GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Monday, 3 September 2007

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

Case of:

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

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

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

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

Transcript of the shorthand notes of Transcribe UK Ltd
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A

THE CHAIRMAN: Good morning. This is the Fitness to Practise Panel hearing inquiring into the case of Dr Skinner. I am Sandra Sturdy. I am chairing the Panel. The other Panel members are Dr Elliot, Mrs Whitehill and Mr Payne. The GMC is on my left with his team. The defence counsel for Dr Skinner is on my right. Dr Skinner is present along with is team. The Legal Assessor is on my right and the Panel Secretary is today Joanna Farrell. Judith Reid is not here today. Hopefully she might be here tomorrow, but we are being ably assisted. Thank you.

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To sum up, this is a reconvened Panel. The Panel adjourned on 16 July as defence counsel had said they would be seeking judicial review. The Panel understands that the judicial review was not sought and we are therefore reconvening today. Is that correct?

MR JENKINS: Madam, it is. Can I tell you briefly why? I do not give the reasons why we did not pursue it, but if we had done so we would not have been able to resume this hearing now. That was part of our thinking. Can I thank you for the time we have been given this morning?

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THE CHAIRMAN: Could I continue?

MR JENKINS: Of course. I beg your pardon. We are continuing the case of Dr Skinner. It is important to maintain the anonymity of the patients in this case. Please do not refer to them out of this room. Please remember to switch mobiles off. If you have any need to have a discussion amongst yourself could you do it outside.

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The approximate sitting times are 9.30 to one, 1.45 to five, with two breaks in each section. For the first three days the Panel will be prepared to sit a bit later than five should the need arise, or should a witness be in the middle of being interviewed etc.

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I have a further point from the Legal Assessor who would like to talk about the allegation.

THE LEGAL ASSESSOR: One of the final notes I made before we adjourned on 16 July is that a number of amendments are made to the allegations. The Panel now have the green allegation. It was said that the amendments would be admitted on Monday, 3 September. It is my understanding they have not formally been admitted so that is probably a preliminary that needs to be dealt with before anything else.

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MR JENKINS: I can deal with that. There is just one slight problem and that is head 23(a). I tried to admit it at the start of the hearing and the evidence from Dr Skinner was that he did not suspect a diagnosis of B12 deficiency. For the other matters that have been amended, yes, I can make those admissions.

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THE CHAIRMAN: Mr Kark, do you want to discuss 23(a)?

MR KARK: It is not a position I have come across before, I have to confess, where a doctor has admitted a head of charge and then sought to withdraw it. It was something pointed out by one of the Panel members, that in fact Dr Skinner had made no note in relation to a diagnosis of B12 and my recollection is Dr Skinner agreed with that and said, “I cannot now remember why I admitted it in the first place.” If on that basis he seeks to withdraw his admission, I think it would be right to allow him to do so.

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THE CHAIRMAN: That means that 23(a) now is not admitted.

Mr Jenkins, your case for the doctor.

MR JENKINS: There is a witness I would like to call now, a Dr Fink. I know there may be an objection to me calling him. Can I tell you who Dr Fink is and what he can deal with? He is a doctor who is a clinical microbiologist/virologist. He is an honorary senior lecturer at the University of Warwick and he also works as a general practitioner in the UK. He is registered with the GMC as a specialist in microbiology and virology and he is also registered with the GMC as a general practitioner. He has been in medical practice for a number of years. He treats a number of patients, quite plainly. He has an interest in chronic fatigue patients and he has treated a number of patients with the signs and symptoms of hypothyroidism. He is able to talk about his own treatment of such patients and how he can deal with them. He deals with cases where the blood chemistry results are within the reference range, but he will nonetheless treat patients who have signs and symptoms of hypothyroidism. In other words, he is a doctor who treats the sort of patients…

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MR KARK: I did not intend my learned friend to give the entirety of the evidence, rather an outline, otherwise the point of the objection is rather lost. My objection is simply this: that Dr Fink is not, as I understand it, put forward as an expert witness. He is not an expert in this field of medicine. He is another general practitioner. He is another general practitioner who I expect will come along and say, "On occasion I may have done something similar to Dr Skinner."

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He does not speak to the evidence in this case, as far as I understand it. He has not seen any of the patient notes in this case. He has not read any of the transcripts of the evidence that you have heard. He does not know anything about these particular patients. Nor, I suspect, are we going to hear anything about his own patients in terms of their notes and their medical backgrounds etc.

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If he is not an expert, then what is he? You either have witnesses of fact or you have expert witnesses. Expert witnesses are entitled to give their opinion, but normal witnesses are not. If he is not an expert, then, in my submission, his evidence is simply irrelevant, because he is another GP with other patients doing other things. If he is an expert, then his expertise needs to be established. He is not actually giving expert evidence about this case. My learned friend has been kind enough to furnish me with what is in fact an e-mail from him to Mr Jenkins' instructing solicitors about how he bases his evidence. He has not seen any of the notes or any of the evidence in this case.

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That is my short objection.

THE CHAIRMAN: Thank you. Mr Jenkins.

MR JENKINS: May I reply? In this case you have four patients, A to D, who had signs and symptoms of hypothyroidism and blood chemistry which is said to be within the normal or the reference range. The argument in this case is whether it was appropriate for

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Dr Skinner to treat those patients and, if appropriate to treat them, how should he have treated them? He is accused of being irresponsible in his approach.

The witnesses that you have heard from the other side include some GPs, but the expert evidence comes from Professor Weetman who does not recognise that there may be such patients, that is those whose blood chemistry falls within the reference range, but who have signs and symptoms of hypothyroidism. He has never seen a patient like that and he has certainly never treated a patient like that. Mr Lynn is in a similar position.

You are then being asked to judge whether Dr Skinner's treatment was appropriate or responsible or irresponsible based on experts or evidence from witnesses who have never treated such a patient, and yet they say that someone who does is behaving irresponsibly. What I am hoping to do is to call another doctor who does treat such patients and who is able to say that he treats patients who show signs and symptoms of hypothyroidism, even where their blood chemistry may be within the reference range.

You are four people. Three of you are lay and one of you is medical. You have to base your judgment on what is appropriate or inappropriate or responsible or irresponsible on the evidence of doctors. I suggest Dr Fink is one such. He is able to add his own perspective to this class of patient. As I say, both Professor Weetman and Mr Lynn do not recognise that those are patients who require treatment at all. Again, Professor Weetman says that someone with chemistry within the reference range, but who is showing signs and symptoms of hypothyroidism is outside his experience. I suggest that such patients do exist. Some doctors do treat them and I would like to call a doctor who does treat such patients.

It is fair to say that Dr Fink has not studied the case notes with respect to patients A to D, but he is able to give a perspective from his own practice of treating similar patients to those from A to D. If he is called and it seems as if his experience is wildly different from that which may be relevant to the cases of A to D, then of course you can place less or no weight on his evidence. To the extent that he is dealing with the sort of patients that you have to deal with in this case, I say he is perfectly entitled to give evidence before you.

Mr Kark says he is not an expert. He is a GP. He is a GP who treats such patients. Do experts get some special status by stepping into the witness box? No, they do not. They are just practitioners who are able to give evidence about their own experience. He has been treating such patients, as I understand it, for about ten years, not a huge number, but about ten years' worth of experience in treating such patients. I say I would like to call him.

If I cannot call him, all you have to make decisions about this case - you have not allowed yourselves to hear from a patient - all you have heard from are two of the four patients concerned, other doctors who are in the anti-group and to experts who do not treat that kind of patient. I would say you should be eager to get evidence from various sources. Dr Fink would be a different source of that sort of evidence. That is the basis upon which I seek to call him.

THE CHAIRMAN: Mr Kark, do you have anything further?

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MR KARK: No.

THE LEGAL ASSESSOR: First of all, it is a decision that the Panel has to make whether they should 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 subject to Rule 34 of the Fitness to Practise Rules which we are proceeding under.

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Have either side considered the fact that in order to make such a decision the Panel ought to see the witness statement?

MR KARK: That is always the difficulty when you have a Panel who judges the facts and the law. I think Mr Jenkins has given a fairly full synopsis of what he expects the witness to say. I would have thought that you have sufficient, but if you feel you have to see the statement then, frankly, I would rather have the witness here to give evidence and be cross-examined. Once you see the statement obviously it is going to be very difficult for you to entirely put it out of your minds.

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MR JENKINS: I am sympathetic to Mr Kark's concerns. It is about letting cats out of bags. I have tried to summarise what he says. He says he treats patients who show some of the signs and symptoms of hypothyroidism but whose chemistry is within the reference range. He recognises that his treatment is ad odds with what some - many endocrinologists would accept as appropriate. That is, I think, all I think you need to know.

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The Panel can insist that they want to see the statement but I would discourage you from doing so. I hope you would accept Mr Kark and I have dealt with things fairly. If it is felt necessary to see the statement nonetheless, we can select the relevant paragraph or so and you can see that.

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THE LEGAL ASSESSOR: Again, the decision is going to be for you. Mr Jenkins has pointed out that he can give evidence of expertise. The problem is there is a difference of an expert witness and it is a very clear difference. An expert must help a hearing to achieve the overriding objective by giving objective and unbiased opinion on matters within his expertise. Dr Fink is not being put forward as an expert. He is not under an expert's duty and obligations as far as we are aware, namely an obligation to the person from whom he receives a duty which overrides any obligation to the person who instructs him, which includes an obligation to inform all parties in the court if his opinion changes.

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He has not studied, or as far as one is aware - or you are aware, to be precise - he has not studied the papers in this case or the patients' files in this case, which leaves, you may think, a slight problem, and it is a matter for you, where, for example, it is encapsulated by Mr Jenkins, it is said that, for example, he has examined a number of people who show some of the signs of hypothyroidism, are those the same signs as the patients that you are considering, or are they different signs, or are they combined with different factors? One does not know and it is a question as to how much help it may be.

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At the end of the day you have the right to hear any evidence which you wish to, but it is a right which is bounded, as I said right at the very beginning, by Rule of Procedure 34: any evidence which you consider "fair and relevant" to the case before you, whether or

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not it would be admissible in a court of law.

Beyond that, I cannot help very much. Does either side have anything to say on that which I have said?

MR JENKINS: What I would say is whether or not he is an expert - and I put him forward as an experienced practitioner - all witnesses have an obligation to assist the tribunal. They all take an oath. I do not think there is any additional burden that experts take on if they have come to assist the tribunal. Every witness who takes an oath has a duty to tell the truth and to assist, under pain of prosecution.

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THE CHAIRMAN: Thank you. We will now adjourn to make this decision. Thank you.

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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

D

THE CHAIRMAN: Mr Jenkins, the Panel has considered your application to call Dr Fink as a witness. You have informed the Panel that Dr Fink is a practising GP who has treated patients in a similar manner to Dr Skinner. Mr Kark objects to Dr Fink being called as a witness at this stage of the proceedings because he is neither a witness of fact nor an expert witness and does not, therefore, give relevant evidence.

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The Panel has been referred to Rule 34 of the General Medical Council's (GMC) (Fitness to Practise) Rules 2004. The Panel considers that it may be assisted in some way by evidence given by Dr Fink about the way in which he treats his own patients in order to aid it into making due inquiry into the allegation.

MR JENKINS: Thank you very much. I will ask for him to be called.

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COLIN GRAHAM FINK, Affirmed
Examined by MR JENKINS

Q I wonder if you could give us your full names and your professional qualifications, please?
A My name is Colin Graham Fink. My professional qualifications are an Honours BSc; a doctor of philosophy; basic medical qualification and Fellowship of the Royal College of Pathologists.

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Q Could you tell us when you qualified in medicine?
A 1979.

Q Can you tell us what your present workload is?

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A Yes, I am the Medical Director and microbiologist with a major interest in virology for a company which I set up with a colleague called Micropathology Limited.

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We provide a rapid diagnostic service very largely for the NHS tertiary referral centres.

Q I think you started your career in biological sciences?
A That is right.

Q Your doctorate is in that area?
A Yes, it is in a mixture of virology and cancer studies.

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Q I think you then spent a number of years in acute hospital medicine?
A I did.

Q Tell us where?
A I worked in Kidderminster Hospital as a Senior House Officer and a registrar for about 18 months. I worked in Selly Oak Hospital in acute medicine for six months, and house jobs of course in Nuneaton and in Shrewsbury, so I have been in the West Midlands. Then I spent several years in Walsall Hospital doing biochemical medicine. I spent two years as a research fellow in the University of Birmingham Medical School and then went off to Oxford - I did a bit of general practice in between and then went off to Oxford for five years.

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Q I understand. You have told us about eye work, the ophthalmic study of your work. Tell us a bit more about that.
A My wife was a consultant ophthalmologist. It became very apparent when I was setting up the laboratory that there was a lack of rapid diagnostics, which was hugely important for treating eye disease. As antiviral medicines became available, the rapid diagnostic facilities were not available in the NHS. We set this up quite quickly. We provide a rapid diagnostic service for both viral and bacterial and fungal disease for the Birmingham and Midland Eye Centre and also a number of other eye hospitals in the United Kingdom.

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Q I think you also treat patients presently?
A Yes, I do. I have an interest in chronic fatigue, which is believed to be of infectious origin. I have collected patients over the years in which I have interest. We have actually done some interesting research on some of the problems of viral recrudescence, that is the reappearance of chronic viral disease in some of these patients, which curiously - and this is why I have an interest with Gordon Skinner - is seen in some cases of hypothyroidism.

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Q I think you are registered with the GMC as a general practitioner?
A I am.

G

Q As well as a virologist?
A I am; that is right.

Q You told us about an interest in chronic fatigue. Over what period of time have you pursued that interest?
A I have had the interest for 15/20 years but I have pursued it for ten years.

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Q Does that mean you have been treating patients ...

A

A It does.

Q ... for that type of field of medicine?
A Yes, not a huge number but yes.

Q You mentioned hypothyroid patients.

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A Yes, indeed.

Q Do you treat hypothyroid patients?
A Yes, I do.

Q Are you able to tell us roughly how many patients you may have treated over the last ten years or so?

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A That is quite a difficult question to answer. About 100 possibly.

Q I see. How do those patients come to you?
A Some are self-referrals because of chronic fatigue. Some are from colleagues and some I have actually acquired in my place of work.

Q I think you work, as well as at the University of Warwick, as an honorary senior lecturer?

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A Yes. They found it cheaper to give me a senior lectureship than to pay me for giving lectures.

Q Let us come back to the patients that you treat. What sort of patients are you dealing with?
A I can perhaps give you three which I have mentioned in my e-mail to you as

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examples. One lady of 52 who had cardiac angina who was a non-smoker, who was becoming more and more sleepy and lethargic. She was actually the manager of the research science park that I worked on. I looked at her one day and I said, "I wonder whether your thyroid is functioning properly", because she presented with some of the signs of hypothyroidism. She then told me that her mother had died of a stroke in her late 60s and was diagnosed a year prior to that as being grossly hypothyroid. I investigated her and found that her thyroid biochemistry was at the lower end of the reference range

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but her thyroid stimulating hormone was normal.

I asked her if she would consider treatment. She said she would be very pleased. I gradually increased her dose of thyroxine and her angina disappeared completely, which was hugely beneficial for her: she lost weight and she got better. I kept her GP informed and he was delighted. She is now continuing on the treatment of 100 micrograms of

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thyroxine daily.

