

GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (MISCONDUCT/PERFORMANCE)

On:
Monday, 9th July 2007

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

Case of:

GORDON ROBERT BRUCE SKINNER MB ChB 1965 Glasg SR

Registration No: 0726922

(Day 6)

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

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

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

Monday, 9th July 2007

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

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

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

Mr Kark?

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

THE CHAIRMAN: Thank you.

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

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

THE CHAIRMAN: Thank you.

MR JOHN LYNN (sworn)

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

Thank you for coming to give evidence to this

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

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

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

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

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

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

20 Thank you, Mr Kark.

21 Examination-in-chief by MR KARK

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

24 THE CHAIRMAN: That would be C7?

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

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

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

8 A. Yes.

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

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

16 Q. Practising as what?

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

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

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

5 A. 1978 at the Royal Post Graduate Medical School until
6 2006.

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

10 A. That is correct.

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

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

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

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

1 amount.

2 Q. Are those all thyroid patients?

3 A. 90 per cent of them.

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

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

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

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

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

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

1 when taken at the time of day.

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

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

14 A. Clinically, do you mean?

15 Q. Yes.

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

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

22 A. Yes.

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

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

9 Q. You say in your paragraph 8:

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

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

15 A. Yes.

16 Q. Why do you say that?

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

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

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

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

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

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

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

1 Q. I didn't mean personally.

2 A. No, well, I can make the comment, everybody else was
3 a lot happier than I was, and it takes time to get used
4 to having a normal thyroid function. Patients, if they
5 are on thyroxine, often want to stay on it because they
6 feel good, and they will often be severely toxic, and
7 we have great difficulty getting patients who are
8 addicted to thyroxine -- thyroxine is almost an
9 addictable drug. Once you go on it and you have got
10 used it, it gives you a buzz feeling and you run all the
11 risks of being unwell on long-term treatment.

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

19 Q. If the TSH is suppressed -- and we look at some notes
20 here in this case -- really below a negligible reading,
21 so it is below or at 0.01 TSH, what effect does that
22 have on the thyroid gland?

23 A. If you are taking exogenous TSH, it will make the
24 thyroid atrophy. When we explore patients for other
25 reasons, when they have been on long-term thyroxine,

1 there is hardly any thyroid there.

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

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

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

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

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

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

6 A. Oh yes.

7 Q. Such as?

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

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

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

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

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

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

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

23 Q. You mentioned men in particular.

24 A. Yes.

25 Q. Is there any danger to women?

1 A. In what?

2 Q. Of osteoporosis.

3 A. Yes.

4 Q. Again, any particular group of women who are thought to
5 be --

6 A. Post menopausal. That is what the evidence shows, but
7 one must make the point that if you put a 25-year-old
8 woman on thyroxine unnecessarily, post menopausal women
9 may already have problems with osteoporosis through
10 other causes.

11 You may be putting somebody on, as I have already
12 said, a drug for 40-odd years or maybe longer, and you
13 still do not know its long-term effect.

14 Q. Apart from osteoporosis, what other problems are thought
15 to arise?

16 A. Excessive -- there are cardiovascular problems. Atrial
17 fibrillation in particular can occur with an excess of
18 thyroxine, and this in itself is a complication which
19 can lead to cardiac failure, et cetera, but this is
20 fairly rare because it would be picked up fairly soon
21 and would be more in the elderly where there are other
22 factors.

23 Q. If you are having to put a patient on large doses of
24 thyroxine, do you warn your patients about the possible
25 side effects?

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

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

13 A. Absolutely.

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

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

21 A. Yes.

22 Q. They may be different, I expect.

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

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

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

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

10 Q. Why the time of day it is taken?

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

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

1 a set time in the day.

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

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

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

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

24 Q. You say in paragraph 10:

25 "In recent years there has been considerable

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

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

9 A. Yes, I believe so, yes.

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

11 "In summary, patients with a TSH of less than
12 5 mIU/L do not have either overt or subclinical
13 hypothyroidism and do not need thyroid replacement."

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

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

1 times a day.

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

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

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

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

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

25 A. Yes.

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

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

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

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

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

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

25 A. Yes, sorry, I apologise. Yes.

1 Q. I am in your paragraph 14 at the moment.

2 A. Yes.

3 Q. Subsequently, on 13th May, her TSH was 1.45. You have
4 also noted that she had had a slight heart problem
5 during her pregnancy.

6 A. Yes.

7 Q. I want to ask you the relevance of that if you're
8 putting someone on thyroxine?

9 A. It was not clear from the notes what exactly it was.
10 I suspect it was a non-significant murmur of the heart.
11 Often during pregnant you either get a flow murmur --
12 I doubt if it was anything more sinister than that.

13 Q. All right. We know that Patient A had received advice
14 from a Dr Veitch, back in October 2002, telling her she
15 was clinically euthyroid, and then she goes on to
16 a consultation with Dr Skinner on 16th January 2003
17 where he made a diagnosis of hypothyroidism. He was
18 particularly interested in the lack of hair on her
19 eyebrows.

