegation against the doctor of doing something that falls outside accepted practice, if you are told of that doctor, "Well, he has never tried it before and he is floundering around in the dark", that is plainly relevant to whether the doctor is behaving in an irresponsible way or in an inappropriate way – "No one does it that way, he has never done it that way himself before, but he has experimented on this patient". That is plainly of relevance to the issue of irresponsibility.

If, on the other hand, the doctor has done some procedure on many occasions previously, has adopted an approach that he has followed in many cases previously and has

considerable experience and success in undertaking that process, that too is plainly relevant to the question whether the doctor is acting in an irresponsible or inappropriate way. If Mr Kark's suggestion is the right way to approach this, then no medical boundary will ever be pushed forward. There is no role for one doctor to explore, with the benefit of a lot of experience behind him, a different way of treating patients, and that cannot be in the interests of the medical profession as a whole, or certainly of patients present or future.

I say that you should receive this evidence. I promise you that I am not going to call a thousand witnesses. I am going to call one, if you allow me to call Sue Conway, and she is the only witness I shall call at this stage, but I think it right that the patient voice should be heard so that you can assess the experience of Dr Skinner in dealing with this class of patient. That again is the application and the way in which I reply to Mr Kark's response.

THE CHAIRMAN: Thank you, Mr Jenkins. Legal Assessor, please.

THE LEGAL ASSESSOR: At this stage Mr Jenkins, on behalf of Dr Skinner, applies under Rule 34 of the Fitness to Practise Rules to introduce the evidence of Mrs Sue Conway. That rule says:

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

It refers to the fact that where evidence would not be admissible in criminal proceedings in England, the Committee or Panel should not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable.

You do not have the actual witness statement of Mrs Conway, but you have before you testimonials, which were put before you I think at a very early stage in these proceedings. What I have is a two-page testimonial dated 15 February 2007; a further one dated 22 June 2005; and one dated 25 July 2006. I think that is all the information that you have. I look to make sure that I have identified the correct documents; it seems as though I have.

The evidence that it is sought to be put before you is, in one sense, limited by the case of *Campbell* to which you have been referred. It is a matter for you whether the evidence, if it comes from Mrs Conway, is relevant to the issues that you have to decide. You are deciding on the allegation and you have before you the paragraphs that relate to four separate patients, the actions done by Dr Skinner in relation to those patients and the allegation that in relation to those actions his conduct was inappropriate, unnecessary, irresponsible, not in the best interests of that patient and may place that patient at risk of harm. Those, I think, are common to all four cases.

Mrs Conway, in relation to the letters, did not know any of those four patients, and indeed there is no reference in her letters as to precisely what treatment – particularly, for example, blood tests, thyroxine, what sort of thyroxine or Armour thyroid – she got, but it is clear that an amount of what she says is a testimonial in relation to the doctor.
In relation to that, I refer to the summary of *Campbell*. I look at paragraph 46,

sub-paragraph (3). The case of *Campbell*, of course, referred to Professional Conduct Committees conducting their hearings under the old rules, therefore of necessity at the stage of findings of serious professional misconduct. You conduct your findings under the new rules and you are at the stage, before that, of fact finding, before, depending on your fact finding, you go on to impairment, and before, depending on your finding on impairment, you go on to the question of sanction. So, you are at one stage before *Campbell* even, and certainly two stages before what was regarded in *Campbell* as the time when testimonials would be relevant.

The relevant passage in the summary at sub-paragraph (3) states:

> "although they [the Panel] can, if they think it right to do, consider the circumstances in which the practitioner found himself when committing the relevant misconduct, they should always be alert to the possibility that such circumstances may be more properly relevant to the question of penalty…"

For this purpose, sanction, the words being interchangeable there –

> "...rather than to the question whether the professional misconduct was serious; in particular committees should not use personal mitigation to downgrade what would otherwise amount to serious professional misconduct to some lesser form of misconduct;
>
> (4) at this stage, the number and strength of the practitioner's testimonials will almost invariably be irrelevant; they will usually be relevant to the question of the appropriate penalty [sanction]."

There is another identifiable problem so far as Mrs Conway's evidence at this stage is concerned. She can give evidence only as to what she says happened to her. She is not put forward as an expert. An expert who is identified as an expert is entitled to give opinions about the practice or the behaviour, matters within his expertise that he is called to give evidence about; interchangeably, he or she. She is not an expert. She can say what happened to her. She cannot give her opinion of what happens to others. I think both sides would agree that it would be improper for her to be asked that, it not being within her expertise.