What was particularly interesting about this lady was that after about seven or eight months she lost some of the vigour that she had regained. When I checked her thyroid chemistry again, she had stopped converting thyroxine to Tri-iodothyronine ---

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Q T3.
A T3, the more active component. I was then obliged to put her on a small amount of T3, which is very convenient because the tablets are not made to give a small dose, so

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she divides the tablets into three every day, has one of these every day and she has for the last five years remained extremely well.

Q I was not going to take you through the detail of clinical cases that you have dealt with, but I will deal if I may in general terms. This was a lady, clearly, whose blood chemistry fell within the reference range?

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A Oh, yes. She was towards the lower end of the reference range.

Q I understand, but within the reference range nonetheless?
A Yes, indeed.

Q Have you treated other patients whose chemistry falls within the reference range?
A Yes.

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Q Have you treated those patients with thyroid replacement therapy?
A Yes.

Q Again without dealing with specific patients, if we can, tell us your experience of treating patients whose blood chemistry falls within the reference range?
A It is something that I do not undertake lightly and I look very carefully at the patient and consider the signs and symptoms that the patient presents with. There are occasions when treatment does not seem to have any effect and on those occasions, after a reasonable trial, I may consider discontinuing the treatment. However the others, where there is a very clear clinical advantage, of course they stay on treatment.

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Q The Panel has heard evidence from a professor and from another senior doctor to the effect that patients who have chemistry - blood chemistry - within the reference range cannot have signs and symptoms consistent with hypothyroidism.

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MR KARK: No, that was not the evidence actually. Cannot have signs or symptoms consistent with. My recollection is that it was always accepted there was not a cross-over of signs and symptoms, for instance with depression and other features. What they were saying - and I accept this - was that, unless the biochemistry is outside the reference range, then it is not diagnostically or not diagnostic of hypothyroidism.

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MR JENKINS: Can I read from Day 6 and this is Mr Lynn, my cross-examination. On page 51 of Day 6 I asked the question:

> "But the issue I want to ask you about is your experience of treating patients who may have signs and symptoms but normal chemistry.
> A I have none because it is an entity which doesn't exist":

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Q (*To the witness*) Did you hear that?
A I did.

Q That is one of the experts, "… it is an entity that doesn't exist", a patient who has signs and symptoms of hypothyroidism but chemistry within the normal range.

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A Well, this is one of my great concerns. This has been taken so much to be the law that there are biochemistry laboratories - indeed my niece reported to me one this week,

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she is a doctor - where they will only do a thyroid stimulating hormone assay, they will not do any other assays, and if that is normal then the general practitioner has no opportunity to discover whether this patient has a low T4. Therefore there are a whole cadre of people walking around who have substandard medicine, because nobody will look to see whether they could possibly be low in the reference range and therefore hypothyroid, or subclinically hypothyroid, if you wish. So, I am afraid I disagree with that and I think it reflects very poorly on British medical practice that this is such a rigid interpretation.

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Q Do you place limits on what you can prescribe by way of thyroxine for patients?
A That is a very interesting question, because I am constantly surprised and one patient whom I inherited from Professor Hoffenberg ---

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Q Tell us who he is, before you go on.
A Alas, it is the late Professor Hoffenberg. Professor Hoffenberg was the Professor of Endocrinology and the Professor of Medicine at Birmingham and in my view was - I did not care for him personally, but I had a very great respect for his abilities as a physician and he was prepared to look at the patient, rather than the rules.

Q Forgive me, I interrupted you. You inherited a patient from him?

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A I inherited a patient from him, who was treated. She was grossly clinically hypothyroid and normal levels of thyroxine replacement had no effect on her and whilst ---

Q What do you mean by normal levels of thyroxine?
A Say 100 to 150 micrograms of thyroxine. She was on 250 micrograms of thyroxine daily, and on that level she regained her normal activity as a teacher and her hair grew back and she was a healthy lass. When she passed from his care to another endocrinologist, this other endocrinologist thought this was absolutely shocking treatment, reduced her thyroxine to 100 micrograms a day and she became appallingly clinically hypothyroid. She came to me in desperation, as the daughter of a colleague, and I put her back on the dose, gently increasing it, that Professor Hoffenberg had had her on and she regained her normal self. This was a surprise to me, and it was further evidence that one has to treat individuals as individuals and there are no hard and fast rules on the way biochemistry works.

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Q I understand. Can I just summarise then what you have told us. You are prepared to treat patients who show signs and symptoms of hypothyroidism …
A Yes, indeed.

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Q … but where the chemistry falls within the reference range?
A Yes.

Q You have suggested that you have had some success in that regard?
A I know I have had some success.

H

Q I understand. You told us with the first patient that you had placed her on T4 thyroxine?
A Yes.

A

Q After seven months, you told us, it was no longer being converted to T3, the active element?
A Yes, her T3 level was dropping steadily and so I then added in T3 and she regained the vigour that she had originally regained from the treatment.

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MR JENKINS: Yes, thank you very much, Dr Fink. Would you wait there, because you will probably be asked questions by others.

Cross-examined by MR KARK

Q Dr Fink, I think you run the laboratory that Dr Skinner often uses?
A That is so.

C

Q Is that right?
A Yes, indeed.

Q In fact, in our papers we will see your name and your laboratory being used. If I can just give you an example, it is our file 1, tab 2, page 16.
A Is this *here* somewhere?

D

Q Yes, you will find it - you probably do not need all of those files *there*.
A Can you repeat your reference?

Q Certainly. It is tab 2 and, if you look in the bottom right-hand corner, it is page 16. Is that your laboratory?
A Yes, it is.

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Q In fact we can see your name, can we not?
A Yes.

Q Those documents are sprinkled all the way through our papers. So, how often does Dr Skinner use your laboratory for these tests?
A We will receive bloods from Dr Skinner perhaps sometimes once a week, sometimes twice a week, sometimes once every two or three weeks. It depends presumably on his clinical activity.

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Q When you talk about the reference range, the reference range is really created by each laboratory, is it not, depending on the patients whose blood you are analysing?
A Yes, and in this case the reference range comes from the Biochemistry Department of University Hospital Trust Birmingham.

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Q Did you say that you had treated about 100 patients was it in a year, or in total?
A No, no, no, in total.

Q In total?
A Yes.

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Q Over what period of time?

A Well, I suppose that is ten years.

Q Over ten years?
A Yes. I see a lot of chronic fatigue patients, but I certainly do not treat them all as hypothyroid.

Q Approximately what proportion of your chronic fatigue patients do you find are hypothyroid?
A I do not know the exact answer to that, but I would say it is somewhere between ten and 20 per cent.

Q Have you done any training in this particular field?
A I was in metabolic medicine for three years in Walsall Hospital.

Q When was that?
A I think 1982 to 1985.

Q Since then?
A Not directly in metabolic medicine, no.

Q Can we just take your cardiac angina patient as an example. You say her chemistry was at the low end. You do not have any of the notes I do not suppose with you, do you?
A (*No verbal response*)

Q What do you mean by the low end?
A Her TSH was well within the normal range, but her T4 was somewhere down at about 11 or 12 picomoles per litre.

Q What did you consider that to be due to?
A In view of the family history and her physical presentation, I felt that she had a very high chance of being hypothyroid.

Q Did you consider I think it is called secondary hypothyroidism, a disease of the pituitary?
A No, I did not in this case.

Q Did you refer her to an endocrinologist?
A No.

Q Of the 100 patients are you saying that that is the total number of your hypothyroid patients, or is that the total number who were outside the reference range - I am sorry, within the reference range that you treated?
A I cannot be sure that all were within the reference range, but the vast majority were within the reference range.

Q Some seemed to show some benefit and others did not?
A No, the 100 that I left on treatment did show benefit.

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Q That you left on treatment?
A Yes, I mean I am quite selective in whom I will treat.

Q When you were treating these patients, did you have a particular goal so far as their TSH was concerned?
A No. Some people seem to drop their TSH to almost undetectable levels and others do not. That seems to be quite a variable response.

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Q Is there any danger of which you are aware of allowing a patient's TSH to drop to undetectable levels?
A No. I am not aware of any danger, if they are adequately treated and if they are well, but if they showed any other signs, if their TSH were very low when they presented, I might consider what you have just mentioned, which is pituitary failure. That would not be taken in isolation.

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Q You are not aware of any difficulties about treating a patient with thyroxine and keeping a patient with very, very low or unrecordable TSH?
A I have never found a patient with an unrecordable TSH, but I have found patients to have low TSH.

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Q What do you regard as low?
A .08.

Q You are not aware of any particular dangers of treating a patient for any length of time if their TSH level is below 0.1, for instance?
A I am not aware of any dangers.

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Q Do you do bone density checks?
A If appropriate. I refer people for things like that.

Q Is it not likely to be appropriate because the research demonstrates – I think we heard particularly if a woman was kept on thyroxine and their TSH was somewhere below 0.1 that there was a danger of osteoporosis and thinning bone density?
A I think the danger of osteoporosis and treatment with thyroxine is rather over-egged, but I accept that there is in some cases some risk. In people of that age group, particularly in women, bone density can be a problem for other reasons.

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Q Yes, it can, but there is research that demonstrates that if the TSH gets below 0.1 bone density is a significant problem?
A Without checking I am not aware that my patients have dropped their TSH to below 0.1.

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Q If you felt that your patient was below 0.1 what would you do?
A I have one patient at least that I can think of where it is down to .08, but that is within experimental variable for the biochemistry. If I feel that somebody is in danger of osteoporosis I would refer them.

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Q How often do you do blood tests on these patients?
A Once they are settled and well, generally every six months or every nine months,

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but more often whilst I am beginning to treat them.

Q I was going to ask you about that. If you decide to alter the dose, particularly for increasing the dose, you would want to know what the blood chemistry was doing, would you not?
A Yes.

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Q Can we take it that you would almost invariably do a blood test?
A I would wait three or four weeks to allow them to metabolically adjust.

Q Once they have started?
A Yes.

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Q Before you ever started them on thyroxine would you do a blood test?
A Yes. I have in all cases, but I can see a situation where if somebody was so overtly myxadematous I might start the treatment at the same time as taking the blood.

Q In the normal course of events you would always want to have a blood test, would you not, before starting a patient on thyroxine?
A That would be my practice, to take blood at least as I started them.

D

Q You would always want to have a blood test before you altered the dose?
A I would alter the dose based on clinical signs and the biochemistry.

Q You do not ignore TSH levels, do you?
A I do not think they are a primary diagnostic tool, but I do take note of them.

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Re-examined by MR JENKINS

Q What other risks are there of treating patients?
A It is said that thyroxine can induce atrial fibrillation, as we have heard, and metabolic bone problems and manic behaviour. I have seen acute thyrotoxicosis in my clinic practice when I was in hospital, but I have never, ever seen thyrotoxicosis induced by thyroxine treatment.

F

Q What would you say is the risk of inducing atrial fibrillation in a patient if you are giving them thyroid replacement therapy?
A I cannot give you a percentage, because my practice is obviously limited. I have never seen it, but I do check.

G

Questioned by THE PANEL

DR ELLIOT: I wanted to ask you about something you said in your evidence. You said that you do not undertake treatment lightly?
A Yes.

H

Q Why?
A I regard any chemotherapy to be something which has a clinical responsibility and so I assess my patients very carefully.

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A

Q You said that you do blood tests regularly when you are treating people?
A Yes.

Q What blood tests do you do?
A If I am treating somebody with thyroxine I will always ask for a TSH, a T4 and a T3.

B

Q You would have the T4 levels as well?
A Yes.

Q Do you have a level of T4? Do you have a reference range when you are treating people?

C

A Most people I have treated stay within the reference range. One or two will creep above it, but if they remain clinically well, providing there are no other grounds for concern, I just keep an eye on that.

Q You said that you check your patients for thyrotoxicosis?
A Yes.

D

Q Did you mean by that that you check them biochemically or clinically?
A Both.

Q If someone's T4 was in the biochemically thyrotoxic range and they were clinically well, would you be concerned about that?
A Not if it is… The one example I can think of is the manageress of the research park who runs at about 21, which is slightly outside – although, I think they have changed

E

the reference range now, so it has now come back within the reference range, but she runs at about 21 picomoles per litre. It is well and her T3 with the extra T3 runs within the reference range. I am quite happy with that and she is clinically euthyroid. The other case that I mentioned, Professor Hoffenberg's patient, her T4 is 36/37, which is well outside the reference range, but she remains clinically well and euthyroid.

THE CHAIRMAN: You said you have never seen thyrotoxicosis in your patients?

F

A I certainly have not seen thyrotoxicosis in my patients, but I have never seen thyrotoxicosis in a patient given exogenous thyroxine. I have seen thyrotoxicosis and thyroid crises in patients admitted to hospital. None of them have been on thyroxine.

Q You said that you like to keep your reference range within the accepted range, which obviously you have at your laboratory. Did I hear you say you keep TSH within the

G

normal range, but T4 could sometimes be above?
A The TSH drops below the reference range on a number of occasions, but in my patients mostly, and quite surprisingly, on quite large doses of thyroxine the T4 remains the reference range, but occasionally it creeps above the top of it.

Q The link between thyrotoxicosis and excessive T4. When does a patient become thyrotoxic?

H

A Unfortunately, it is not a question I can answer. It is an individual observation and I have never seen it in patients who are treated with thyroxine. I have seen it through

natural disaster when the patient goes into a thyrotoxic crisis, but that is through their own thyroid gland over reacting.

Q You use Dr Skinner's laboratory or he uses your laboratory. What about any other sort of lecturers or conferences? Do you do things together? Following on, are you interested in the anti-ageing process that thyroxine has been used for?
A Apart from my personal worries about ageing, I have no interest in the anti-ageing process.

Q On sharing lectures and conferences with Dr Skinner, have you been involved in any of the similar institutions that he has been involved in?
A No, not really. We are old contemporaries. I will even to so far as to say good friends. We discuss the mechanics and the physiology of individual patients, but that is really the limit. He has interests which overlap with mine, but I do not often see… I do not think I have ever seen him since I left the biology department in conferences.

Q But you do discuss patients?
A Very much, often.

Q Over the telephone?
A Or we do meet on occasions. I am prepared to meet him.

Further re-examined by MR JENKINS

Q I think you have set out in the e-mail that you sent to Dr Skinner how you know Dr Skinner and how well you have known him over a number of years?
A Yes.

Q It is just that you had not been asked questions about that by me.

THE CHAIRMAN: Mr Kark, is there anything further?

MR KARK: No, thank you.

THE CHAIRMAN: Thank you, Dr Fink.

(*The witness withdrew*)

MR JENKINS: Madam, I am going to invite the Panel to take a short break for ten minutes or so. It is approaching the time when you would normally take a break. It may be that we will go into speeches after that point.

THE CHAIRMAN: I therefore assume that you have no further witnesses.

MR JENKINS: That is why I am asking for the break. I think that is probably right.

THE CHAIRMAN: We will meet again at 11.30.

(*The Panel adjourned for a short time*)

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MR JENKINS: Madam, that is the evidence I call on Dr Skinner's behalf as to the facts.

THE CHAIRMAN: Thank you, Mr Jenkins. Mr Kark, you are ready then for closing speeches.

B

MR KARK: Yes. I would like to start by passing out a document that we have prepared previously, but which has not yet been given to the Panel. If I pass it up first, I will then explain what it is. Mr Jenkins has a copy.

THE CHAIRMAN: This will be C11.

MR KARK: Yes, if it is going to be given a number. (*Same handed to the Panel*)

C

The purpose of this document is simply to help you find your way around the papers more easily. You will see that there is a chronology on the left in relation to each patient. You will be able to find all the blood tests and all the medical notes that are relevant, as well as any letters by reference to the right hand column which gives you the tab in file 1, the tab and the page reference. There is then a very brief and I hope anodyne summary to give you a clue as to what the particular document or reference is. I think that will be a useful document for you, particularly when you are trying to look at the gaps between blood tests and consultations and that sort of thing.