20 Is that something you come across in hypothyroidism?

21 A. Well, one sees it in very severe hypothyroidism,
22 patients with TSHs in the 60, 70s and 100s, but I have
23 not seen it in an instance where somebody's TSH was
24 1.49, which although well within the reference range, is
25 right low down in the reference range and really would

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

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

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

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

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

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

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

21 Q. Why not?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 You say:

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

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

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

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

25 "The prescription of thyroxine was completely contra

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

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

5 A. Because it wasn't necessary.

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

13 You say:

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

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

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

25 Q. Can we turn please to Patient B.

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

9 A. Yes.

10 Q. -- and within the reference range.

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

17 A. I think that's wrong.

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

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

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

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

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

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

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

14 A. I thought that was outrageous, I must say. Here is a T4
15 of 39 and I apologise for the mistake in my less than
16 0.01. This woman, if she walked through the door and
17 was shaking a bit, you would say she had severe
18 thyrotoxicosis and in fact had iatrogenic
19 thyrotoxicosis, and was grossly overtreated for
20 a condition she never had.

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

25 A. Usually they presented to you because they have either

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

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

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

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

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

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

13 It is a diffuse disease of the thyroid.

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

17 A. Absolutely.

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

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

25 The entry in the middle, we're still on

1 20th January, so it is the entry in the middle of that
2 page: do you see marked "Second consultation"?

3 A. Yes.

4 Q. And do you see:

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

7 A. For one month, yes.

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

11 A. Mm-hm.

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

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

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

20 MR KARK: I said, "an incident".

21 MR JENKINS: I understand.

22 MR KARK: But that was the complaint that I think she made
23 on 20th -- it should have been, I think,
24 21st January 2003.

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

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

5 A. Sorry, absolutely, yes.

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

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

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

14 I do not think you need to comment on that.

15 But he says:

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

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

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

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

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

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

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

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

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

4 Can excessive alcohol exacerbate the situation?

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

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

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

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

19 A. That is correct.

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

23 She was seen, we know, by Dr Skinner on
24 6th March 2004. We know that he thought her to be
25 hypothyroid. He took a blood test, and you say in your

1 report:

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

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

7 A. Not in my view.

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

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

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

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

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

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

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

4 Q. But no blood test?

5 A. No blood test.

6 Q. And he says:

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

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

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

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

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

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

1 have been on any of it?

2 A. No. Absolutely.

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

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

11 A. Undetectable.

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

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

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

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

1 they're inappropriate.

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

8 The patient was seen by Dr Andrew Rodin on
9 7th March 2005, and her present TSH by then was normal,
10 but we know from the evidence that we've heard that in
11 about October 2004, she had actually taken herself off
12 thyroxine.

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

14 A. I would have thought about four weeks.

15 Q. -- will come back to normal?

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

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

24 You say:

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

1 complications, osteopenia and possible osteoporosis."

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

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

6 Q. Of what, sorry?

7 A. Of the density range.

8 Q. Bone density, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

1 a blood test?

2 A. By a blood test, yes.

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

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

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

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

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

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

25 Again, in your view, for this patient to be

1 prescribed thyroxine, was it appropriate and necessary
2 or not?

3 A. I would feel this was totally inappropriate.

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

6 A. Yes.

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

10 A. No.

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

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

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

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

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

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

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

7 Q. The patient saw Dr Skinner again on 18th November, and
8 we know that he gave her a further prescription of
9 thyroxine at 125 micrograms and then upping it to
10 150 micrograms, and then up to 175 micrograms.

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

13 A. None whatsoever.

14 Q. That is in November.

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

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

1 Q. You say finally this:
2 "[This patient] was inappropriately given thyroxine.
3 There [was] no suggestion at any stage that she had any
4 signs or symptoms related to hypothyroidism."
5 Can we just have a look at tab 8 and the very first
6 page, which I hope are Dr Skinner's typewritten notes.
7 A. Yes, first consultation.
8 Q. She was saying she had been ill since her last baby.
9 She was tired, but she had a good appetite, her weight
10 had gone up, she ached all over, especially her lower
11 back, she had poor concentration and memory, and she was
12 very upset and crying. Arms and legs paraesthesia, side
13 visions off wiggly lines.
14 First of all, are those symptoms and signs of
15 hypothyroidism that you come across?
16 A. These symptoms could be for almost any condition,
17 depression -- I do not understand what side vision
18 hallucinations are, but these tests should be taken into
19 account that at the time the TSH was only 1.9, which,
20 even with the strict American criteria, is well within
21 the lower end of the reference range -- sorry,
22 apologies, within the reference range, and in my view
23 this patient did not have hypothyroidism.
24 Q. Two final matters.
25 We often see this in Dr Skinner's notes of side

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

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

7 Q. You haven't come across it?

8 A. No.

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

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

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

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

1 hypothyroidism in 20 years.

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

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

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

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

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

1 what's the danger?

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

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

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

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

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

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

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

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

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

10 MR JENKINS: Quarter past would be very kind, thank you.
11 (10.55 am)

12 (A short break)

13 (11.15 am)

14 THE CHAIRMAN: Mr Kark, ready to resume?

15 MR KARK: Yes, thank you.

16 THE CHAIRMAN: Mr Jenkins, sorry.

17 Cross-examination by MR JENKINS

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

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

23 Q. I understand.

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

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

7 A. Yes.

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

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

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

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

23 A. No.

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

25 You told us patients can be referred by other

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

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

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

1 Q. The generality of your patients, would they be patients
2 where a blood test had already been done and they fell
3 outside the reference range?

4 A. No, they would come on their own, but usually if
5 referred by the GP, they would come with a letter and
6 they would be outside the reference range or within the
7 range, and they are concerned by the GP because there
8 was symptomatology.