Ultimately, therefore, if you consider that question, you may consider that her evidence amounts to the fact that she had in her experience extremely good treatment from Dr Skinner. It is question for you to say whether that amounts to evidence that you consider to be fair and relevant to the paragraphs in the allegation that you have before you and the matters of fact which at this stage you have to decide.

That is my advice.

THE CHAIRMAN: Thank you, Legal Assessor. Does either side have anything further to say?

MR KARK: No.

MR JENKINS: No, thank you.

THE CHAIRMAN: At this stage we will decide this matter *in camera*.

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

STRANGERS HAVING BEEN READMITTED

D E T E R M I N A T I O N

THE CHAIRMAN: Mr Jenkins, the Panel has given careful consideration to your application under Rule 34 of The General Medical Council (Fitness to Practise) Rules 2004 to call a patient of Dr Skinner's as a witness at this stage. It has also noted Mr Kark's objection to this.

Rule 34 states:

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

You have submitted that the evidence of this witness is relevant to the factual questions in the allegation of whether it was appropriate and responsible for Dr Skinner to initiate treatment in Patients A, B, C and D. You have accepted that the evidence of other patients would not normally be relevant at this stage of proceedings. You have, however, given examples of exceptions to this and have submitted that this is such a case. You have submitted that the witness's evidence should be admissible under both of the above sub-paragraphs.

Mr Kark has objected to your calling this patient as a witness on the grounds that she is only able to give evidence as to the treatment she herself received. He has submitted that this is not relevant to the questions that the Panel must decide at this stage.

The Panel notes that this witness has no knowledge of the treatment received by the four patients in this case. She is not called as an expert witness and is not professionally qualified to give an opinion on the treatment of the other patients in this case. This question can only be answered by the expert witnesses, and other medically qualified witnesses who have given evidence.

The Panel has noted and considered the judgment of Lord Justice Judge, Lord Justice Longmore and Lord Justice Jacob in the case of *The Queen (on the application of Jennifer Campbell) v The General Medical Council* (Case number C1/2004/1271), quoted by both

Mr Kark and the Legal Assessor.

The Panel considers that any evidence she may give amounts to testimonial evidence. Indeed one of her documents, submitted earlier in this case as exhibit D4c, is headed to this effect. The Panel has determined that, in line with the judgment cited above, it is not appropriate for her evidence to be adduced at this stage in proceedings. Your application to call this witness, at this time, is therefore not successful.

Mr Jenkins?

MR JENKINS: I wonder if you would give me five or ten minutes just to look at that decision. It may be that we will ask for it to be judicially reviewed. I do not mean that in any way discourteously, but it is an important case and we may take the view that it is a decision that should be reviewed by a judge or judges, and in those circumstances I may have to invite you to adjourn. We are adjourning anyway until a later time, but if you would allow me five or ten minutes, I am sure that we shall be able to come up with a decision.

THE CHAIRMAN: That is fine. We will adjourn until five-to-four.

MR JENKINS: Thank you very much.

(*The Panel adjourned for a short time*)

THE CHAIRMAN: Mr Jenkins.

MR JENKINS: Thank you, madam. I am afraid I am going to seek a Judicial Review of that decision. I do not mean to appear critical of the Panel, but plainly it is an important aspect of the case and we would like the decision you have made to be reviewed by judges in the Administrative Court. I do not know when we can organise such a hearing to take place. Mid July going into August is not the best time to find High Court Judges waiting to hear cases. We are obviously optimistic that we can get the hearing dealt with before the case is otherwise due to resume.

In those circumstances, I am going to invite you to adjourn the hearing now and not continue with it. The rules that govern adjournments are set out in the 2004 rules at paragraph 29. Can I just read it to you:

> "…the Committee or Panel considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit."

I am reading you the relevant parts of rule 29. Plainly, if I would like to call Mrs Conway's evidence in part 1 as part of the evidence on the facts it is best if I can have a decision from the court before we take the matter any further. In those circumstances, I would invite you to adjourn the hearing now.

In the circumstances that we would have to conclude this part of the case by the end of

tomorrow I would like to think that we have not actually lost a great deal of time, knowing that we have to adjourn for a number of weeks in any event. I would like to think that we had not lost days and days of time that we would otherwise spend sitting.

Madam, that is the application and the reason that I make it.