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THE CHAIRMAN: That is very helpful. Thank you.

MR KARK: This undoubtedly is a complex case and it has not been made any easier, I suspect, by the six and a half week gap we have all had in the proceedings. You have received a number of complex pieces of information and research and it may appear that your decision-making process is going to be a very difficult task. I do not suggest it is simple, but it is not insurmountable either. I suggest that if you approach this in a particular and logical way the process can be made easier for you and the task is nowhere near as difficult as it otherwise might be. I do not suggest that your approach should be simplistic, but there is a logical way through what might appear to be a minefield.

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The first and most obvious piece of advice I can give is to concentrate on the charges and go through them one by one. One or two warnings: this hearing is just like any other case that you have heard in the past. Dr Hertoghe said to you on a number of occasions, "This is why your decision is so important." What he meant was that the future treatment of people by using thyroid therapy was in your hands. First of all, it is completely inappropriate for him to make those sort of comments as an expert witness. It would be equally inappropriate for you to be swayed or even concerned by those comments. This is a case, as I said to you right at the beginning of the hearing, about these specific charges and these patients.

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Let me set out my suggested approach and if it finds favour with you, then please adopt it as a method of leading you towards the correct determination, whatever that is. There are obviously central issues in the case and there are also some side issues. The central issues first.

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A

Stepping back from the individual charges for a moment, was it appropriate or not for Dr Skinner to prescribe thyroid treatment and to keep on prescribing it in the circumstances of these individual patients? You can ask yourselves 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? That includes the continuing of prescribing of thyroxine in the light of the blood test.

B

If it was within the bounds of acceptable medical practice to do so, then you may think that it would be very difficult for the GMC to prove any of the allegations relating to thyroxine as being inappropriate, unnecessary, irresponsible, et cetera. On the other hand, if your answer to that first question is, no, it was not within the bounds of acceptable medical practice at the time to prescribe thyroxine to any of these patients looked at individually, then of course you go on to consider each of the allegations individually. But having found that it was not within the bounds of acceptable medical practice at the time, you will, I expect, find the resolution for those later questions, as set out in the heads of charge, much easier to decide.

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Another warning, if I may. Do not be influenced by Dr Skinner's intentions. You may feel, I do not know, that he had the best intentions in the world. He may believe passionately, as I put to him, he may believe very strongly that what he is doing is right. His patients may well love him. This is not a case - and there are some GMC hearings where intention is relevant - but this is not a case in my submission that Dr Skinner's intentions or his state of mind matter, at least not at this stage. What matters is whether it was medically right or medically wrong to do what he did.

D

You heard from Dr Cooke, Dr Blair, Dr Summers, Dr Ince, Dr Cundy, (*inaudible*), Dr Stewart. Each of them in their own way have disapproved of what Dr Skinner was doing with their patients. Some of them took positive steps to stop him. Two of them went so far as to complain to the GMC.

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In addition, you heard from two expert witnesses called by the GMC. Professor Weetman is one of the leading endocrinologists in the country. He has an impressive medical background. He specialises in this area of medicine. He is Dean of the Sheffield Faculty. He has lectured in practically every country in the world. You may think he knows his subject backwards. Mr John Lynn is a thyroid surgeon with enormous experience, and still sees, I think he told us, about 3,000 patients a year. He is, as it were, at the pole face of thyroid problems day in and day out. Each of them told you that Dr Skinner's practice was not in line with current medical thinking and was wrong.

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Dr Skinner does not, of course, have to prove he is not guilty; it is for the GMC to prove the case against him, but you are entitled to weigh up the quality of the experts called by either side.

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The defence were unable to produce a single UK-based doctor, let alone an endocrinologist, who supported Dr Skinner's behaviour in respect of these four women. The closest they got was this morning with Dr Fink, but he was unable to give any evidence of course about these particular patients.

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The defence called Dr Hertoghe from Belgium. He launched a fierce attack upon

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Professor Weetman and Mr Lynn. He claimed, in parts of his evidence, that Professor Weetman's report was misleading and unfounded on science. He will claim that Professor Weetman did not have the educational learning to write such a report, despite the fact that he had not looked at his CV first. He claimed parts of Professor Weetman's report were, in his words, "embarrassing".

B

Dr Hertoghe is not an endocrinologist at all. He is not on the specialist register in this country or in any other country, although the way he spoke you may have thought he was. He was undoubtedly a colourful character. Even he accepted that, in respect of these four patients, he would not have been able to find a responsible endocrinologist in England, America or Belgium who would have prescribed thyroxine to any of these patients in the way that Dr Skinner did.

C

You do not simply have to rely on expert evidence. You can take into account the views of the other doctors who were treating these patients. Let me repeat, this is not about good intention or bad intention. It is not about whether patients liked Dr Skinner. The case is about the charges before you and whether Dr Skinner's practice was out of line with accepted medical practice at the time.

D

What are the issues raised by the experts in relation to what is accepted medical practice? The first is whether or not the test of the TSH level is an accepted standard across the world for the diagnosis of a sick thyroid. The second issue which was raised was what was the appropriate level of which there was accepted to be a thyroid condition? The third is whether it is acceptable to treat someone within the reference levels with thyroid replacement hormone.

E

Dr Skinner would argue that the test should not be whether they are biochemically euthyroid, but whether they are clinically euthyroid. The danger, of course, is that if you only use the clinical test, you are going to treat people who have a perfectly healthy thyroid but do have other conditions. That is the danger of missing the differential diagnosis.

F

When he was giving evidence - and I am not going to ask you to turn up each reference that I give you, but I will give you some references during the course of my address to you. I will read out from the transcript what was said. The first one is Day Five, page 35. This was in answer in fact to Mr Payne. Mr Payne asked Professor Weetman:

> "Could it not be said that Dr Skinner is being confronted with these signs and symptoms and to make someone better he is using an alternative method to make them better?"

G

Professor Weetman said this in answer:

> "There are two problems with that approach. My main concern in all of these cases is that by all accepted criteria these patients do not have thyroid failure. They have, however, very profound symptoms and signs. These are all recorded. These are serious issues. There is no doubt that these patients felt very unwell indeed and, therefore, there must, by conventional reasoning, be an alternative cause for

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> those symptoms and signs. That is my main concern. There is not an alternative type of endocrinology. There is only one endocrine system, there is only one defined set of blood tests, and if you fall within those parameters and you have profound symptoms, then you need to look for another cause. That is the position that every endocrinologist and physician would take.

B

> The second thing is about treatment ... However, the principle of such treatment should follow one of the earliest concepts a medical student learns about treatment, 'First do no harm'."

He says:

C

> "... I fully accept the need for doctors to continually challenge dogma and, where dogma has been challenged, I make it clear in my report."

He, it is being suggested, lives in an ivory tower. He is at one far end of the debate, says Mr Jenkins. You will have to consider that. You are entitled to look at the views of the other doctors who dealt with these patients.

D

The difficulty is that what Dr Skinner was doing was treating people with the signs and symptoms of hypothyroidism, but he was ignoring, in effect, their chemistry. The danger there is that you have a perfectly healthy thyroid but the patient has other problems. That, of course, is the danger of the missed diagnosis.

E

We live in a world where we all have many different features and troubles in life. It is no doubt that we would all like to look better than we do, some would prefer to be thinner, some will prefer to be taller, shorter, larger. There are all sorts of conditions in human life that we would rather not face. That does not necessarily mean that we all need thyroxine. It might help people temporarily, but it is a medication to be given not when we are down in the dumps or we have many other problems, but when the thyroid is diseased. That is the line that Professor Weetman and others take. It is not to be used as a general pick-me-up, to move things along a little faster than they would otherwise go.

F

Dr Hertoghe told you that in his view something like 30 per cent of the population would at one time in their lives need thyroxine. That, you may think, was an extraordinary figure. That would appear to be Dr Hertoghe's view, but it is not the view of the medical world. If the thyroid is sick, it undoubtedly requires treatment, but the only way of finding that out is by testing its function.

G

It is worth bearing in mind Mr Lynn's experience, that the reality is that patients whose thyroid function is within the reference range very rarely have anything to detect at all. I will just give you the reference for that: Day Six at page 6. You will recall that the evidence was that because the TSH testing was so much better than it used to be, the sort of signs of hypothyroidism that we saw when we looked at Dr Hertoghe's pictures from 40 or 50 years ago simply do not and should not occur now.

H

Mr Lynn told you that patients who are on thyroxine often want to stay on it because they feel good and they will often be severely toxic, and it is an addictable drug; Day Six at

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page 9.

What are the problems? Primary thyrotoxicosis, the research demonstrates, produces a loss of bone density. There is an increase in the risk of fractures in patients who are thyrotoxic and have a TSH below normal; Day Six, page 12. All of Mr Lynn's patients who are on thyroxine have regular bone density checks to make sure they do not run into difficulties.

B

What about the reference range? Mr Lynn dealt with this on Day Six, page 17. The Yearbook of Endocrinology 2006:

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

C

Let me turn to Patient A. You may want to have your heads of charge available to you. Can I deal with heads of charge 3(b) and (c) first of all, which allege that Dr Skinner took an inadequate history and carried out an inadequate examination? You will recall that that was based really on Professor Weetman's report and upon his evidence. It is fair to say that Mr Lynn, when he was asked about this, described the notes and the examination. I will just get it for you; I think it is Day Six, page 96 and 97. He described the notes as "totally adequate".

D

Obviously you will have to take Mr Lynn's view firmly into account. You can review the notes yourself. You will have to consider this, that these were the notes of Dr Skinner who has seen these patients really as a secondary referral. According to Professor Weetman, he should have been looking at these patients *de novo*. That was the line that Professor Weetman took.

E

So far as 3(i) and (j) are concerned, this is in relation to the suspicion that the patient was suffering from a B12 deficiency and suspecting a diagnosis of secondary hypoadrenalism. Again, Mr Lynn was asked about this on Day Six, page 98, by Dr Elliot. He said:

> "I think this is very difficult because often doctors use these letters"

F

- in other words a reference letter or a letter to the GP -

> "as an aide memoire to themselves when they look at the patient again. If he felt that there was secondary hypoadrenalism, and I'm not sure whether he meant of the - I presume he meant a low cortisol, then it would be appropriate to do a 24 hour urinary cortisol and also to do the serum cortisol and what's called an ACTH.
>
> If he put it as an aide memoire, it is not very clear that when he saw the patient again, then he might think: well, it may be that. I'm sorry to be vague, but ...
>
> But basically, if he felt that she had either of these conditions, you really should investigate them. If you think there is a condition you

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should investigate it."

Dr Elliot asked him:

"Q Yes. Should he have referred the patient to a relevant specialist for evaluation?
A I think that's hard. I think that he could organise 24-hour urinary cortisols, he could organise the ACTH, they are only blood tests, and if they were normal, it would stop the necessity for a referral. I wouldn't be critical of that, but ideally those tests should have been done."

B

MR JENKINS: Could you read on?

C

MR KARK: Yes, certainly. I am going to take it that in due course you will go to these references and read on for yourselves, but on this occasion I will.

"... ideally those tests should have been done, or else it may have been using the aide memoire for him at a later date to think about it."

D

MR JENKINS: Thank you.

MR KARK: Professor Weetman was critical of Dr Skinner's examination and note-taking. Mr Lynn thought the examination and notes were sufficient and that evidence plainly helps Dr Skinner on those charges.

E

The central charge relates to the use of thyroxine in these circumstances. Patient A's referral letter is of some interest. Again, I am going to turn these up. I do not ask you to on each occasion, but please do if you wish to. It is tab 2, and it is page 9 of tab 2. Patient A gave evidence about this on Day Two, page 33. She was suffering from extreme tiredness, she had had glandular fever and postnatal depression quite severely and she had had these problems of shadows around the sides of her vision, she said. She said that:

F

"… one of my eyebrows was short, not very long and he said that that was an indication of under active thyroid in that the eyebrow is often shorter ... I remember my blood pressure being taken but the rest is quite vague ... He may have looked in my eyes but that was about all I can remember …

G

Q What about the blood tests? Was he going to wait for the blood tests to come back or not?
A No, he said to start taking the thyroxine now ... I did ask him about any side effects but I was happy to take the thyroxine. I was extremely ill, looking for a solution.

H

Q What did he say about side effects? He said: 'Oh, you are not one of those are you?'",

A

and he explained that miserable people go to health shops and cheerful people go to McDonalds.

Dr Skinner did in fact take blood tests, but he did not wait for them before starting treatment. When he did get them back - and just to see the chronology for a moment, which may help you - we can see from the chronology that the referral letter first of all from Dr Skinner to Dr Cooke was on 17 January 2003. It appears at 215 in your - I am sorry, the referral from Dr Skinner to Dr Cooke was on 20 December 2002 at 144 in your bundle and also at 209. Then we have the consultation with Dr Skinner on 16 January and the prescription for thyroxine on the same day.

B

The letter gave this patient's TSH, and the most recent TSH for the patient was a TSH of 1.45 back on 13 May 2002. So, that is the last blood test that Dr Skinner has before he starts this patient on thyroxine. When he does get the blood tests back, again from your chronology you will see that it comes back on 21 January 2003, the TSH is still 1.4 and the T4 was 12.2.

C

Dr Skinner did not tell the patient it would appear about those blood tests but, if a doctor was going to take any notice of TSH levels at all, he would not have started this patient on thyroid replacement therapy. It is not as bad a case as some of the others, but the experts agree that no endocrinologist in this country, America or indeed Belgium would have started this woman on thyroxine. Dr Skinner said nothing to the patient about the side effects of the drugs, nor did he do any antibody tests to check the patient's concerns about autoimmune thyroiditis.

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When her blood tests came back, he did not change his mind and he did nothing to stop her taking the drugs. His letter to Dr Cooke is at tab 2, page 15, and he describes her TSH readings in the following way. He says:

E

> "I know that she has had one or two highish TSH readings but unfortunately nobody seems to have carried out an FT4 which will be at the laboratory end of things …"

To describe a TSH of 1.49 as "highish" is, with respect, a mis-description. According to Professor Weetman, the thyroid function tests that came back in July were, as he put it, normal. That is Day 4, page 29. Will you just give me a moment? (*Pause*) Yes, and it carries on at 30. He is referring to the TSH levels from July 2001 and May 2002 and I asked him:

F

> "In your view in any sense could either of those be regarded as highish TSH readings?
> A No … However one wants to look at it these are entirely normal".

G

When she called - when the patient called - trying to get through to Dr Skinner, she spoke apparently to his wife who told her to stop taking thyroxine. Professor Weetman did not think that was acceptable, but that is not a direct criticism of course of Dr Skinner himself. When Dr Skinner spoke to her, he switched her on to armour thyroid. It appears that he told her that he did not have her blood tests back yet - that is Day 2, page 38 - and

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that is possible because she rang him about four days after starting treatment and the blood tests are dated 21 January 2003, so about five days after the original consultation.