9 Q. So there were GPs sending patients to you where patients
10 had signs and symptoms but their blood test result was
11 within the reference range?

12 A. Yes.

13 Q. And what would you do with such patients?

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

20 Q. So you can't tell us whether a trial of thyroxine for
21 a patient who had signs and symptoms which may be
22 consistent with hypothyroidism, but who had chemistry
23 within the reference range, you can't tell us whether
24 that was successful or not because you have never done
25 it?

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

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

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

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

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

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

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

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

3 A. Yes.

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

6 A. Sorry?

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

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

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

19 A. Yes, a small number of them.

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

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

1 Q. Why are they falling outside what you've called in your
2 report the normal range?

3 A. Reference range.

4 Q. You call it the normal range again and again. In your
5 evidence you have said reference.

6 A. Yes, and I apologise, it is misuse of term. It is
7 a reference range.

8 Q. There is a misuse of terms inasmuch as one can start
9 thinking of it as normal, whereas in fact it is not
10 normal at all, is it?

11 A. No, it is a range of -- 95 per cent of the patients who
12 are going to be within that range.

13 Q. What are we to say about those who fall outside of that
14 range?

15 A. If they fall outside that range, we will -- let's say it
16 is high, the TSH is high, and they have no symptoms,
17 I would follow them up, and if they then became unwell,
18 I would in fact treat them. I have a safety mechanism
19 for it because in fact we look at them very carefully
20 and we follow them up. I'm not making a decision on
21 a single TSH which could vary from day to day, hour to
22 hour.

23 Q. Subclinical hypothyroidism is the small group of
24 patients -- if you look at the chart to your left,
25 I hope it makes sense to you, it is not one that I drew,

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

4 A. It is a bit of a scribble.

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

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

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

12 A. Yes.

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

15 A. Mm-hm.

16 Q. But whose chemistry falls below the reference range.

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

19 Q. I am sorry.

20 A. It is important to get it right.

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

24 A. Yes. These going up there, yes.

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

1 whether subclinical hyper or hypothyroid patients should
2 be treated?

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

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

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

16 A. Yes.

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

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

20 Q. It is indeed.

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

23 A. No.

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

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

6 A. Absolutely.

7 Q. -- as any signs.

8 A. Absolutely.

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

14 A. That is my experience.

15 Q. It does not exist?

16 A. Yes.

17 Q. That is your experience.

18 A. Yes.

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

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

1 range.

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

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

7 Q. What does that mean?

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

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

17 A. I don't agree, sir.

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

19 A. Being mentally ... Definition of health?

20 Q. I've thrown a bouncer at you.

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

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

1 play any part in that?

2 A. I am sorry, I cannot hear you.

3 Q. If you were to give me a working definition of "health"

4 with reference to thyroid function, does how the patient

5 feels have any part of in that definition?

6 A. Of course it does, but I do not find in my own

7 experience that they have complaints of lack of health

8 with TSHs which are below 10.

9 Q. Well, can I suggest that the experience of others may be

10 markedly different from yours.

11 A. You are quite entitled to say that, sir.

12 Q. Can I go on through your report -- well, I should say,

13 your definition of thyrotoxicosis involves reference to

14 chemical results.

15 A. Yes.

16 Q. And signs and symptoms.

17 A. Yes.

18 Q. But your definition of hypothyroidism does not involve

19 reference to how the patient feels or any symptoms.

20 A. That's quite logical, because overactivity produces

21 a much more specific set of signs and symptoms than

22 underactivity.

23 Q. What are the signs and symptoms of underactivity?

24 You have set them out in your report, haven't you?

25 A. Yes, but they are vague and you will -- they are vague,

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

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

6 A. In the majority of them.

7 Q. The majority?

8 A. Yes.

9 Q. Can we come on to Patient A.

10 A. Yes, of course.

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

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

19 A. Yes.

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

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

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

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

5 A. If I may continue, sir?

6 Q. Please do, yes.

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

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

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

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

23 A. I thought, yes. I presume so.

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

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

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

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

10 A. Not by Professor Franklyn.

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

15 A. Mm-hm.

16 Q. Can you tell us whether she indicates that?

17 A. There is a letter?

18 Q. It is tab 1 of the large bundle, page 55, I think. 56.
19 55 is the invitation from Professor Franklyn to express
20 a view.

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

23 A. She says:

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

1 hypothyroidism."

2 Q. But she goes on to talk about bowel symptoms. We know

3 that this lady had earlier complained of constipation,

4 which was alleviated by the prescribing that was done

5 for her?

6 A. She continues:

7 "I explained there is no specific indication as

8 driven by her thyroid function test for this to be

9 continued or indeed expected to be helpful."

10 Q. Do you infer from that that Professor Franklyn is saying

11 to the patient: you should stop it? Or is she saying,

12 as she says to the GP, effectively it is for the patient

13 to choose?

14 A. I think what she's saying, reading between the lines, if

15 I'm allowed to, that she doesn't need thyroid

16 replacement, I think she makes that absolutely clear,

17 but she feels that she will not spontaneously stop the

18 thyroxine and thought it was better if should would be

19 on the synthetic thyroxine than the Armour preparation.

20 Basically I think that she should have stopped the

21 thyroxine there and then.

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

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

24 "I [have] ... explained there is no specific

25 indication as driven by her thyroid function for this to

1 be continued."