MR KARK: Madam, I think the application has some force. The next step would be for me to make a speech. If Mr Jenkins is going to take this decision to appeal it seems rather nonsensical for me to make a speech not knowing whether the High Court is going to uphold this decision or not and potentially, if it were to overrule it – I do not think it will – then I would have made a speech. You would then have to hear witnesses or a witness and so I think the application has some sense.

However, before you do adjourn, if you are going to adjourn, I wonder if we could deal with the amendments to the charges. I think it might make sense to do those now (a) because it is very fresh in our mind – the evidence you have heard is fresh in our minds – and (b) so that before we come back next time we will know exactly where we are on the charges.

Can I run through them? Perhaps I can do it first and then I expect Mr Jenkins may want to address you. My note is that 2(b), having been amended, has now been admitted in evidence. It is a matter for Mr Jenkins whether he wants to formally admit that to make life easier or not.

4(a) has also been admitted in evidence with the amendment.

7(b), that Dr Skinner make no note in the patient medical records of such a conversation, I think has been admitted in evidence, but he has not admitted 7(a), which is that the new symptoms could have been an adverse effect to the prescription, nor has he admitted 7(c). It is just 7(b), not making a record, which has been admitted.

8(b), with the amendment of the word "normal" to reference has, I believe, been admitted in evidence. 8(e) we would propose to amend to this extent:

> "You provided Miss B with a prescription for Sodium Thyroxine. After 17 June 2003 the prescription was to increase to 125µg a day for three months;"

That is based on the evidence that we heard. I have cut out the incremental increases that we heard, but I do not think they matter. We know that is the evidence and we know that that is what Dr Skinner thought was the right thing to do.

The next head of charge is 12(b) which I would ask you to turn to. I would ask you to strike out the words, if you agree, "for an unknown period of time". In fact we heard, I think, that it was going to be for three weeks, but we can simply strike out the words "for an unknown period of time" because it is really the prescription of Thyroxine and Tertroxin about which complaint is made. I think that, to that extent, was admitted in evidence, but we will hear from Dr Skinner's team.

The next relevant head of charge is 17, which starts:

"On a day unknown before 8 May…"

We can now put a date on that. I am pausing.

THE LEGAL ASSESSOR: There was still a question over 16(e).

MR KARK: You are quite right. I had missed that in the scribble of what passes for my note. 16(e) with the amendment, I believe has been admitted in evidence.

In respect of 17, we can now put a date on it. It is 6 March 2004, so it would read:

"On 6 March 2004 you prescribed Miss C with Sodium Thyroxine."

I would cut out "at an unknown date and for an unknown period of time". It is obviously causing difficulty. Again, what matters is that Thyroxine was prescribed.

In respect of 19(b), again I would take out "for an unknown period of time".

In respect of 21(b), this was the prescription, as it has turned out in evidence, that would appear to have been prescribed by Dr Summers. I would accordingly amend this to:

"You advised that Miss C be provided with a prescription for Sodium Thyroxine of 150µg per day and Tertroxin 20µg per day."

I would take out "for an unknown period of time". So,

"You advised that Miss C be prescribed with Sodium Thyroxine…"

etc. and take out the words "for an unknown period of time".

In respect of 22, therefore, I would take out the words "prescribing to Miss C or", so that it would read:

"Your allowing the continuation of a prescription…"

I suppose it ought to be "to Miss C was", so:

"Your allowing the continuation of a prescription to Miss C was…"

In respect of 23(a), I think we will have to wait and see. I would like to read the notes about this. It was originally, I think, admitted and then Dr Skinner wondered why he had admitted it in evidence. We will then have to look at whether the evidence is there to support it. That might be something for speeches rather than amendment now.

Finally, 25(d) with the amendment, I believe, has been admitted in evidence. My recollection is that we have already amended 25(f) by adding the word "Thyroxine" after the word "for".

27(a) with the amendment of the word "reference" for "normal" has been admitted in evidence.

In 28(b) I think the date has already been inserted as 17 November and properly admitted, formally admitted.

31(a) at the moment reads:

> "On or about 6 January 2005 you received a further result from the blood sample taken by you on 24 August 2004, showing that the level of Tri-iodothyronine (hereinafter referred to as T3) which was within the reference range,"

With that amendment of "reference" I believe that has been admitted in evidence.

That is the end of those relevant charges.

THE CHAIRMAN: I think there has been a query about 31(a).

THE LEGAL ASSESSOR: 31(a) was not actually admitted in evidence. There were two words of "showing that" and the "reference", but I did not record anything about admitted in evidence for that one. I may well have missed it.