The basis of the case is upon the first prescription and the change of dose and drug are relevant to your considerations. The defence will no doubt quite properly point out that this patient was kept on thyroxine by Drs Cooke and by Professor Franklyn and that she is still taking it. Professor Weetman dealt with that aspect of the evidence on Day 4 at page 30 and 34, where he said this:

B

> "I think Dr Franklyn was confronted by a problem that I have seen very frequently. Patients who have even"

- I think been -

C

> "started on thyroxine unnecessarily with normal blood tests and the patient wishes to continue on thyroid hormone despite the evidence to the contrary. As we have heard from one of the general practitioners it is usually possible to get these patients off such treatment and then they go on to have normal thyroid function but certain patients refuse to come off thinking they have benefit from it in which case it is correct to take the pragmatic approach that Professor Franklyn has taken and that is to continue with T4 if the patient wishes to have it provided the TSH is maintained within the reference range. The danger with this, as I think we have seen with two of the patients, is that patients taking thyroxine tend to adjust the dose as they see fit ... Therefore that policy, although pragmatic, does run the risk at the TSH can become suppressed over a long period of time unless properly monitored".

D

E

When you look at what the other doctors who looked after these patients did when compared to Dr Skinner, one has to bear in mind that they appear to have regarded him, Dr Skinner, as an expert and there are references to him being a consultant.

F

Once she had left Dr Skinner's treatment she was kept on thyroxine, but her TSH levels were kept within the reference range and that is a feature which is singularly lacking when Dr Skinner treats his patients. She told you that she is now on 100 micrograms thyroxine because she felt it had a beneficial effect. That is Day 2, page 39.

G

Dr Cooke, who was the closest the defence got to agreeing that it was reasonable to treat a chemically euthyroid patient with thyroxine if the lab tests demonstrated her to have very low levels, apart of course from Dr Fink to whom I will turn later, and he would in certain circumstances treat a patient with thyroxine provided her tests continued to fall well within the reference ranges. That is Day 2, page 64. That was not something realistically that Dr Skinner ever bothered about.

H

So far as B12 deficiency is concerned, Dr Cooke also dealt with that at Day 2, page 55, and effectively he dismissed the issue of this patient having B12 deficiency. He was one of the many who told you that there is not much point in giving B12 orally in any event. It has to be by injection. You may remember Mr Jenkins asking perhaps somewhat

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innocently, "I do not know why, if it was so ineffective, do drug companies continue to supply it over the counter?", and there is an obvious answer to that.

The experts on Patient A. You heard of course from Mr Lynn, who reviewed her notes. He said that her TSH of 1.49 was well within the reference range - this is Day 6, page 20 - and his view was that that would exclude biochemically any suggestion that the patient had hypothyroidism. He said that this patient was:

> "… distinctly, in my view, not hypothyroid",

which is Day 6, page 21. Again, at Day 6 page 25 of Mr Lynn:

> "She is a relatively young woman, she's going to be on thyroxine for [the rest of her] life … She doesn't need to be on it".

Professor Weetman, Day 4, page 30:

> "Was this treatment by thyroxine, in your view, at that stage justified?
> A No",

and again the TSH levels in his view were normal.

Let me turn to Patient B. Dr Blair, of course, was the only witness who gave evidence directly about Patient B and so her story is told from the chronology of her treatment which we can follow from the notes. Back in February of 2003 she was very depressed and, according to Dr Blair's evidence, had scored in the moderate to high area on a Beck's Depression Test. That is Day 2, page 78. You will find the Beck's depression score if you refer back to the chronology that I gave you slightly earlier. You will find a Beck's depression score on 5 February 2003, which is at your tab 3, page 109, where her Beck's depression score was 22 out of 30 which I think put her in the severely depressed category

That was the position that she was in when she saw Dr Skinner on 20 March 2003. This patient was one of those who had been on the Internet and she had ticked off the signs of hypothyroidism. Dr Blair did not refer her to Dr Skinner and so Dr Blair received what I have referred to as "the dog house letter", which is at tab 3, page 113. Dr Blair's view, when he got that letter from Dr Skinner, was encapsulated by his answers at Day 2 and it is page 79. I quoted the letter to him, which said this:

> "[Patient B] is one of these difficult situations where she seems almost classically hypothyroid with a number of typical features ...",

and then he sets out the features which he finds "quite common in hypothyroidism". He says:

> "… notwithstanding the thyroid chemistry she is hypothyroid ..."

I asked Dr Blair:

A

> "As a general practitioner did you think that this woman was classically hypothyroid",

and he said perhaps obviously, "No".

He was concerned about the letter that he had received from Dr Skinner and so discussed the case with an endocrinologist. His evidence about that is at Day 2, page 79 again, where he says:

B

> "I took the opportunity of discussing the letter with an endocrinologist and when I saw the patient I passed on the information I gained from the endocrinologist specialist, Dr Thompson, that there was no basis or justification for taking thyroxine in the situation of normal thyroid function tests".

C

Well, both Professor Weetman and Mr Lynn agreed with that view. For Professor Weetman's view about that, you can go to Day 4, page 38. He was asked:

> "On the basis of this examination and those blood tests, can you see any basis whatever for starting this patient on Thyroxine",

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and his answer was, "No".

What happened with this particular patient was that she was put on thyroxine and nine months after that treatment had begun, by 5 December 2003, her TSH was at 0.1, which I think was really unrecordable, and her T4 was 39. That is at tab 4, page 8, if anybody wants to find it, of the main file. Then on 24 January she had her second consultation with Dr Skinner and you will recall that she had had during that period palpitations. Despite that a further patient(*sic*) for thyroxine was given and to it was added Tertroxin, and this was the occasion, you will recall, when the prescription was actually refused by Tescos.

E

THE CHAIRMAN: Excuse me, Mr Kark. I am sorry for interrupting. You said 24 January, did you?

F

MR KARK: 21 January was the second consultation. No, if I said 24th, I am sorry. It is 21 January for Patient B, the second consultation with Dr Skinner when the palpitations were mentioned, and the note of it is at tab 4, page 4. Forgive me for that inaccurate date. This was the prescription that was refused by Tescos and it was followed by a letter of complaint to the GMC from Dr Jordan.

G

Dr Blair had been advising this patient against taking thyroxine and, as we go on through the chronology, you will see that Dr Skinner writes to Dr Blair on 28 January talking about despite the highish T4 readings she is still hypothyroid, and that is at tab 4, page 11, and talks about back stacking, but of course you will recall that on this occasion no T3 blood test was taken and so Dr Skinner is coming to that view effectively by the look of the patient. All that he knows is that her TSH is negligible and her T4 is at 39, which is plainly well outside the reference level. Because to him she looks hypothyroidism he makes an assumption that she is therefore not converting. So, without doing any further

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blood tests he changes this patient or puts this patient on to T3.

Then Dr Blair complains to the GMC in February 2004. In March there is the third consultation with Dr Skinner where he has made the note "about three-quarters of an hour of beating heart". Again, despite that, he does not take a blood test. He continues with his prescription and he writes to Dr Blair:

> "I still think she is hypothyroid."

You have to ask yourselves: what on earth is the basis for that and why is he ignoring effectively what is happening with the patient?

In July 2004 he alters the prescription again. This time Dr Skinner puts the patient on to 150 micrograms for three months. No blood tests are taken. Then we know from the patient notes that the patient herself has decided to try and stop and reduce thyroxine. That is at 328. She manages to get herself down to 100 micrograms and her TSH gradually begins to come back up. Her T4 comes back down again. We have the note in October 2004 at tab 3, page 29:

> "Patient is off thyroxine."

By November her TSH is back to 2.4, as it was in fact in January 2003, so almost two years before, and her T4 is at 13.5.

Pausing there for a moment, if this patient's problem had been that her thyroid was sick, then you would have expected that the function would have diminished, but it has not. Absolutely nothing has happened to that thyroid at all, except that she has been put on thyroxine for a considerable period and then, as soon as she comes back off it, her thyroid fortunately comes back to normal. You will also recall the patient saying to Dr Blair at tab 3, page 122 in the patient notes, that she had not noticed any difference since the pills finished.

Professor Weetman was highly critical of this treatment. He said that there was really no basis whatever for thinking that this patient's body was failing to convert T4 to T3. There was no basis for starting the patient on T3 (D4/40 – 42). In his view the problem was that the patient did not need thyroxine in the first place. He was critical of the lack of action once the patient had complained on two occasions of heart palpitations. He said:

> "A In this patient I would have done an ECG, an electrocardiogram, which is a tracing of the heart which will make sure there is no serious underlying problem and what I am saying here is that she could just be unfortunate and have a coincidental rhythm problem that could have been unmasked by either alcohol or thyroid hormones or both, but certainly she has presented with new episodes of palpitations and either one follows Dr Skinner's line of reasoning that this is not thyrotoxicosis, I which case an ECG should certainly be done because there is no other explanation, or one follows my line of reasoning saying that this is due to excessive thyroid hormone, in which case reduction of the thyroid hormone level to a normal

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> biochemical level of TSH and complete cessation of palpitations on its own would be reassuring, but I think new palpitations in an other wise fit and healthy person do demand one of those two steps."

That is D4/41.

B

When asking yourselves, if you do, the first question I posed to you: was it acceptable medical practice to prescribe thyroxine in these circumstances, you should take into account, in my submission, not only the views of the two experts, but those who are directly responsible for this patient's care and did what they could to stop Dr Skinner.

C

When you hear the sweeping statements made by or on behalf of Dr Skinner, such as, "The patient got better on Thyroxine", which is something that he said occasionally, please bear in mind – and this patient is a good example – that the reality is demonstrated by the medical notes. The patient did not notice the difference when she came off the thyroxine. Patient B should never have been given thyroxine in the first place, according to the two eminent GMC experts.

D

Mr Lynn at D6/26 said to prescribe a dose of 225 micrograms of thyroxine is a considerable amount. When by December 2003 her TSH had dropped to 0.1 – and this was the occasion when the lab referred to it as a slight over replacement with thyroxine – Mr Lynn described that as outrageous, saying this patient was grossly over treated for a condition that she never had. That is D6/27. When she was put on Tertroxin again, Mr Lynn's view, as well as Professor Weetman's, was that there was no basis for that whatever (D6/30).

E

So far as the alleged failure to convert is concerned, Mr Lynn's evidence was that there are rare genetic entities where you will get a conversion problem. Here the explanation of the levels was the misinterpreted clinical features and was incorrect.

For your note, Professor Weetman dealt with the history and record taking at D4/37, with thyroxine at D4/37, thyrotoxicosis, which he said this patient was suffering from, at D4/38 and the change to T3 at D4/40 to 42.

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Dr Hertoghe also dealt with this patient at D10/199. He was dealing with Patient B in the period after the second consultation. I asked him:

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> "Q With that blood test the patient has been under treatment for nine months with thyroxine. With that blood test of less than 0.1, T4 of 39, palpitations, you would not have dreamt of giving this woman Tertroxin, would you, without another blood test?
> A And I would have lowered the dose in the meanwhile.
>
> Q Sorry, what is the answer?
> A I would not have increased the dose. I would have lowered the dose and done another blood test if there were palpitations."

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I pushed him on it:

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> "Q You cannot suddenly stop thyroid medication. I will ask you once more. Do you accept that you would not have given this woman T3 without a further blood test?
> A Yes."

B That was the view, for what it is worth, of the expert called on behalf of Dr Skinner.

I should have given you another reference. Mr Lynn's view on the quality of the notes you will find at D6/101. Again, it is right to say that he viewed the notes as being perfectly adequate, so again, you will have to consider conflicting views of Professor Weetman and Mr Lynn.

C Can I turn to Patient C? This was the lady who started originally with Dr Summers and then she moved down to Wimbledon where Dr Ince tried to look after her. You heard from Dr Summers, who had in fact prescribed thyroxine to this patient, but he had only done so on the basis of the advice from Dr Skinner, who he believed was a specialist in the area of thyroid treatment. The first that he heard about his patient receiving advice from Dr Skinner was when he received the dog house letter dated 10 March 2004, which is tab 6, page 2. He said he had not referred her.

D

He was asked by Mr Jenkins whether he might have been asked for a referral letter which he had forgotten, but the reality is that there would have been no reason not to give her a referral, unless perhaps he knew of Dr Skinner and disapproved of his methods. The reality is there was no referral and Dr Skinner would not have needed to write the dog house letter if there had been a referral.

E The letter by Dr Skinner refers to the patient being likely to be hypothyroid. In fact, the letter that he writes to this patient's GP, if we turn it up, makes no reference to prescribing the patient with thyroxine. He simply says:

> "I thought it was quite likely she was hypothyroidism, although not seriously hypothyroidism. I have taken a blood sample for thyroid chemistry and should have the results in ten days. I will let you know what goes forwards at that point in time."

F

You might have thought it would be very relevant to tell the general practitioner, "I have stared your patient on thyroxine. Her blood tests, which you have at tab 6, page 3, were perfectly normal, as I would refer to it, certainly within the reference range. There was a TSH of 2.2 and a T4 of 11.6. She was started on thyroxine. By the second consultation which took place on 6 May 2004 the patient had already put her own dose up and she was taking 200 micrograms. Dr Skinner reduced that, but added T3, apparently on the basis that, in Dr Skinner's view, the thyroxine was not working well enough. Again, what does that mean? It means that her symptoms are not sufficiently or markedly better.

G

That is a problem we come across again and again. Dr Skinner having made the diagnosis of hypothyroidism, he does not seem to reflect upon that diagnosis when the symptoms do not entirely resolve themselves. He presumes that the patient therefore is not getting enough thyroxine or he presumes that the patient is not converting the T4 properly to T3 or backstopping, as he calls it. He makes that presumption in the face of TSH levels

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which, as a result of his prescriptions, are unrecordable and the patient is, certainly according to Professor Weetman, hyperthyroid not hypothyroid.

The true problem may be that the original diagnosis was wrong and the patients' problems do not emanate from a sick thyroid. Dr Skinner wrote to Dr Summers again following the second consultation. He tells Dr Summers this: this is no evidence of toxicity. He has not done a blood test, so how does he know? He knows, he says, because he can just look at the patient. That means that he is waiting for signs, over signs of toxicity to manifest themselves.

B

The third consultation was on 7 August and he does take a blood test on that occasion, the results of which are at tab 6, page 10. I will read them out for you. They are in your chronology. The TSH was unrecordable, less than 0.1. The T4 was 25.5. Dr Skinner simply tells his patient that her levels are a bit on the high side. He has not given this patient, or indeed any of his patients, warnings about the possible effects of having an unrecordable TSH. He simply says, "You are a bit on the high side."

C

In August 2004 it was Dr Summers who set up a repeat prescription for this patient, but he did so only on the basis of the information that he had from Dr Skinner. He said when he gave evidence at D2/95, that he had not received the blood test and if he had done so he would not have issued the prescription.

D

Dr Ince took over from Dr Summers at the beginning of September 2004 when this lady moved down to Wimbledon. She told you that she saw the patient on 7 September 2004 and the patient was not sure if she was happy with her prescription. That is the transcript at D3/15 and it is in the patient notes at tab 5, page 1, another patient for whom the sweeping statement, "The patient felt better" may not apply .

E

Dr Ince saw her patient again on 5 October and she recorded this in the notes. It is her evidence on D3/17:

> "Had a chat with patient. Has been seeing specialist but feels no better on Thyroxine."

F

The next contact Dr Ince had was the telephone call on 28 October 2004:

> "To stop all medication. Feels a lot better off medication."

In fact, the patient had stopped taking the medication a few weeks before that conversation. The note is in the medical records at tab 5, page 2.

G

Dr Ince's view of the original blood tests of 10 March 2004, to which she refers in her note of 28 October 2004, was that the patient was euthyroid and she noted:

> "Thus no response to treatment."

H

Dr Skinner's response had, of course, been in May to put the patient on to Tertroxin without taking a blood test to see what was happening with the patient's blood. So, this GP had recognised pretty immediately that this woman was being prescribed the wrong

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medication and was so concerned about it that she decided to take further advice. She wrote first to Dr Skinner (her letter at tab 5, page 9).