2 She says exactly that.

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

4 take it.

5 A. You are splitting words, sir.

6 Q. Or that it is bad for her.

7 A. That's ridiculous.

8 Q. Is it ridiculous --

9 A. If I say to a patient: listen, there is no specific

10 indication for you to continue your treatment for -- let

11 us say you are a mild diabetic with loss of weight, you

12 have been able to reduce weight. The patient to take

13 the advice? I don't agree.

14 Q. Can I turn to the Armour Thyroid. You deal with it at

15 paragraph 12 of your report on page 6.

16 I think Armour Thyroid is regulated, as are all

17 medications in the United States, by the Food and Drugs

18 Agency, the FDA.

19 A. Absolutely, yes.

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

21 A. Yes.

22 Q. They are not known as a lax regime, the regulation

23 authorities, the FDA in the United States.

24 A. Absolutely.

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

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

3 A. In the United States.

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

5 A. Yes.

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

8 A. Yes.

9 Q. Is that prescribed in this country?

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

17 Q. You do not use Armour yourself?

18 A. No.

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

21 A. I only use thyroxine.

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

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

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

1 together?

2 A. No.

3 Q. Why not?

4 A. I find it very difficult to control.

5 Let me start again. I do not use it because (a)

6 I cannot see the logic on it, because I do not see

7 patients who are unable to convert T4 to T3. I do not

8 think it is an entity which occurs in the general run of

9 thyroid patients, and also, if one's going to use it, it

10 is very, very -- we have problems -- I know you do not

11 want me to discuss the thyroid cancer patients, but in

12 fact they can get tachycardias, arrhythmias, excess of

13 absorption, it is rapidly absorbed, it is not bound to

14 anything and it is, therefore, difficult to control, and

15 I see no use for it when I've got a very satisfactory

16 substance, T4, which will replace the patient -- and

17 gives a steady level, you get a steady level with it.

18 Q. What proportion of your patients are thyroid cancer

19 patients, roughly?

20 A. A 100 a year new ones. I was seeing one in 15 of the

21 cancers in the country. Oh, but you see they go on

22 forever, I would say in the clinic of 50 patients there

23 would be 10 thyroid cancer patients.

24 Q. Are you able to tell us, what view is there taken

25 benefit medical practitioners as to the levels of

1 hypothyroidism in the population?

2 A. I think people realise it is very common.

3 Q. We are talking about 1 per cent of the population, or

4 10 per cent, or more?

5 A. I do not know what their perceived view is, but it is

6 common, and many of them will treat the patients within

7 their clinics themselves.

8 Q. I understand that, but I mean, common, are you able to

9 give us a sort of ballpark figure as to common --

10 A. It depends on age group. I suspect in a 60-year-old

11 patient it must be somewhere in the region of 3 to 5 per

12 cent of a raised TSH.

13 Q. What about hyperthyroid patients?

14 A. Most likely the same sort of percentage. Many of them

15 are --

16 Q. So we are talking about millions of patients in this

17 country?

18 A. Absolutely.

19 Q. Millions of people.

20 A. Yes.

21 Q. I will come back to the reference range. If we are

22 talking of millions of people and 5 per cent of the

23 people in the reference range fall outside reference

24 range chemistry, we are talking about hundreds of

25 thousands of patients who would fall outside the

1 reference range?

2 A. Yes, I take your point, but because they fall outside
3 the reference range does not mean they need any
4 treatment.

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

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

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

16 A. Yes.

17 Q. Which countries are we talking about?

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

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

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

1 Q. I think you have seen Dr Hertoghe's report?

2 A. Yes.

3 Q. Which includes a number of laboratory results for
4 patients in Germany where the TSH range is exactly that.
5 What about in the United States, are you able to help us
6 what the reference range is now?

7 A. They are trying to reduce the reference range to about
8 2.5 because of the large study.

9 Q. When you say they are trying to, what does that mean?

10 A. That is what has been suggested, but not everybody has
11 accepted it. After all, you say there is a reference
12 range, not everybody is going to follow the reference
13 range in different parts of the country.

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

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

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

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

2 A. I have it here, yes.

3 Q. I am assuming it is a big book.

4 A. No, it is a little book actually.

5 Q. Oh good.

6 A. I marked it for you.

7 Q. 222 to 223.

8 Can I just have a brief look at it?

9 A. Of course you can. (Handed).

10 There is a comment by Mazzaferi at the bottom.

11 (Pause).

12 Q. I am going to ask that we could hang onto it for

13 a moment and photocopy some pages from it. Is that all

14 right?

15 A. Yes.

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

17 A. Yes.

18 Q. If Mr Kark just looks at the references.

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

20 MR JENKINS: If you look at reference number 1 on page 223

21 that you are now looking at, Mr Lynn, is it Bunevicus,

22 is it I-U-S or just U-S, the first reference.

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

24 Q. I-U-S?

25 A. Yes.

1 Q. It is not correctly spelt in your report.

2 I think that Bunevicius paper suggested that

3 patients did well on T3 and T4 together. Yes?

4 A. Yes, in the short-term I understand, but that was just

5 one study and there were many other studies, several

6 other studies, that in fact didn't confirm this.

7 Mazzaferi's comment:

8 "For now there is insufficient evidence to recommend

9 T3/T4 therapy for hypothyroid patients."

10 But he does make the comment, which I would agree

11 with you that:

12 "Yet why so many patients seem dissatisfied with

13 thyroid hormone replacement therapy remains a major

14 clinical conundrum of our time."