MR KARK: I have.

THE LEGAL ASSESSOR: I see various people nodding. It has. Okay.

MRS WHITEHILL: Could I just clarify 24(d)?

MR KARK: 24(d):

> "You suspected that Miss C might be suffering adrenal failure,"

MRS WHITEHILL: Have I wrongly recorded that?

MR KARK: That has not been admitted, no, I think I can safely say. I would be delighted if someone has a note. Others have a note that it has been admitted. We would have to go back through the transcript. Perhaps what matters now is whether it is admitted or not. We will have to review the transcripts.

MR JENKINS: At the moment I am just dealing with the application to amend the notice of charges. I have no objection at all to the amendment being made. It may seem as if we have already made a mistake about 23(a) and admitted something which should not have been admitted. I am going to ask for some time to confirm that any further allegations are admitted. I think it is very likely that those that have been amended will be admitted. I wonder if you would allow me the luxury of speaking again with Dr Skinner so that we can be sure we are admitting things that should properly be admitted. Again, Mr Kark's application is for leave to amend and I have no objection at all to the amendment as

sought. I would like to see everything typed up. My notice of hearing is covered in three different coloured pens. I think if we get a properly typed up version things would be a little more clear. Again, I do not anticipate any difficulty at all. I anticipate that we will be admitted those amended allegations.

THE CHAIRMAN: I am sure that is the right way forward, to have it typed up.

MR KARK: Would it be possible to do that this afternoon, because it would be nice to have a clear way forward after today, rather than to have this hanging over us.

THE CHAIRMAN: Yes, I think that is fine, if it can be accomplished. It probably can.

THE LEGAL ASSESSOR: Forgive me. I have got a bit confused at the moment. Mr Jenkins, you have made an application for an adjournment. You have not actually mentioned a date. Am I right in saying that it is an application to adjourn to 3 September?

MR JENKINS: I think that is the date.

THE LEGAL ASSESSOR: That being the next date when the Panel is available and the room is available.

MR JENKINS: It is.

THE LEGAL ASSESSOR: It being said that there are five days available for that period of time, including the Saturday and the Sunday.

MR JENKINS: Yes. I know it is a prospect that we all look forward to. If, on exploring when the Judicial Review could take place, we find that it is after that date we will, of course, notify the GMC, because some consideration will have to be given about whether it is appropriate to resume at all on 3 September, rather than go ahead with a hearing which may be clearly subject to an appeal. If we were to go ahead on a false basis on 3 September, that would be very unfortunate. It may result in having to have the whole hearing once again. That would be very unfortunate, not just for the Panel, but for the witnesses who have given evidence and others who have been in attendance.

That is the application, to adjourn the case so that we can have a Judicial Review. I am optimistic that the timescale that has been suggested, namely to resume on 3 September, is one that we can work to. If it appears that that is impossible we will certainly notify the GMC so that further consideration can be given.

THE LEGAL ASSESSOR: When do you anticipate the earliest time that you could notify the parties that 3 September is a practical date, in other words, that you are going to be able to have the hearing before then.

MR JENKINS: I do not know an answer to that, I am afraid. We will do it as soon as we can.

MR KARK: It is difficult, but I am absolutely sure that we should retain the date of 3 September, because otherwise we know there will not be an appeal by that date. It may

help Mr Jenkins to have that solid date to inform the listing office at the High Court that it has to be heard by then, otherwise we will be lost forever.

THE CHAIRMAN: I think that sums it up adequately then. Unless, Mr Jenkins, you have something further to say?

MR JENKINS: No, madam, I think you as a Panel will want to consider whether you want to grant me the adjournment or not.

THE CHAIRMAN: Yes.

MR JENKINS: Thank you. I have nothing to add.

THE CHAIRMAN: Yes. We will now go into camera to make a decision and hope that the allegation reprint will be sorted out within the next half hour or whatever. Thank you.

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

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: The amendments, as proposed, have been agreed. Now, Mr Jenkins, do you wish to make any further admissions?

MR JENKINS: I am sorry, I have spent the time talking to members of the public gallery and have not gone through these with Dr Skinner.

If you are to adjourn the case I will certainly start the hearing next time by indicating which further admissions are made.

THE CHAIRMAN: Thank you, Mr Jenkins.

Basically, the Panel has agreed under paragraph 29 for the adjournment to September 3 to allow a judicial review and so we are now adjourned. Thank you.

(The Panel adjourned until 9.30 am on Monday, 3 September 2007)