Pausing for a moment, we should not think that that is a perfectly normal thing for her to have to do, for a young GP to have to write to another doctor effectively asking him to justify his treatment of a patient. His reply at tab 5, page 11 says this:

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

When he gave evidence he said that was a typo for:

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

Whichever one it is, this doctor did not think she was hypothyroid. You may think that is slightly typical of Dr Skinner supplanting on to somebody else what he himself was thinking. What Dr Ince did was she spoke to her local endocrinologist, to Dr Springer. Dr Springer put her on to Dr Prentice, a consultant endocrinologist at the Mayday University Hospital. Dr Cundy then wrote a letter to the GMC. She had written to Dr Prentice and got his reply, which again I do not need to take you to. It is in file 2 on this occasion, tab 2, page 5. Again, in his view this lady was not hypothyroid.

If the doctor's practice had been acceptable medical practice, it is surprising, if not astonishing, that not one of these practitioners thought so and they all went as far as they did. You have to take it into account when answering the first question I posed: was this acceptable medical practice at the time? The reaction of the doctors - who were not experts - who discovered what Dr Skinner was doing with their patients demonstrates, in our submission, whether it was acceptable or not.

Dr Cundy's evidence - it is he who wrote to the GMC, and his letter, as I say, is at file 2, tab 2, page 6. It was also interesting in relation to the perceived effects of thyroxine. He gave evidence on Day Three. I am going to turn that up. He said this:

> "Q What were your concerns for this patient of your practice?
> A Thyroid medicine is a profound medicine. It is a hormone which affects virtually every part of the body and, as with all hormones, in excess or inadequate quantities can cause damage to the body. Thyroid hormones, when prescribed in excess for even short periods, can cause quite severe damage and in long periods can cause permanent and severe damage to patients.
>
> I am particularly concerned about a class of patients that are generally young ladies, who often describe symptoms as being tired all the time or not quite feeling the full vigour they should, who were quite often prescribed Thyroxine as a 'pick you up', maybe a bit of a tonic, inappropriately by doctors such as Dr Skinner."

You will perhaps remember the slightly startling piece of evidence from Dr Skinner about

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how nurses in his heyday used to use it in their student days to make them jollier for the party. I expect he may regret giving you that piece of evidence. That is the problem with thyroxine. It is, it may have been pooh-poohed by others when Mr Lynn said this, is an addictive drug. You may think it is addictive in just that way. Whether it does have the effect of a pick-me-up or not, that is the perceived effect by some. So whether it is by reason of a placebo effect, as Dr Skinner ended up saying, or a genuine effect, one has to be just as careful to avoid putting patients on to a significant drug which they do not require.

B

You may remember, I do not know, the various problems in the 70s and early 80s when a number of doctors were found prescribing amphetamine. Amphetamine was referred to in our case as a diet pill, but it was thought to be a very good thing in the 1970s until people thought perhaps it is not such a good thing. This is not so very different. It is medically the wrong thing to do.

C

Patient C eventually came off thyroxine and Tertroxin and was back to normal by around February of 2005. Again, I do make the point that if Dr Skinner had, as he claimed, been treating a diseased thyroid, the addition of thyroxine would not of course have cured the disease; it would simply replace the T4, which was not being made by the thyroid, thus it is called replacement therapy, so you would expect the thyroid to have worsened or diminished over a period of time. The patient's thyroid went straight back to normal, her TSH level goes straight back to normal. There was nothing wrong with her thyroid.

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Dr Skinner sent a letter to the GMC on 18 June 2005, which you have in your file 2, tab 2, page 7. He refers to this patient as having significantly improved on thyroid treatment. That is not supported by Dr Ince's note, that she felt better when off the medication. Once again, you will have to consider whether there is an element of revisionism. I am not saying he does this necessarily deliberately, but you will have to consider whether there is an element of revisionism when Dr Skinner writes his letters.

E

When Dr Ince was cross-examined, she was asked if she had checked this lady's pulse and heart, because of course there was criticism of Dr Skinner in not doing so. She said that she had not done that; Day Three, page 29. It is also fair to relate that Dr Ince had not put her on any medication that could affect her heart rate. Dr Skinner *had* done so. That failure is a specific criticism in the charges.

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Dr Prentice, from whom Dr Ince had received advice, gave evidence on Day Four. Dr Ince's letter to him and his reply you have. His view was that she was not hypothyroid but hyperthyroid. She had been made hyperthyroid by the treatment. In his view - Day Four, page 62, again let me just turn it up:

G

> "Q Having seen the blood tests that you saw, first of all could you see any basis upon which this patient should have been started on Thyroxine?
> A No, none at all without further tests."

When he was asked some questions by Mrs Whitehill - Day Four, page 63 - he said:

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> "The second set of blood tests after she had been started on a

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> combination of Thyroxine and T3 indicated thyrotoxic range of thyroid hormone levels both from the T4 and from the T3 treatments. So it is up to a level which we would normally start treating for an overactive thyroid and could lead to heart and other complications in the long and short term, which I am sure you have been told about.
>
> B
>
> Q With her blood results in that range, would she be experiencing any symptoms of thyrotoxicosis?
> A Patients may not be feeling any symptoms of thyrotoxicosis because it is well-known by thyroidologists that quite often patients have a lot of symptoms of an underactive thyroid and do not have an underactive thyroid and in the same instance some patients who have thyrotoxic blood tests can actually become very tired and apathetic and as a form of apathetic thyrotoxicosis. So we know that you cannot rely on symptoms, you have to do a combination of the blood tests and see if that concurs with your symptoms and then you can feel justified that that is the cause of the symptoms and then you can go on to make a diagnosis and then give the patient the correct treatment and then see again if the patient returns to normal and recovers. But tiredness can be seen at the upper end of thyrotoxicosis and also with an underactive thyroid, so you have got to be sure you are dealing with the right condition."

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Day Four, page 63.

Mr Lynn's evidence as well of course - Day Six, page 33 - was on the basis of her tests. There was no reason to treat her as hypothyroid; she should never have been put on thyroxine. He again felt that the notes that Dr Skinner had made were perfectly satisfactory.

E

Dr Hertoghe again dealt with this patient. Perhaps I can just deal with this before we break. Day Ten, page 209. I was asking him about the third consultation on 7 August and her prescription for 150 micrograms. I said this:

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> "The TSH, as reflected by blood tests in August of 2004, and we have the lab report at page 10 if anyone wants to have a look at it, was down to - well, it was unrecordable. Less than 0.1, we heard, meant unrecordable. Her T4 was well over the reference range at 25.5. Her T3 was 8.9. How would you describe those levels if they're accurate?
> A Hyperthyroidism."

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That was the effect of Dr Skinner's medication.

Madam, I am about to turn to Patient D. I wonder if that would be a convenient moment.

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THE CHAIRMAN: Whatever you think. You are suggesting stopping now?

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MR KARK: I would rather deal with Patient D in one piece, as it were, so if we could

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have a slightly early lunch.

THE CHAIRMAN: Yes, we will reconvene at quarter-to two.

(*The Panel adjourned for lunch*)

B

MR KARK: I am aware I have been going some time. If I go on too much longer we are all going to need some of Dr Hertoghe's anti-ageing medication! I have quite a lot I need to say, so forgive me.

I thought I had finished on Patient C, but I had not set forth this one point. You will recall, in relation to Patient C, that there is a charge relating to the suspicion of a diagnosis of B12 deficiency, which Dr Skinner has now withdrawn, and that he, Dr Skinner, failed to perform any investigation on Miss C to assess a B12 deficiency, and also head of charge 24, "You suspected that Miss C might be suffering adrenal failure", and Dr Skinner failed to refer Miss C to an endocrinologist.

C

I ought to make specific reference to the evidence to that, just to draw your attention to it so you know where it comes from. Professor Weetman gave evidence about this on Day Four, page 46. It was based upon the note that Dr Skinner had made in his notes at tab 6, page 8; it simply had the reference "B12" on the right-hand part of the page. I asked Professor Weetman:

D

> "Q ... if this is a signal that he was either prescribing B12 or suspected B12 deficiency do your comments apply as before?
> A Yes."

E

Then he goes on to deal with cortisol levels. He said this, Day Four, page 47:

> "As I mentioned the adrenal glands are two glands which lie above the kidneys and are responsible for the secretion of a hormone called cortisol amongst several other hormones. I will concentrate on cortisol because it is the most significant. Cortisol is responsible for the body's response to stress and without it a patient can succumb and die following any major stress such as an illness or infection. It is a very serious but rare condition. The commonest cause of adrenal failure is again autoimmunity."

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Then towards the bottom of that page, he says:

G

> "A cortisol between 100 to 400"

- which is what we have in the blood test, which I will refer to in a moment -

> "cannot be used to diagnose whether adrenal failure is present or not ...
>
> Q If Dr Skinner was concerned at all about the possibility of adrenal supplementation ought he to have taken steps?

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> A He should. This is a patient who after all has a normal thyroid function, does not have hypothyroidism and has a number of symptoms and a cardinal sign of hypoadrenalism, namely low blood pressure. If he seriously suspected this potentially life-threatening illness, he should have either undertaken a (*inaudible*) test, having received this cortisol result, which is equivocal, or he should have referred it to an endocrinologist."

B

The cortisol level that he was referring to, just for your note again, is at tab 6, page 10 of file 1. Apologies for having missed that.

Let me move on to Patient D. Patient D, of course, gave evidence before you on Day Three, starting at page 32. She had had problems with lethargy and lack of energy. She had a family history of thyroid disease. Dr Stewart was her GP. He gave evidence to you and you will find his evidence from page 66 of Day Three onwards. He was, undoubtedly, a cautious man. He told you he had been her GP for 23 years.

C

On 19 July, Dr Stewart told his patient that her blood tests were completely normal. Her blood tests can be found at tab 7/6. He said he told the patient, in his letter - tab 8, page 3 - that he did not want to refer her to Dr Skinner. Indeed he said:

D

> "We are not sending any patients to Dr Skinner at the present time and I trust will be investigated by the General Medical Council ..."

Those words did not go down very well with Dr Skinner, nor indeed with his patient.

E

Having been told that her test showed that she was euthyroid, she, the patient, was not happy. She went on to the internet and got some information on hypothyroidism and ticked off the checklist that you have at page 8 of her notes; tab 8, page 8. When she saw Dr Skinner for the first time on 24 August 2004, she was told that although her results were within the normal range, they were borderline. At the time that she goes to see Dr Skinner, her TSH is at 0.67 and her T4 was 13. If those results were borderline, they were not borderline hypothyroidism; they were, if anything, borderline hyperthyroidism.

F

Dr Skinner responded rather crossly when he saw Dr Stewart's letter, but one might forgive him for that. What he started his letter by saying was this:

> "I am sure you know that I have never met this patient and thus the predication that I would be prescribing thyroxine for her would seem presumptuous to say the least."

G

It was not actually particularly presumptuous; in Dr Skinner's own evidence, about 95 per cent, I think he said, of patients who walked into his clinic walked out with thyroxine. I will take you to that quote in due course.

Despite her TSH results being within the reference range - which he knew because he had her blood tests provided by the patient - he did indeed, as Dr Stewart had imagined he would, start her on thyroxine.

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The blood test result following that first consultation, the consultation is on 24 August and he takes the blood test and he gets the results back on 26 August. By this time, the blood test reveals the following: her TSH is 1.9 and her T4 is 14.2. That is tab 88, page 16. Those blood tests reveal that her pituitary appeared to be functioning correctly and producing TSH within the reference range and her thyroid was responding by producing T4 within the reference range. There was quite simply no evidence of a sick thyroid.

B

Dr Stewart described the TSH levels of this patient from that day, 26 August, as an:

> "… an excellent result. It is right in the middle of the normal range",

which is Day 3, page 73. The two are both showing normal thyroid function.

C

Dr Skinner wrote to Dr Blanchard, another doctor at Dr Stewart's practice, on 3 September describing the patient's T4 as "a little low", and you will recall that when he wrote to the patient about those blood tests he said this:

> "I enclose your thyroid chemistry and although it is not significantly abnormal I believe you may benefit from a trial of thyroid replacement based on your clinical features".

D

Well it was not significantly abnormal, in our submission, on the evidence. Her results were not abnormal in any way.

She classically, having been started on thyroxine by Dr Skinner, kept increasing the dose and felt in her words "better and better" and she said she was feeling much better once she was on 100 micrograms. Dr Skinner also suggested that she take B12, which advice she seems to have declined, and Dr Stewart then wrote the letter of 7 September to Dr Skinner asking him to discharge his patient from Dr Skinner's care "… as we did not refer her in the first place".

E

That is the second letter that a GP in practice has felt it necessary to write to Dr Skinner about his practises. Dr Stewart had never in his 23 year career had to write such a letter before. Again I do not need you to turn it up, but for anybody who wishes to it is Day 3, page 76, where I asked him this:

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> "Is it quite common for you to write a letter such as this?
> A This is the only one I have ever done in 23 years",

G

and in answer to the Chairman he was asked:

> "Just to clarify for me again, all the partners in your practice wrote the letter to the GMC? … Is this because you felt the patient was in serious danger?
> A I was allowing the situation to continue until the patient became thyrotoxic. That was the point when I thought I really did have to do something. I had never written to the GMC before, I hope I never have to do it again. What made me actually write the letter was the

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patient becoming thyrotoxic. That is what I was not happy about".

It is important, in my submission, not to be complacent about that. You have to bear in mind the reaction of the doctors who actually were dealing with these patients when you consider the first question that I have asked you to set for yourselves - the primary question. When you ask yourself that primary question, if you do, you may want to ask yourselves, "Well, why did all these GPs write to Dr Skinner? Why were they so concerned?" They were concerned because Dr Skinner was doing something that was out of line with accepted medical practice.

The next time that the patient went to see Dr Skinner was on 18 November and it was the day before that that the prescription seems to have been written out. (Tab 8, page 23) That, as you know, occurred again with this particular patient that the prescription was written in advance of the consultation.

Dr Skinner told you, well, he sometimes gets confused about dates. That is one possible explanation, but there is of course another and that is that he knew exactly what he was going to be giving these patients - this particular patient - before she even got to his door. He did not get a blood test before increasing the prescription as he did, and the second consultation you find the notes of that at tab 8, page 24. The prescription for thyroxine which is the day before that, 17 November 2004, you will find at tab 8, page 23.

He does the same thing again on 23 February. He increases the dosage. In neither case did he get a blood test before he changed the dose, and even Dr Hertoghe says that that is something that he would have done.

Then there is the fourth consultation on 18 August, that is 18 August 2005, when again he does exactly the same thing. First of all the prescription is two days before the consultation, it is an increased dosage, there is no blood test taken and yet there is a claim by Dr Skinner to the doctor, to the GP's surgery, where he says this. Let me just read you the letter. It is tab 8, page 33:

> "A note on [Patient D] who continues to improve on thyroid replacement but is still a long way from being euthyroid …"

This is 18 August 2005 and he has been treating her since August of 2004. She is still apparently a long way from being euthyroid, but he is not considering whether in fact his whole approach to this patient may be wrong:

> "I [had] planned that she increase to 125 micrograms per day but in fact she is still taking the 150 micrograms … and I have suggested she proceed to 175 micrograms … and then 200 micrograms … and I will review her three months' time at which point I will recheck her thyroid chemistry".