15 Q. Yes. The aim of treatment is to improve how the

16 patients feel, as well as, you would say, maintain their

17 blood chemistry within appropriate levels. Surely

18 practitioners should be exploring different forms of

19 therapy, T3 and T4?

20 A. Absolutely, but it has not been my experience that that

21 has been the case, that we had very satisfactory results

22 of putting patients on T4.

23 Q. You do not put patients on T3.

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

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

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

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

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

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

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

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

14 Q. I am grateful.

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

20 A. Yes.

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

23 A. Am I allowed to open my own documents?

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

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

1 is it not?

2 Q. The Panel have it in Professor Weetman's report, page 6.

3 It is the UK consensus statement that Professor Weetman

4 talked of.

5 A. BMJ 1996 "Consensus statement for good practice and

6 audit measures and the management of hypothyroidisms and

7 hyperthyroidism".

8 Q. That is right. What we have told about it was that

9 a correct dose was one which relieved symptoms and would

10 in most patients result in a "normal or raised serum

11 thyroxine concentration, that's T4, a normal

12 tri-iodothyronine concentration, that is T3, and

13 a normal or below normal serum thyroid stimulating

14 thyroid concentration.

15 Can I paraphrase that: the correct dose was one

16 which are relieved symptoms and would in most patients

17 result in a normal or raised T4, a normal T3, and

18 a normal or below normal TSH concentration.

19 A. Absolutely.

20 MR KARK: Professor Weetman did go on after that to say that

21 thoughts about that had moved on.

22 MR JENKINS: He did, in 2004 and 2005, are the references he

23 gave, and we are dealing with patients in 2002, 2003,

24 2004 and then 2005.

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

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

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

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

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

18 A. I do not think --

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

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

23 Q. Well, there we are.

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

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

3 A. If they had hypothyroidism.

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

7 A. Yes.

8 Q. That is understood?

9 A. Yes.

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

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

15 Q. What, T3 and T4?

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

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

20 A. No.

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

23 A. Not at all.

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

1 Patient B --

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

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

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

10 A. Mm-hm.

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

15 A. Absolutely.

16 Q. Because it was the wrong treatment.

17 A. Yes.

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

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

1 she was given.

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

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

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

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

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

1 A. Absolutely.

2 Q. If it achieves therapeutic benefit, then that will help
3 us with the diagnosis.

4 A. Yes, I accept that.

5 Q. If the treatment that is provided on the basis of
6 a tentative diagnosis, if the treatment works, it tends
7 to confirm that the diagnosis was correct.

8 A. I am not sure that is true.

9 Q. I did not say it did prove it, I said it tends to prove
10 it. It is evidence that must tend to confirm --

11 A. Yes, if you get better on something, you relate the two
12 together.

13 Q. If the symptoms that the patients were complaining of
14 and the signs that Dr Skinner noted were actually
15 there -- and, again, you are in no position to
16 contradict that they were -- what do you say of
17 a practitioner who starts a trial of thyroid replacement
18 therapy for such a patient?

19 A. I think in this instant it is wrong because of the TSH.

20 Q. Can I suggest it would be not unreasonable to start
21 a trial and see whether the symptoms are alleviated?

22 A. I think it would be much better to not start a trial, to
23 do several TSHs, see what happens, and then decide what
24 to do. I do not believe a trial should be done using
25 a single TSH.

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

8 A. I can remember.

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

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

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

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

11 A. Absolutely.

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

14 A. Yes.

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

20 A. Absolutely.

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

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

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

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

9 Let us agree that is wholly undesirable?

10 A. I am glad you agree that is undesirable.

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

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

19 A. Mm-hm.

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

22 A. Yes.

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

24 A. By reducing the dose.

25 Q. That's one way.

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

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

7 Q. Can I ask what you mean by initially?

8 A. 10/15 years ago.

9 Q. Right.

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

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

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

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

1 I think these risks are small, but still real.

2 Q. Yes? Can those risks --

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

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

13 A. Yes.

14 Q. If they are on thyroxine?

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

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

25 A. The small risk.

1 Q. -- the small risks they are exposed to?

2 A. Yes.

3 Q. Would you agree there are other studies that suggests
4 there is no risk to hypothyroidism patients?

5 A. Yes, I agree. Hyper we're talking about?

6 Q. Hypo. Hypothyroidism patients who are given replacement
7 therapy.

8 A. Yes. I agree.

9 Q. Are there any studies?

10 A. There are other studies that say there are no risks but
11 there are studies that say some risks and if you're
12 practising safe medicine, you have to practice the risk
13 factor, not the non-risk factor.

14 Q. I understand. Can we break it down. There are studies
15 that deal with thyrotoxic patients?

16 A. Yes.

17 Q. Hyperthyroid patients.

18 A. Yes.

19 Q. Studies that suggest patients are at risk to osteopenia?

20 A. Minimal, and they're only really at risk if their TSH is
21 significantly suppressed down to about less than 1.

22 Q. These are patients with thyroid disease?

23 A. Thyroid -- and on thyroxine.

24 Q. Are there studies that deal with patients who are on
25 replacement therapy?

1 A. Yes, there are studies. I think some of them are sort
2 of patients with thyroid cancer, who are replaced with
3 thyroxine, and I don't know the results of those.