Her last blood test was back in January of 2005, and you may think that really all of the experts agree that you cannot just go on changing or altering dosages - certainly not increasing dosages - without finding out what the blood chemistry is doing.

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The GP practice on this occasion took it further and they wrote to the GMC on 31 August 2005. Again that cannot have been an easy step for them to take, which should not be dismissed lightly.

The fifth consultation with this patient took place on 18 November. As I have said, again the prescription had been written out two days previously and the reading of 24 November, when the blood test did come back, demonstrates that in Professor Weetman's words, "This lady had become thyrotoxic", and Dr Skinner described the readings in his letter to Dr Stewart as being "on the high side".

B

The readings that he described as being "on the high side" was that the TSH was unrecordable and the T4 was 27.2. There had been no check on this lady's blood since August 2004, so for about 15 months she had been prescribed thyroxine without a further check.

C

Again the doctors at the practice wrote to Dr Skinner at the end of the year, December 2005, once again asking him to discharge this patient from his care and complaining in that letter of "iatrogenic thyrotoxicosis"; in other words, thyrotoxicosis caused by doctors.

Dr Skinner replied to that on 4 January with his "good servants but bad masters" letter at tab 8, page 46. You will have to ask yourself if he was using the blood tests as servants at all, because in reality he was consistently ignoring them.

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This patient undoubtedly felt better after she started on thyroxine and she had more energy, she could get about more and, as she said, had it not been for Dr Skinner she would not be here giving evidence. She would probably be asleep on a sofa. That is a point that Mr Jenkins I am sure will hammer home to you. We do not shrink from that evidence and you may think it was right to call her, but the fact that she did feel better and had more energy does not necessarily mean that it is the right thing for her medically. Her TSH when recorded in November 2005 was, as I have said, unrecordable and, if anyone thinks that that is the natural state in which she should be, I would submit that they are wrong based on the evidence.

E

You will also remember that right at the end of her cross-examination by Mr Jenkins she mentioned a racing pulse in January of 2005 when perhaps, as she put it, she had taken a bit too much. That is Day 3, page 61. She reduced her own dose accordingly. Just a reminder that there are dangers and that this is a significant drug. That lady is, in the view of the experts, at potential risk and only time will tell what the result will be.

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Can I say this. This is not an ethical question that you are having to resolve; in other words should people be offered a happier, livelier, shorter life with thyroxine? The question is was it medically the right treatment? It can only medically be the right treatment if the thyroid is sick in the first place. That witness told the Chairman that she felt best when she was on 200 micrograms, but she had now reduced it and was beginning to feel more tired again.

G

The latest position with Patient D was described by Dr Stewart on Day 3, but unfortunately I have a note of page 873. Would you give me one moment? (*Pause*)
I think it is actually coming back to the note that I read earlier. At page 86 he was asked:

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> "What was the quality of this lady's life in the period just going up to July 2004? Are you able to help us?
> A Yes, I can. I will try, anyway. She had recently split from her partner that she had for many years. She had three children … and she was very traumatised, she was very upset … She was comfort eating, unable to follow a diet …",

B

and there were a number of other problems:

> "I think the main thing that has contributed to her improvement is not thyroxine but the fact that she has found a new partner who is very supportive …"

C

Now that may of course not be the total answer and I am not suggesting for a moment that it is, but there are so many features to these various patients' lives that, in my submission, to place all of the benefit as it were to thyroxine would be incorrect.

Dr(*sic*) Lynn's evidence about Patient D was that in his view it was totally inappropriate to start her on thyroxine and the prescriptions which followed were totally inappropriate,

D

there being no basis for increasing the dose, and again he made the same comment about the adequacy of the notes.

This lady, you will recall, had a palpable goiter. According to Dr Skinner's note she had not noticed it herself, but her mother had. The goiter Professor Weetman deals with at Day 4, page 50, and I will not take you to that now.

E

Mr Lynn was asked about the reference range and he confirmed that even applying the USA reference range, which he described as being preventative, he did not think these patients would have been treated because their TSH levels were all within the USA reference range. That is Day 4(*sic*), page 65.

The reality is that at the moment there is no reference range, so far as we have heard in the evidence, anywhere in the world where these patients would have been treated by an

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endocrinologist. In his view, no reasonable doctor would have prescribed thyroxine for any one of these four patients. He was not saying that these patients were not ill and it does him, with respect, a disservice if that were suggested.

Let me just deal with it quickly now. He was asked:

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> "And what would you do with such patients?",

in other words those who had signs and symptoms of hypothyroidism, but their blood chemistry was within the range:

> "I would do as I said, I would check their thyroid function regularly. I wouldn't take one TSH, I would see how they went. I would check their antibodies. If there was any hint of any other pathology, I would investigate them fully, and these patients did not get put on

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thyroxine",

and so he is talking about his own patients there:

> "So you can't tell us whether a trial of thyroxine for a patient who had signs and symptoms which may be consistent with hypothyroidism, but who had chemistry within the reference range, you can't tell us whether that was successful or not because you have never done it?
> A I haven't done that but these patients have been followed up, some of them for 20 years".

B

Mr Jenkins asked him:

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> "But the issue I want to you about is your experience of treating patients who may have signs and symptoms but normal chemistry.
> A I have none because it is an entity which doesn't exist.
>
> Q Right. So if I produced a patient to you with signs and symptoms with chemistry within the reference range, you would say that is not a hypothyroid patient?
> A I would say it is not at hypothyroid patient but this patient must be watched and regular TSHs done, make sure there are no other problems and follow them. I would not discharge them, they have come to me because they are unwell".

D

So, he is not dismissing the patient. What he is saying is if their blood chemistry is normal then, whatever their problem is, it is not hypothyroidism. Well, that was the view of Mr Lynn.

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Professor Weetman, I am not going to go through his evidence as I have dealt with it as I have gone through, but to describe him or to suggest that he is the one in an ivory tower would not, in my submission, be accurate or fair. He has been specialising in this area of medical practice for some 20 years and he still runs thyroid clinics weekly. He explained why the TSH from the pituitary was used as an indicator, why it is a very sensitive indicator and he described how very rarely the TSH can be misleading with a low or normal TSH and a low T4 which, as he said, would be a classic sign of pituitary disease.

F

I am not going to go into the various pieces of research and the study. You will remember that he was roundly attacked by Dr Hertoghe for misquoting the Zulewski study. If one can dredge that back from the dim past of our memories, that was the study which was looking at the issue of diagnosing hypothyroidism on clinical signs. In fact what had happened was that Dr Hertoghe had simply read the abstract, whereas Professor Weetman was quoting from the body of the work.

G

Professor Weetman's conclusion in respect of all four patients appears at D4/57 of his evidence. I remind you of what he said in his report first of all:

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> "Q You say at the end:

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> ‘His practice is completely out of step with normal matters of dealing with hypothyroidism. Dr Skinner is not trained as an endocrinologist.’
>
> You have now seen quite a lot of material produced by Dr Skinner, I think. Is that right?
> A Yes.

B

> Q Including a book that has been written by him?
> A Yes.
>
> Q Has your view changed about his training and expertise?
> A No, but I think it would be helpful if I could expand for the Panel to say that by stating as I do I am not saying that hypothyroidism should only be treated by endocrinologists. Far from it. General practitioners are perfectly able to treat hypothyroidism in general practice, primary hypothyroidism. I think that the difference here is that Dr Skinner is working outside of accepted guidelines and we heard from GPs on this score and is treating patients inappropriately by endocrinological standards when a GP might have sought advice from an endocrinologist about this sort of dilemma, someone who is apparently hypothyroid yet the blood tests keep coming back normal. That would be the point at which a GP would seek alternative advice.”

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Professor Weetman was also expansive and keen to point out the dangers of missing alternative diagnoses. That, you will remember, was one of the key elements of his evidence (D5/9 and D5/35). He dealt with this in answer to Mr Jenkins:

> “A …The biggest concern I have about these four cases is that the patients were not biochemically hypothyroid, had very profound symptoms, and therefore it was highly likely that alternative diagnoses existed, should have been sought, and were not. Sooner or later a patient will have a serious illness and be misdiagnosed as hypothyroidism based on this approach and suffer consequences.”

F

He was asked more about that. He said:

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> “A …I have never said at any point that such patients are healthy. I have just told
> you that my major concern is that these patients are not just not healthy, alternative diagnoses are being missed.”

That is D5/9.

H

Let me turn to Dr Skinner’s evidence. I am not going to deal with it in great detail. He agreed, first of all, that he had had no training in this field of medicine, nor, since he had changed his practice, to concentrate on hypothyroidism, had he taken steps to update

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himself. If you want the references, this is all from D8/3 and D8/165. In fact, he was being asked questions by Mrs Whitehill:

> "Q Did you undertake any further training to help your practice and expertise in that area?
> A I didn't undertake any specific training, no.
>
> B
>
> Q Did you undertake any training around clinical skills and examination?
> A I didn't. Perhaps mistakenly I thought I was getting a bit long in the tooth for that to be perfectly honest."

His views on blood testing are, I think, pretty clear. You will recall his statement that

C

there is no TSH level with which he would not be comfortable. Can I give you the references again for what he said about blood testing? First of all, it is D8/17. I put to him:

> "Q Do you agree that where a disease of a gland is suspected the basic test that should always be performed would be a blood test?
> A Yes, I do…"

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I have to confess, I thought I had won some sort of victory there, but he hurriedly followed up with:

> "…sort of.
>
> Q Sort of?
>
> E
>
> A Well, I think it is giving a funny impression to the Panel. I always do it, so, well, that is a yes."

He carried on in this area on pages 20 to 22. I quoted from his book:

> "Q The diagnosis of hypothyroidism should be made on clinical grounds. This is the most important statement in this book. When
>
> F
>
> you say clinical grounds you mean the presentation of the patient, do you?
> A Yes."

I asked him:

G

> "Q To remind you of the evidence yesterday, 'There is no level of TSH that I would not be comfortable with." Do you stand by that?
> A Yes. We are not talking massively high levels, of course, but I am not concerned with a TSH of zero. I do stand by that."

On the same topic at page 150 and page 180 of the same day.

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His reaction to monitoring and to the heart palpitations suffered by Patient B does bear brief examination. He dealt with this on D8/75. You will recall that in relation to Patient

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B she was getting repeated prescriptions and there were no further blood tests after 5 December 2003 until September 2004. I asked him this:

> "Q How was she getting these further prescriptions?
> A This sounds awful, but I suppose I must have been writing them for her.
>
> B
>
> Q Yes?
> A Yes, in conjunction with Dr Blair.
>
> Q Dr Blair was not giving her prescriptions?
> A I said in conjunction. He was monitoring the patient regularly.
>
> C
>
> Q He was monitoring her, telling her to try and put the Thyroxine?
> A I have no information about that at all. The patient was returning for monitoring to the family practitioner.
>
> Q You did not take any blood. You did not see her. Dr Blair was looking after her, but you are the one giving her the prescriptions?
> A I accept that, but I don't accept it is necessary to take the blood sample in those circumstances. I trust my colleague who is monitoring it."

D

It does not take much thinking about that that, you may think, is almost absurd. Dr Blair, on the one side, is saying, "Please stop this. My patient should not be on Thyroxine", and Dr Skinner who is giving her prescriptions for Thyroxine and saying, "Dr Blair is there monitoring it." That cannot be a good situation.

E

The 95% figure that I gave you earlier came from D8/136 when I asked him:

> "Q So of your patients that do walk through your door, you say a very large number. Can you give us a percentage who are actually, in your view, hypothyroid?
> A The patients who don't come on a prescription, who don't come already.
>
> F
>
> Q Who come for a diagnosis?
> A I would say about 95 per cent.
>
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>
> Q Does that mean that 95 per cent of those patients walk out either with a prescription for Thyroxine or with advice to their general practitioner to give them a prescription for Thyroxine?
> A Yes."

If that answer is correct, that 95% of people who walk through Dr Skinner's door come out with a bottle of thyroxine in their hand, then that may give you a clear pointer as to what is going on. These are patient led consultations, you may think, and what the patient is looking for is thyroxine and what Dr Skinner almost invariably is seeing is hypothyroidism.

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I have not dealt in great detail or any real detail of the dangers of hypothyroidism. There is a great deal of research. The current thinking seems to be that, although it is not the T4 that is the problem, if a woman's TSH is suppressed below 0.1 there is a significant danger, particularly to post-menopausal women, of osteoporosis. We have also see in Patient B in two instances, tachycardia. We actually heard of a third incidence of tachycardia with Patient D.

B

Professor Weetman dealt with this in more detail in answer to questions from Dr Elliot at D5/39. I will not take you again in any detail to that. He talks about atrial fibrillation and iatrogenic hypothyroidism. He says:

> "A The risks with osteoporosis, as I mentioned, there are no good studies showing that there is any increased risk of fracture. But, as I mentioned, more recent research has shown that bone markers are increased when thyroid hormone levels are raised."

C

Could I give you one warning simply about the transcript? Quite often "hyperthyroidism" has been mis-described as "hypo" and *vice versa*. You will readily understand within the context when you read it. There is no criticism of the shorthand writers, because it is very difficult when one is speaking to distinguish between the two.

D

Coming back to the dangers, wherever the research eventually ends up, it is not for Dr Skinner to ignore the research about the dangers of over treatment, nor should he be ignoring the manufacturer's warning or, indeed, those of the BNF. They may be right and they may be wrong, but if there is a real risk he should be warning his patients and he should be taking care to keep the TSH within the reference levels. His own words that there is no level of TSH with which he would not be comfortable, frankly, is a hair-raising attitude and one with which not even his own expert could support.

E

On the issue of harm to the patients, could I just remind you that the charges do not allege harm? What they allege is placing the patients at risk of harm. He was asked about this, both by the Chairman and also by Dr Elliot at D5/39. He deals with the risks and he deals with the meta-analysis reported in the Journal of the American Medical Association that at the level of 0.1 of TSH there was an increase of incidence of complications. He also said this at D5/43:

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> "Q One final question. Again, it is really just asking you to confirm something which I believe you have said. Have you found any evidence that any of these four patients were harmed?
> A Not directly."

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Then he was asked by the Chairman:

> "Q My question is related to all four of the patients and, basically, I am sure you have covered it in your report, which is very thorough, but my question is this: has this treatment, relating to all four patients, been in their best interests and has it, perhaps, put them at

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> harm with these treatments?
> A I have mentioned here the need for a prolonged period of time in order to see effects, and I have mentioned figures of ten years, for instance, in the context of atrial fibrillation.
>
> I think, as I have said previously, my main concern is that alternative diagnoses were suspected that, fortunately, turned out not to be the case, such as adrenal failure, and that by continually assigning patient symptoms to hypothyroidism and not following up adequately other possibilities there is a risk of harm to newly presenting patients. Not, fortunately, to these patients."

B

There is no evidence – and I accept this entirely – of actual risk of harm, if you ignore the palpitations, the beating hearts of Patient B and Patient D, but it is not, as I say, for this doctor to ignore those risks, nor is it for him not to warn his patients about them.

C

Dr Hertoghe was not objective. He did not truly meet the requirements of an expert witness. His main interest seemed to be running his anti-ageing practice, which is a branch of medicine which many might question. He met Dr Skinner apparently at an anti-ageing medicine world congress. He is President of the International Hormone Society, which he started off claiming was the most important endocrine society in the world. It is certainly in the unique position of being an endocrine society without a single endocrinologist on its board. Its president was a computer specialist and a co-founder lost her licence to practise.

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His attitude to thyroxine would not find favour in many countries with any respectable doctor. As I said, he would have approximately a third of the population of thyroxine.