4 Q. Are there studies that might be directly relevant to the
5 patients that we're looking at here, patients who are
6 thought to be hypothyroid who are given replacement
7 therapy, the studies as to --

8 A. I can't answer that question, sorry.

9 Q. So you say it is a theoretical risk.

10 A. Yes -- no, I say that some studies say that you can have
11 fractures, some studies say that you can't, and
12 therefore as a matter of responsibility we shouldn't use
13 a drug which may have a risk.

14 Q. I understand. I think most drugs would carry some risk
15 of some kind.

16 A. Yes, but only if you need to give the drug for
17 a therapeutic effect, not if you have to give it to
18 somebody who doesn't have a condition.

19 Q. I agree, and that is the underlying question, but most
20 drugs carry the risk of side effects.

21 A. Yes.

22 Q. Some of them potentially serious.

23 A. Yes.

24 Q. The issue is: what's the degree of risk that the patient
25 might be being exposed to? Are they aware? Is it

1 explained to them that there is some degree of risk?
2 Secondly, what's the benefit to balance against the
3 degree of risk and the patient agreeing --
4 A. Yes, absolutely.
5 Q. -- to accept that risk?
6 A. Absolutely.
7 Q. Those are questions for almost any kind of medical
8 intervention, whether it be a surgical procedure that
9 you might undertake or for prescribing.
10 A. Mm-hm.
11 Q. And so far as atrial fibrillation is concerned, again,
12 there are ways of minimising any risk to patients and it
13 is a risk that's very small anyway.
14 A. Yes, I accept that.
15 MR JENKINS: Thank you very much, Mr Lynn.
16 Re-examination by MR KARK
17 MR KARK: In relation to that last topic, as I understand
18 it, you are saying that if there is a risk it increases
19 as the TSH reduces.
20 A. Yes.
21 Q. In your practice, do you check bone density?
22 A. Yes, we would check bone density every two years.
23 We would do that if a woman came to our clinic anyway.
24 Let's be honest, women should have their bone density
25 done every two years anyway because osteoporosis is

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

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

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

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

15 A. Yes.

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

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

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

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

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

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

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

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

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

1 quite difficult test them.

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

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

12 A. No.

13 Q. Or now?

14 A. No.

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

21 A. Yes.

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

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

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

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

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

8 Q. Sorry, overt hypothyroidism?

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

17 Q. Sorry, overt hypothyroidism?

18 A. Overt.

19 Q. Meaning what?

20 A. Overt means open, visible, clinical.

21 Q. Right.

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

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

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

7 A. Yes. I would regard a large dose of thyroxine,
8 200 micrograms. 200 micrograms would suppress almost
9 everybody. We would normally for replacement doses,
10 let's say, a 70 kilogram woman, 1.6 micrograms per
11 kilogram body weight, so that's just under
12 100 micrograms. So 100 micrograms is, in my view, about
13 the replacement dose for a patient to replace them.

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

1 DR ELLIOT: So you would consider in that case
2 200 micrograms to be a large dose.
3 A. I would regard 200 micrograms an extremely large dose of
4 thyroxine.
5 DR ELLIOT: Is it a large dose of thyroxine in the treatment
6 of hypothyroidism?
7 A. Oh, I believe so.
8 DR ELLIOT: Okay. I want to ask you now about what I gather
9 was your own personal experience of the effects of
10 thyroxine and your observations on patients who take
11 thyroxine replacement therapy. Thyroxine itself has
12 a feel good factor.
13 A. Yes.
14 DR ELLIOT: How much research has been done on that? What's
15 the reason for it?
16 A. I do not know, I can't your answer question, but I've
17 been sitting in that clinic for years and, of course,
18 this is anecdotal, and one must accept it as anecdote,
19 but there is undoubtedly a feel good factor. The real
20 problem is patients who, rather like the four patients
21 of Dr Skinner, have gone on -- I am just using that as
22 an example -- and, in my view, have been inappropriately
23 treated for hypothyroidism, who take thyroxine, and then
24 often gradually over the period of years increase the
25 dose.

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

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

11 DR ELLIOT: I understand, yes.

12 I think you said that it was addictive.

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

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

17 A. No.

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

23 A. I have the charges here.

24 DR ELLIOT: Have you seen the charges?

25 A. Somewhere.

1 DR ELLIOT: They're in a yellow sheet.

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

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

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

6 I've obviously seen these before.

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

9 This is in charge 3, 3A -- 3B and 3C:
10 "You took an inadequate history. You carried out an
11 inadequate examination."

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

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

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

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

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

9 MR KARK: Yes, thank you.

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

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

17 A. Page 1?

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

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

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

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

5 A. Yes.

6 DR ELLIOT: Which is presumably why it has been transcribed.

7 What I wanted to ask you about was there, in your
8 opinion, as a doctor who sees many patients with thyroid
9 and other disorders, do you feel that Dr Skinner's
10 history taking was inadequate?

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

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

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

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

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

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

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

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

2 A. The B12 deficiency.

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

4 What you may find helpful in this context is

5 a letter to the doctor, which you'll find behind tab 2

6 on page 15.

7 Do you think it is reasonable for someone in

8 Dr Skinner's position simply to inform the GP of the

9 suspicion of B12 deficiency, or do you think that is

10 something he should have investigated himself?

11 A. Well, I think he says perhaps B12 deficient with yellow

12 lemon tint in the skin. He has mentioned it and

13 it would be ideal if he said: why don't you do a B12

14 test? Check the B12. But he's actually mentioned it

15 and written back to the doctor. I think it is a moot

16 point, but I don't really feel that it is inappropriate.

17 DR ELLIOT: Thank you.

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

19 DR ELLIOT: Yes --

20 A. But the obvious thing, if you think it is B12 deficient,

21 you do a B12 -- after all, he thought she was thyroid

22 deficient, so he has done --

23 DR ELLIOT: Yes. Can I take you now, again the same tab, to

24 page 27. It is the second page of the letter.

25 A. Sorry, I can't hear you.

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

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

5 "You suspected a diagnosis of secondary
6 hypoadrenalism."

7 And charge J:

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

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

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

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

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

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

7 A. I think that's hard. I think that he could organise
8 24-hour urinary cortisol, he could organise the ACTH,
9 they are only blood tests, and if they were normal,
10 it would stop the necessity for a referral. I wouldn't
11 be critical of that, but ideally those tests should have
12 been done, or else it may have been using the
13 aide memoire for him at a later date to think about it.

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

17 Just to remind you, this was the patient who had
18 been prescribed a small dose of thyroxine,
19 25 micrograms, and in fact she said in her evidence
20 immediately she developed severe headache and tension --

21 A. That is right, yes.

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

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

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

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

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

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

8 DR ELLIOT: Thank you.

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

14 A. Are you able to help me with those?

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

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

20 A. I regard those notes as perfectly adequate.

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

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

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

5 A. You know, this is perfectly satisfactory.

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

7 A. Is there a written note?

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

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

13 DR ELLIOT: Thank you very much indeed.

14 THE CHAIRMAN: Further questions? Mr Payne?

15 MR PAYNE: Good afternoon.

16 A. Good afternoon.

17 MR PAYNE: Can you hear me okay?

18 A. Yes, thank you very much.

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

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

23 MR PAYNE: You said your career has spanned approximately
24 30 years.

25 A. Since 1964 when I qualified.

1 MR PAYNE: I believe when you were giving your evidence you
2 said that you've seen people over a period of many
3 years.
4 A. Yes.
5 MR PAYNE: I also believe that you said that you've seen
6 some people who didn't have a thyroid problem but
7 developed in later time.
8 A. That is right.
9 MR PAYNE: Why did they come to you in the first place?
10 A. I can't answer that. Maybe they felt generally unwell,
11 maybe they thought they needed to be viewed by a doctor,
12 they may have had minor abnormalities of their thyroid
13 function when I saw them, but I followed these patients
14 up.
15 Unless it was equivocally nothing, if they were
16 patients we had any concern about, they would be
17 followed up, and in fact when I left the Health Service,
18 the clinic, obviously for cost reasons, that stopped
19 because these patients were all sent back to the general
20 practitioner. But basically I was following up any
21 doubtful thyroid problem since 1978 when I was appointed
22 at the Hammersmith and any doubt at all about a patient,
23 we kept them and I saw them myself.
24 MR PAYNE: Would it be fair to say that going back all those
25 years, that those people were referred to you by their

1 GPs?

2 A. Yes.

3 MR PAYNE: So they would have visited their GP with certain
4 signs and symptoms, and one would think they would have
5 taken the relevant blood test.

6 A. Yes.

7 MR PAYNE: But they were referred to --

8 A. And sometimes they may have had a mildly raised blood
9 test -- because my policy was not to treat them.
10 Sometimes they were thought rather like Dr Skinner
11 thought, with his patients, where I disagree with, that
12 they were hypothyroid and would I see them, and then
13 I didn't let them go, I kept them. Unfortunately one
14 was so busy, one didn't have the time to document or put
15 everything on computer because it was a different age,
16 we do now, but no then.

17 MR PAYNE: I understand. I'm right in thinking that as far
18 as your opinion is, the evidence you've given us, that
19 the only true test is for the blood test to see --

20 A. Yes, I believe that to be so.

21 MR PAYNE: But these people were referred to you,
22 couldn't -- it is impossible for the symptoms to start
23 actually before the readings are outside the level?

24 A. In my view, I don't agree with Dr Skinner's view, I do
25 not believe that patients whose bloods are within the

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

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

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

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

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

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

1 the reference range.

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

4 A. Yes, of course, sir.

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

7 A. And it says:

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

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

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

18 MR PAYNE: I just want to clarify this point, because, like
19 I have said already, I'm not a medical member, I'm a lay
20 member to the Panel, but she came to give evidence, did
21 Patient D, and she gave the signs and symptoms that she
22 had, and we've been given throughout the course of this
23 hearing all the relevant signs and symptoms.

24 Unfortunately for myself, from a personal aspect, my
25 wife has suffered with thyroid problems, and it could

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

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

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

10 A. That's the blood test.

11 MR PAYNE: Thank you very much indeed.

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

14 A. Yes, thank you.

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

19 A. Yes.

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

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

6 MRS WHITEHILL: 16 stone.

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

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

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

15 MRS WHITEHILL: Thank you.

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

20 A. Could you say -- patients who have?

21 MRS WHITEHILL: Hypothyroidism as defined by both the --

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

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

7 MRS WHITEHILL: Thank you, Mr Lynn.

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

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

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

1 50 per cent who didn't get better on its own would get
2 worse and worse and could really look like people out of
3 a concentration camp, thin, starving, cokectic(?), and
4 there was a significant mortality.