E

The witness from whom we heard this morning, Dr Fink, gave no evidence relating to these four patients. He could not. Although interestingly he did not realise it at the time, his name did appear in our papers, because he was running the very lab that Dr Skinner uses regularly – fairly regularly – for his blood tests. He gave you no evidence which was, in my submission, relevant to the issues you have to decide in relation to these four patients. In any event, his evidence was that if there is a change in dose or if you are starting someone on thyroxine – I am sorry to keep coming back to this essential issue – he would have been taking blood tests.

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The evidence that Dr Skinner's treatment of each of these four patients was irresponsible, inappropriate and unnecessary comes, in my submission, from all quarters of the medical establishment. It comes from GPs, it comes from the local endocrinologists who became involved, from Professor Weetman and from Mr Lynn. It even came in part from his own expert witness, Dr Hertoghe and also in part from Dr Fink this morning. All those other GPs and local endocrinologists cannot all be accused of living in ivory towers. It is, in our submission, Dr Skinner who was isolated in his use of thyroxine in these four patients, because he was out of step with accepted medical practice. He starts patients on thyroxine without blood tests. He continues where the blood tests suggests that thyroxine is unnecessary and he carries on without tests even where patients complain of heart palpitations.

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His practice was, in our submission, completely out of step with that of the rest of the medical world and was consequently irresponsible, inappropriate and unnecessary. Those are my submissions.

MR JENKINS: Madam, I start by reminding you of the burden of proof. It is for Mr Kark to prove every single outstanding factual allegation, and he has to prove it so that you, the Panel, are sure. If he cannot satisfy you so as to be sure, or satisfy you beyond a reasonable doubt, then plainly the outstanding allegations are ones that you will find not proved.

Can I make this observation? This must be a fascinating case for the neutral observer. There is a clash, clearly, of a couple of endocrinologists, and I include Malcolm Prentice from Croydon, whose letter you see, and a number of GPs on the one hand. On the other hand, plainly there are some patients - we do not yet know how many - and there are some other doctors, Dr Skinner plainly one and Dr Fink another.

There is tension, undoubtedly, between the importance to be placed on biochemical tests. Does inclusion within a reference range imply that the patient is normal or healthy? On the other hand, the signs and symptoms that a patient may exhibit. It raises hugely important questions, this case. Again, you will be grateful that you do not have to resolve them, but they are plainly questions that the evidence touches upon.

What is the role of the patient? What importance should be placed upon what they have to say? You will remember that I asked Professor Weetman was he familiar with the concept that when a patient meets a doctor it is really a meeting of two experts, where the patient is the expert in how they feel, how they have felt in the past and what their symptoms may be. The doctor is not the expert in that field.

There is this question, too: is it simply a case where the doctor can say to the patient, "No, no. You are healthy"? Patients will have their own views. One of the important things again in this case is what weight should be placed on how the patient feels and what signs and symptoms they report. There is a clash, plainly.

From the perspective of Professor Weetman, doubtless he would say he is concerned to maintain proper medical standards, proper levels of treatment. It is for you to consider whether this may be some professional turf war between doctors saying, "This is *our* specialist area and others should not be treating this kind of patient". Is there a concern about resources?

As to the turf war aspect, we know that patients who may suffer from hypothyroidism are properly to be regarded as patients that can be treated by GPs, by psychiatrists, by physicians as well as endocrinologists. This is not a field in which the endocrinologist had exclusive domain.

From the perspective of Dr Skinner, and again Dr Fink, you may think what they wish for is what is best for the patient. They may approach this sort of case on the basis that the patient's voice has not really been listened to by other doctors and that too much emphasis has been placed on biochemical results. Again, you know the debate as to what a reference range is and whether every patient should fall within the reference range. We

know that there are many that do not.

From the perspective of the patients, it may be a question of their quality of life. We have heard from at least one, Patient D, for whom her quality of life was nil before she came across Dr Skinner and was treated by him. These are important questions, quite plainly.

The nature of the patients that Dr Skinner was treating fall into several categories. There were some who were already being treated by other doctors on thyroid replacement therapy. You will recall he told you that a significant number of those who came to him were already on treatment by other doctors. Many of the patients had struggled to obtain proper treatment from other doctors in the past and had failed.

You have not heard from many patients. You have heard from two within the hearing. The time has not yet come, you have decided, to hear from other patients who may have been treated by Dr Skinner. But you have his book. You know what he says in his book about other patients, about the satisfaction it can bring for him on a personal and professional level in providing treatment that transforms people's lives. I would invite you to place a fair amount of emphasis on that when you come to consider the questions whether what he is doing is appropriate or irresponsible, which are the key allegations that underlie this case against him.

Professor Weetman, he treats patients who have abnormal chemistry, chemistry outside the reference range. As he told you, for him to see a patient who has blood chemistry within the reference range but signs and symptoms of hypothyroidism, is outside his experience. He has never seen such a patient, someone who has signs and symptoms but chemistry within the reference range. Again, if the reference range is not designed to cover every patient, there must, even on his analysis, be patients who may be hypothyroid but whose blood results are not normal.

How does he deal with the idea that there may be patients who have signs and symptoms of hypothyroidism but chemistry within the normal range? He says they do not exist. He has never seen them. Well, he defines them, then, out of existence.

Mr Lynn - and I gave you the reference this morning, it is Day Six, page 51 of the transcript - he told us that it was an entity that did not exist, a patient who may have signs and symptoms but normal chemistry. I asked him about his experience of treating such patients and he said, on page 51, Day Six:

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

He would say it is not a hypothyroid patient. So for them it is a question of definition. Signs and symptoms do not matter because the blood chemistry falls within the reference range. For them, by definition, it is not a patient who has symptoms of hypothyroidism.

It may be a matter for you, but it is clear, is it not, that there are such patients? There are such patients and you have heard of at least one in this case.

On such an analysis, it is not surprising that Professor Weetman and Mr Lynn should be critical of those who go on to treat patients. On their analysis, it is treatment of a patient

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for a condition from which they do not suffer.

You will have to consider Professor Weetman's position. Is he neutral? Is he reliable as a witness? I say he is hardly neutral. He is the President of an association which has made a complaint about Dr Skinner. Malcolm Prentice - the reference is bundle C2, tab 2, page 5 - is a past official of the British Thyroid Association. He allies himself, Dr Prentice, with the complaint about Patient C. Is he independent, Professor Weetman? He is not. He is President of one of the bodies complaining about Dr Skinner. Look again at the Prentice letter. I suggest that Professor Weetman's lack of neutrality is evident in the evidence that he gave. There is a lack of balance in his evidence.

B

Within the body of the notice of hearing, obviously when we go through patient by patient there are allegations that Dr Skinner's examination and history taking of each patient was inadequate. That, surely enough, was Professor Weetman's evidence. Yet, from the other expert, Mr Lynn, we know that the note-keeping was perfectly good, the examination and history taking were perfectly adequate in every case. Why is Professor Weetman taking such a contrary view from that of Mr Lynn?

C

You will recall as well that Professor Weetman would have wanted most of these patients seen by half a dozen consultants - wanting them to be seen by an ophthalmologist, by a psychiatrist, by a physician - before Dr Skinner embarked on treatment. You will remember that Mr Lynn's approach was completely different.

D

You will recall there was discussion about the research that there may have been into treating patients with thyroid replacement therapy. There was an issue about was there any research about treating such patients with thyroid replacement therapy? You will remember that Professor Weetman said, "Well, there was" - the effect of his evidence was that it was definitive. It was the Pollock paper. I am not going to take you to the paper itself, but I remind you of the evidence that he gave. He was saying that it was a placebo double blind study which was reliable and it refuted the approach that Dr Skinner was taking. If I can find the reference, I will take you to it. It is the transcript at Day Five, page 3. You will remember it was my cross-examination. Day Five, page 3, letter F, my question:

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> "Q What I am dealing with here is whether there is any reliable research into patients whose chemistry is within the 'normal range' but who have signs and symptoms.
> A I have been clear in my report and what I said yesterday. There is only one reliable prospective double blind placebo controlled trial. Like all initial or first or single studies in any area, it cannot be regarded as definitive. I did not say yesterday it was definitive. What I have said is it is the best evidence that we have and the evidence is that there is no benefit."

F

G

I went on to suggest that "an absence of evidence for something is not evidence of absence". So that is the evidence that there is in relation to studies. There have been no other studies into providing thyroid replacement therapy for patients who have signs and symptoms but whose chemistry falls within the reference range.

H

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Professor Weetman's experience obviously is not such that covers that type of patient. They do not exist for him. He has never treated one. So he does not talk to you from a position of strength about patients who have signs and symptoms but normal chemistry. He is calling for more research on the subclinical type of thyroidism. In other words, patients who have no signs and symptoms but chemistry outside the normal range. He is dealing with a completely different group of patients. That is where he is calling for research. But is he able to talk to you about patients who have signs and symptoms but chemistry in the normal range? No, he is not because, yet again, it falls outside his experience.

B

You will recall from the BMJ letter - that you saw a long time ago now - and from his book that it is Dr Skinner that is calling for such research, Dr Skinner who wants there to be research into treating patients with signs and symptoms but whose chemistry falls within the reference range. You may think he bases that on his widespread experience of patients who do have signs and symptoms and who may be improved - and who are improved - on his treatment.

C

What you have been told about the Pollock paper was that that is the only research there is and it is therefore to be taken as reliable. You know as well there are criticisms. I went on later on in the passage that I have given to you to set out before Professor Weetman what those criticisms were. It was a tiny study. The patients were not given an adequate dose; they were given 100 micrograms of thyroxine, not what the BNF suggests might be an appropriate dose. How can that be said to be a proper study? Again, it is Dr Skinner who is calling for more research into that area of medicine.

D

You have been told that, oh well, there is a risk to patients who are provided thyroid replacement therapy, there is a risk of bone density problems, there is a theoretical risk of atrial fibrillation. Again, that research comes from patients who have disease, who are hypothyroid and have been rendered thyrotoxic because of their disease. Have you been shown any paper, any evidence which suggests that patients who have been over replaced with thyroid replacement therapy are at a risk? You have not. There is not such research again. That is the sort of research that Dr Skinner has been calling for.

E

What is important perhaps on the question of whether there is a risk - and I think Mr Kark has effectively conceded that there was not a risk to these patients - is whether Dr Skinner is aware of it. Does he make a note if a patient talks of palpitations or that their heart was racing? He does make a note of it and that is significant. Does he explain to patients when he sees them and when he prescribes for them what they should look out for, what may be concerns, what may be side effects? He does. You know that he spends an hour with every patient that he sees the first time that he sees them. You know as well that that may go way beyond what patients quite often get when they go and see their GP.

F

Again, it is important; so far as Dr Skinner is concerned he was discussing possible side effects with patients. He was noting things that were or might be relevant. As we will see as we go through the details of the cases, on occasion he was writing to the GP of exactly that. On one occasion, Patient C, writing to her about whether she was going to take one of her strategies about taking too much medication. He *was* alive to concerns about patients who might not be benefiting from treatment.

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Can I deal with other issues? One is blood tests. You will recall Dr Hertoghe's evidence that blood tests might mean giving a false result if they were carried out at the wrong time. If you take the medication in the morning and within a couple of hours go on to take the blood test, what are you measuring? Are you measuring the medication they took that morning? You will recall the paper that Dr Hertoghe talked of. It is included in all the material, but I know you have refreshed your memory over the last few weeks. There was a study of those who took their medication in the evening and those who took it in the morning. There are very different levels in blood. Again, Dr Hertoghe's evidence is if you take a blood test after the patient has taken their medication that morning, you are almost inevitably going to be giving yourself a false result.

B

There is also an undercurrent perhaps in Mr Kark's address to you in the suggestion that to prescribe medication in circumstances where the patient may take too much of it or may alter their dose, that that may be irresponsible. I am afraid any prescribing for a patient could be so categorised as irresponsible. Patients can, and sometimes do, alter their dose, whatever you have given them. It would be quite wrong to say that Dr Skinner falls into a different category from any other GP and that, therefore, his prescribing must be regarded as suspect, whereas in any other case a doctor's prescribing would not.

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I do ask you to be very careful when you come to look at the criticisms in relation to patient care for these patients. Who has actually looked at the patients? Dr Skinner has seen them all. He has examined them all. What about Professor Weetman, has he seen a single one of them? Mr Lynn, has he examined anybody? Dr Cundy, who allies himself to the compliant for Patient C, he never saw her and he did not examine her. Malcolm Prentice, the past Secretary of the British Thyroid Association, he has not seen anyone. He got the facts completely wrong in the letter that he was writing, but that did not seem to trouble him. Which of these patients was rendered clinically - *clinically* - thyrotoxic? Where is the evidence for that? None of them, I suggest.

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Again, you have heard Mr Kark very recently on the question of risk. It is alleged that Dr Skinner exposed his patients to the risk of harm. Is it not the case any medical intervention carries a theoretical risk? If a patient undergoes a general anaesthetic, there are real risks attached to that; small but nonetheless risk. Would you criticise the surgeon for exposing their patient to a risk of harm? Of course not. The anaesthetist who undertakes the anaesthetic? Again, no. Almost any medication has potential side effects. Again would you criticise the GP, or the physician in those cases, for exposing their patient to a risk of harm? Not at all. It would be grossly wrong to do so.

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The question is what is the risk in real terms as against the perceived benefit? That is the balancing process that has to be undertaken. When you go through that process with these patients I suggest that firstly there is no real risk to which these patients were being exposed on a clinical trial and, secondly, when balanced against the potential benefits - and, again, Dr Skinner cautioned the patients and spoke to them at length about these matters - you could not say that he exposed patients to risk.

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For the patients who improved (and they all showed signs of improvement in various ways) what explanation do Professor Weetman and Mr Lynn have, because on their analysis these were patients who did not have the condition for which Dr Skinner was treating them? They have to have some other explanation for the improvement, but they

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really do not have one, do they? "There is a placebo effect", was the suggestion from one of them, or that Dr Skinner as a caring and sympathetic practitioner brought about a change. What, in their constipation? That was Mrs A. How likely is that? How likely is it with Ms D her life was transformed simply because the doctor who treated her was sympathetic. I suggest that it is nonsense to suggest that it is simply a placebo effect.

On the general questions - and these are the important questions really for you - the question of whether it was inappropriate or irresponsible for Dr Skinner to prescribe for these patients, I would suggest (and it is an idea I put to you last time we met) that you have to have some regard to the doctor's experience. Is it irresponsible for a very junior doctor to embark upon complicated liver surgery when he has never seen it and never done it before? Of course. It would be madness. However, if the surgeon is experienced, has treated many, many patients in that way before and with great success, one would not say that that doctor was irresponsible, or that the treatment provided was inappropriate.

Again, all doctors will base their clinical practice on a number of features, but not least would be their own clinical experience with other patients, if someone has treated many other patients in a similar way, for similar conditions, and it is obvious that Dr Skinner does not treat a wide range of types of condition. He is a specialist, so far as this type of condition is concerned, and he has a very significant body of experience and success to call on. Again, you know that from his evidence, you know it from his book and you may have formed the view during the hearing of the case that he has a fairly supportive body of patients. That is not because they are all misguided, not because they are being over-treated and are glad for it, but you may think because their lives have been changed for the better as a result of the treatment that they have received from Dr Skinner.

There were differences between what different doctors have said to you in various ways: what sort of dose they would put on; whether they would use T3 or T4; whether they would use armour thyroid. You know that armour thyroid is licensed in the United States by the Food and Drugs Agency. It is not used over here in the NHS, but the fact that it is used in the United States and by doctors there I would suggest is sufficient for you to say, "Well, we cannot say it is irresponsible for a doctor here to use it if it is used in appropriate circumstances".