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

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

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

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

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

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

13 Does that answer your question, Madam Chairman?

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

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

19 MR KARK: If a patient requests.

20 THE CHAIRMAN: If a patient requests a prescription --

21 A. Absolutely not.

22 THE CHAIRMAN: Has his own choice.

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

1 THE CHAIRMAN: Thank you, just one more. T3 and the Armour
2 Thyroid. The ratio with Armour Thyroid T3 is 4 or 5 to
3 1.

4 A. That is right.

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

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

12 THE CHAIRMAN: No greater risk, T3?

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

15 THE CHAIRMAN: Thank you very much.

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

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

22 A. Yes.

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

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

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

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

12 MRS WHITEHILL: Thank you very much.

13 THE CHAIRMAN: Thank you. Any further questions?

14 Further re-examination by MR KARK

15 MR KARK: Just, I think, one.

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

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

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

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

1 Q. Let me take you, by way of example, to tab 4. I just
2 want to ask about one specific aspect of this or two,
3 perhaps. We see that part of this patient's problems
4 were tinglings in feet and arms and then this:
5 "Side vision, hallucinations of lights."
6 We see comments in other patients, I'm not going to
7 go through them, fairly frequent reference to problems
8 with vision. If that's right and the patient was
9 complaining of problems with vision, I want to ask this
10 in as open a way as possible: what would you say, if
11 anything, about the investigation which followed?
12 A. Well, first of all, I don't know what side vision,
13 hallucination of lights mean. I have not a clue, I'm
14 afraid, I'm just like a layperson over this, I have
15 absolutely no idea what it means, but it occurs on
16 several other bits of paper, and it may be a physical
17 sign or a comment that Dr Skinner has found he thinks is
18 appropriate to make the diagnosis, although I myself
19 have never come across it or never seen it referenced or
20 heard of it before.
21 Q. Would you expect there to be any further investigation
22 if that's something that the patient was complaining of?
23 A. In fairness to him, if he actually believes that this is
24 a symptom which he has seen of hypothyroidism, which
25 I think he's wrong about, then I would have thought

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

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

9 A. No.

10 MR KARK: Very well, thank you.

11 THE CHAIRMAN: Mr Jenkins, any further questions?

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

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

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

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

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

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

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

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

1 previously.

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

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

19 THE CHAIRMAN: Thank you.

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

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

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

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

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

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

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

25 MR JENKINS: I agree with every part of that.

1 MR KARK: Then we can move on.

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

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

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

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

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

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

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

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

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

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

19 "I was consulted by my patient [Patient B] on
20 28th January 2003 with symptoms which suggested
21 a significant depressive condition."

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

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

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

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

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

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

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

20 He says:

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

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

4 He writes in the fourth paragraph:

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

16 He says:

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

25 "It is disappointing after 40 years of practice

1 wherein I have had no complaint or litigious procedure
2 that my professional reputation is being sullied by an
3 uninformed and strangely adversarial communication to
4 the General Medical Council."

5 A letter follows, thanking Dr Skinner for his
6 communication.

7 Could I ask you to go to page 20 because the rest
8 you have seen. This puts Dr Skinner on notice on
9 23rd July 2004, third paragraph down:

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

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

20 At page 37 he writes:

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

1 require to be anonymous."

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

5 At page 39 you can see:

6 "The medical screener has decided, on the basis of
7 the same information sent to you, that you should be
8 invited to agree to a performance assessment on the
9 standard of your professional performance."

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

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

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

16 At page 45 he agrees to a performance assessment.

17 He says:

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

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

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

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

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

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

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

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

23 "We write to advise that we have received specific
24 instructions from Dr Skinner to the effect that he no
25 longer agrees to an assessment of his performance being

1 carried out. He makes this decision in the light of
2 recent correspondence which he has had with the Council
3 and appreciates that the Council may take the view that
4 an Assessment Panel must now be convened to consider the
5 question as to whether it is appropriate to make an
6 order that an assessment should be carried out. It is
7 Dr Skinner's contention that this is neither necessary
8 nor appropriate."

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

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

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

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

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

9 Can I then deal with the statement of Sam Jordan,
10 who is a professional performance assessment officer of
11 the GMC, and she produces various documents which can be
12 found in SJ1. Again, I am not going to read through the
13 rest of her statement, but you can see that we begin at
14 page 2 with a letter to Dr Skinner back on
15 12th November 2004. This is over into tab 4 of the same
16 file, writing to him:

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

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

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

1 yourself and your practice."

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

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

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

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

13 "With regard to your qualifications and training,
14 are there any comments, explanations, or additional
15 information that you think may be relevant, which you
16 wish to bring to the attention of the assessors.

17 In conjunction with referring family practitioners and
18 specialised colleagues I have been managing patients
19 with mainly hypothyroidism for ten years."

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

25 Again, I am being very selective and if Mr Jenkins

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

3 At page 27, he says:

4 "I am not a general practitioner."

5 At page 38, paragraph 19, he says:

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

8 Over the page:

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

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

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

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

20 In other words, the standards in good medical
21 practice.

22 He writes this:

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

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

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

8 THE CHAIRMAN: Thank you, Mr Kark.

9 Mr Jenkins, do you have anything further?

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (2.30 pm)

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

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