Also, with regard to the frequency of blood tests. You will see with Patient A that there are different frequencies of blood tests that her general practitioners give her. Four months, then eight months and then 15 months is what the documents show. Dr Skinner is criticised for undertaking blood tests less frequently than some others may do, and there is a clear difference between he and Dr Hertoghe, as an example, and perhaps another difference between he and Dr Fink this morning, as to when and how frequently he would undertake blood tests. What is important is that Dr Skinner does undertake blood tests. He does with every patient on the first time they come and he does do blood tests thereafter.

Mr Kark says, "Well, 95 per cent of the patients who come to Dr Skinner receive thyroxine". Well, it is not surprising. He treats patients with or who may have problems of an underactive thyroid and that is the medication for it. It should come as no surprise that patients who come and who may have such problems should receive the appropriate treatment for it.

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However, the patients who come to see Dr Skinner are not a random cross-section of people walking through that part of Birmingham at all. Many of them will be on treatment from other doctors previously and will already be on thyroxine, or equivalent medication, when they arrive at his door. Others have self-selected, because that is what they believe their problem to be. As you know, Dr Skinner does not just say, "Come in and take a seat. Here is the prescription". That is not the way it works at all. You have heard that from the patients and you will have little doubt that it is an hour that he spends with them on the first occasion that he sees them and half-an-hour, I think was what you heard, thereafter. Again, it should come as no surprise to hear that he is treating patients with the appropriate medication.

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I am going to come to the patients. I am fairly quick with the patients. I am not going to take you through, you will be pleased to hear, the detail of Dr Hertoghe's evidence, or that of Professor Weetman, or Dr Lynn - Mr Lynn, I am sorry.

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Patient A.

THE CHAIRMAN: Would this be an appropriate moment to break?

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MR JENKINS: I am going to be about another 15 minutes and so I am happy to keep going, if that is all right, unless the Panel feel they need a break?

THE CHAIRMAN: No.

MR JENKINS: I do not see anyone nodding.

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Patient A. I am not going to go through the records. You will know them very well by now. She did not like Dr Skinner. She did not like his manner. She improved once he put her on thyroxine. Her symptoms were reduced. The reference is bundle C1, tab 1, page 4. She was definitely better when on thyroxine. She had some headaches and you will recall that she said she felt violent, or emotional. There is reference to that in the correspondence. You will recall as well that her evidence was that, once she started on armour thyroid, the headaches stopped immediately.

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You know that after she stopped being treated by Dr Skinner, Professor Jane Franklyn in Birmingham had a role in the treatment. The reference is bundle C1, tab 1, page 56. Professor Franklyn was content that this patient should remain on thyroid replacement therapy, but she suggested changing from armour (with which one infers she was not familiar) back to thyroxine.

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Dr Skinner was criticised for his notes, you will recall, and Mr Lynn described them as "very satisfactory". Mr Kark has properly reminded you of the reference.

As to the correspondence between Dr Skinner and the GPs, again Mr Lynn made a general comment that he had no criticism at all with Dr Skinner's communication with GPs. I do not repeat that for each of the three patients to come and I do not repeat his views about note keeping, the history taking and the examination. He said in each case words to the effect of that they were perfectly adequate. He had no criticism of them whatsoever.

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Again, you will reflect on why there should be such a gulf between Mr Lynn and Professor Weetman in that regard.

As far as the patient's headache was concerned, you will remember from Mr Lynn's evidence (it is Day 6, page 99) he thought it very unlikely that any headache was due to the thyroxine. He does not criticise Dr Skinner for not making a note if he were told over the telephone that the patient had a headache. He said, "Well, we all do it", and he did not think it was linked in any event.

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That is what I say to you about Mrs A. I would like you to look, if you would briefly please, at the notice of hearing. The outstanding allegations are 3 (b) and (c). Mr Lynn gave the evidence saying those were perfectly adequate.

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So far as (h), (i) and (j) were concerned, the evidence was clearly that Dr Skinner notified the GP in relation to any concerns and Mr Lynn's evidence was that it was perfectly appropriate to notify the GP and that is what happened.

As far as heads 5 and 6 are concerned, I would suggest it was entirely appropriate in the circumstances in which this lady came to see Dr Skinner for him to put her on a trial. It worked, her symptoms improved, she felt better and it could not be described as inappropriate, unnecessary, irresponsible, or the other allegations at 5 (d) and (e) and 6 (d) and (e) for Dr Skinner to have treated her in that way.

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For head 7 (a), the suggestion that Dr Skinner:

> "… spoke to Mrs A on the telephone who complained of new symptoms …",

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they were not new because she had had headaches before:

> "… that could have been an adverse effect ..."

Well, they were not. That was the view of Dr Skinner. Extremely unlikely to have been an adverse effect of the prescription and that is Mr Lynn's view as well. It is a matter for you whether you want to find that one proved or not but, whether you find it proved or not, you should not find any criticism in respect of Dr Skinner in that regard. It was not appropriate, looking at 7 (c), to assess Mrs A or arrange for her to be assessed by her general practitioner. The prescription changed, she was put on armour and her headaches went. That is the evidence.

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Again, there was criticism by Professor Weetman of the history and the examination. Mr Lynn was supportive of Dr Skinner's history and examination. There was reference in the records to this patient having a racing heart. The reference is in bundle C1, tab 4, page 12 and page 24. Dr Skinner is aware of it. He is making a note of it. He is telling the GP about it. He is not ignoring symptoms, or signs, and with this patient again:

> "… she has notably improved since the institution of treatment".

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That is Dr Skinner's note to the GP.

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There is a suggestion, we are just about to come across it in the case of the next patient, Patient C, that there may have been some revision and that Dr Skinner may have been putting in his notes that the patient was improving when in fact they are not. You will have to consider that. His notes were not made with a view to having them picked over at a General Medical Council Fitness to Practise Panel hearing. His notes were made at the time and with the patient in front of him.

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It may be the case that other doctors - well we will come to Patient C in a moment - anticipating making a complaint to the GMC were putting that the patient felt better off the medication. Whether that is said as a result of a leading question to the patient, or because that is what the doctor wanted to hear, one does not know, but to the question of revision I suggest it is a possibility that goes both ways. Again, Dr Skinner was not making his notes thinking, "Well, these are going to be looked at by a Fitness to Practise Panel who will wonder whether I am writing down what the patient is actually saying to me, or not".

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I am not going to go through the notice of hearing with regard to Patient B. The issues are very similar. Of course the suggestion of inappropriate and irresponsible prescribing goes over some period of time, but again I would suggest that it is not inappropriate with this patient with her history for Dr Skinner to try her on a trial of thyroxine and one that may go on for some few months.

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Patient C. You will remember this lady was a lawyer. The history taking and examination were perfectly satisfactory. This is the patient where there was a complaint from Dr Ince and Dr Cundy became involved, but never saw the patient. Malcolm Prentice, the past Secretary of the British Thyroid Association, is told various things. He is told that Dr Skinner saw this patient without writing to the GP. Well, that is wrong. We know it is wrong. Dr Skinner had certainly written to Dr Summers, the earlier GP. Dr Prentice apparently was told that this patient had been started on 150 micrograms of thyroxine. Again, it is wrong.

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Dr Summers, you will recall, said that he only prescribed for this lady because he thought that Dr Skinner was an expert. He had not seen the blood results. If he had seen them, was the evidence that he gave to you, then he would never have prescribed. Well, you will recall we proved in evidence that he must have seen them. If you look at bundle C1, tab 5, page 2, you will recall Dr Ince saw this patient as a new patient, she had concerns about what the patient said she was on and she did a review of the medical records. The review of the medical records was the records that had been handed on from Dr Summers's practice and she says in her note, C1, tab 5, page 2, right at the top of the page, the previous blood test result and she refers to it. That is the one that Dr Summers was sent and so he is wrong to say he had never had it.

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Again, how did the patient progress on the treatment? Dr Skinner has recorded that she was doing reasonably well. Gradual, but reasonably well. It is Dr Ince who is suggesting that the patient feels better off the medication. Well, I have just made the point about the possibility of revision.

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The other issue plainly which prompted concerns about this patient was that she said she

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was on armour thyroid as well as thyroxine and Tertroxin. She said she was on three medications. You will recall in bundle 2 at tab 2 that she filled in a questionnaire. I will just show it to you. It is the day just before she is seen by Dr Ince. It is 31 August 2004. She changed practices and she wrote down that she was on three medications. It is from this that we know she is a lawyer. She said that she was being treated by Dr Skinner, but he was not prescribing armour thyroid. You have got the prescriptions that he provided for her and you have got the documents that confirm what he was prescribing. They are bundle C1, tab 6, at page 8 and bundle C1, tab 6 at page 14. So, she was taking medication other than that prescribed by Dr Skinner.

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One can see why Dr Ince might have been concerned, why she might have wanted to undertake an inquiry. That is how she came to see the earlier blood test result. Again, was it a reliable blood test result that was taken after that time if she is on other medication as well? No, it cannot be said to be a reliable indicator of what Dr Skinner had provided by way of treatment if she is on something else as well.

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The last patient that I deal with is Patient D. This lady describes speaking to Dr Skinner on the first time she saw him as "mind-blowing." You have seen Dr Skinner. You will have formed your own view, having heard him, of how likely it is. She found him sympathetic. She found him caring. She was talking to him about her symptoms and how she felt, how she had been for five and a half years. She was amazed to find someone who was sympathetic, who understood how she felt and how she had been feeling. She had her life completely turned around. She had been a zombie. She had tried to think of excuses for the children not to go to school so that she did not have to get out of bed that morning. She used to take naps three or four times a day. She would send her daughter to the shops. She could not find the energy or the inclination to go herself.

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Was Dr Skinner irresponsible to treat her? Was his treatment of her inappropriate? Again, you may think from his book that the sort of transformation that was achieved in her case, as a result of him prescribing for her, was the sort of transformation he had achieved in other cases too. He was entitled, I suggest, to bear that very much in mind in considering whether to treat her or any of the other patients we have dealt with.

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The possible benefits of transforming what was no life at all to a full life and one where she felt that she could be a proper mother to her children were overwhelming when balanced against the risks which are negligible, even on the analysis that Mr Kark has given you. Again, I say there is no reliable evidence to support what are said to be these tiny risks. The argument, I suggest, in this case with her history and her signs and symptoms – there is no argument at all. It was obvious that it was appropriate to try her on a trial. He did and it was successful. Again, I do not take you through the notice of hearing.

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The general allegation in this case that Dr Skinner's treatment of these patients was irresponsible, I suggest, cannot be borne out by the evidence that you have heard. Again, you have not yet heard the voice of the wider body of patients that he has treated. You know of his experience from his book. He is entitled, like any other doctor, to use his experience in judging whether it is appropriate to treat this patient or that patient. His note keeping is good. His communication skills with the patient are good. He has had one complaint from a patient in years of practice and that is Mrs A who did not like his

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manner. To characterise him, as you are invited to, as irresponsible and doing things which it is suggested he knows are not in the patients' best interests is quite wrong.

Those are the matters that I advance to you at this stage.

THE CHAIRMAN: Thank you, Mr Jenkins. We will now take advice from the Legal Assessor as to how we approach making our decision.

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THE LEGAL ASSESSOR: I have printed out my advice, but I have made a couple of changes to it. There are new copies for the Panel. Basically, I had missed out the burden and standard of proof in my original advice, which I thought was a slightly important thing I ought to have put in. Apart from that, both counsel have copies.

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May I at this stage tender some advice as to the legal principles, which you should bear in mind when you retire to make your decisions?

The facts of this hearing are your responsibility. You will wish to take account of the arguments in the speeches you have heard, but you are not bound to accept them. When it comes to the facts of this hearing, it is your judgment alone that counts.

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You do not have to decide every point, which has been raised; only such matters as will enable you to say whether the facts, in the paragraphs in the allegation laid against Dr Skinner and which you are considering, have been proved. You will do that by having regard to the whole of the evidence including the agreed/admitted evidence and forming your own judgement about the witnesses, and which evidence is reliable and which is not. Dr Skinner has chosen to give evidence (and call witnesses). You must judge that evidence by precisely the same fair standards as you apply to any other evidence in the case.

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This is a case which has generated a certain amount of publicity in the papers, on the Internet and in articles and books. If you have read any of these please put them out of your minds and remember that you are deciding this hearing upon the evidence that has been put before you in this hearing room.

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Dealing with the burden and standard of proof, in this case the GMC must prove that the disputed facts in the paragraph of the allegation that you are considering are true. Dr Skinner does not have to prove that they are untrue.

How does the GMC succeed in proving that the disputed facts are true? The answer is - by making you sure of them. Nothing less than that will do.

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You must consider the evidence against and for Dr Skinner on each paragraph of the allegation separately.

Your important obligation to consider each paragraph separately on its merits does not mean that you should ignore all the evidence of background circumstances. This may well be evidence which will assist you in reaching a decision. Moreover, in a case involving a number of paragraphs in the allegation, it could be (depending on the circumstances) that your decision on the facts of one paragraph in the allegation might

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well assist you in coming to a conclusion on another or other paragraphs in the allegation. Nevertheless, you must reach separate decisions on each paragraph in the allegation having focused on each separately and having formed a separate decision about it.

I deal with experts. An expert must help the hearing to achieve the overriding objective by giving objective, unbiased opinion on matters within his expertise. This duty overrides any obligation to the person from whom he receives his instructions or by whom he is paid. This duty includes an obligation to inform all parties and the court if the expert's opinion changes from that contained in a report served as evidence.

In this case you have heard the evidence of Professor Weetman, who has been called as an expert endocrinologist and expert in thyroid disease and Mr John Lynn, who has been called as an expert endocrine surgeon with special interest in thyroid disease, on behalf of the GMC and Dr Thierry Hertoghe, who has been called as an expert on hormones and anti-ageing, with particular reference to the treatment of thyroid disease, on behalf of Dr Skinner.

Expert evidence is permitted in a hearing to provide you with scientific or medical information and opinion, which is within the witness's expertise, but which is likely to be outside your experience and knowledge. It is by no means unusual for evidence of this nature to be called; and it is important that you should see it in its proper perspective, which is that it is before you as part of the evidence as a whole to assist you with regard to one particular aspect of the evidence.

A witness called as an expert is entitled to express an opinion in respect of the matters which are put to him; and you are entitled and would no doubt wish to have regard to this evidence and to the opinions expressed by the experts when coming to your own conclusions about this aspect of the case.

You should bear in mind that if, having given the matter careful consideration, you do not accept the evidence of the experts, you do not have to act upon it. It is for you to decide whose evidence, and whose opinions you accept, if any. You should remember that this evidence relates only to part of the allegation, and that whilst it may be of assistance to you in reaching decisions, you must reach your decisions having considered all the evidence.

Those are all the matters that I would wish to address you on in this matter, unless either Counsel has anything to say.

MR KARK: No, thank you.

MR JENKINS: No, thank you.

THE CHAIRMAN: Thank you for that. We will now be going into camera and we will be deciding whether the alleged facts which have not been admitted have been proved to the Panel's satisfaction.

To remind you, the booking of this case so far is Monday, Tuesday and Wednesday - we will not be sitting on Thursday and Friday – and Saturday and Sunday.

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We will now go into camera.

(*Discussion re housekeeping matters*)

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

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(*The Panel later adjourned until 9.30 a.m. on Tuesday, 4 September 2007)*

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