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Considerations on Fitness to Practise Panel Determination 7th September 2007

Gordon R B Skinner

I thank the Panel for their courtesy during this hearing and for their due attention to a considerable body of information from Mr Kark and Mr Jenkins. The importance of this case can hardly be underestimated for the future health of literally millions of patients.

It is gratifying and crucial that the Panel have acknowledged that in certain patients - if there is clinical evidence - a diagnosis of hypothyroidism is tenable with institution of appropriate treatment.

Other rulings surely fly in the face of 'Good Medical Practice'.

1. A suspicion of a diagnosis or even (Patient C) where an appropriate test was commissioned is taken to indicate that the practitioner failed to investigate this possible diagnosis. This implies that any practitioner who ever suspects any diagnosis is automatically negligent if he/she does not make a referral to a Specialist with expertise in that area. I vigorously reject this position; in the case of patients A and C, the matter was drawn to the attention of the Family Practitioner and cortisol investigation commissioned for patient C which has been transmuted from due care to a felony. Would it have been preferable if I had been negligent and not bothered to check the cortisol level at all? This is a critical point of principle and the Panel are surely not asserting that if a Family Practitioner suspects anaemia, he/she should not do a haemoglobin investigation but refer a patient immediately to a Haematologist. This philosophy was asserted by the GMC Expert Witness and would engender multiple referrals and render medical practice an impossible undertaking. Professor Weetman did suggest that Patient A who was improving apace on thyroid replacement could have gastric carcinoma, Addisonian failure and indeed a brain tumour as she had a transient headache. Common sense is critical in medicine and practitioners must be allowed a sensible level of clinical judgement.

2. The misconception of biochemical thyrotoxicity will seriously threaten the future health of patients. Thyrotoxicity is a clinical judgement based on clinical features and (unlike Patient B who showed no evidence of thyrotoxicity) this is an indication to reduce the level of replacement. This condition must be discriminated from biochemical hyperthyroidism which per se does not require therapeutic intervention..

The issue is that there can be an enormous variance in thyroid hormone levels but the result of this in terms of penetration of cells or effect on body organ will be hugely variable. I have seen patients with high thyroxine levels who were not in the slightest thyrotoxic and indeed I have seen patients who were hypothyroid with thyroxine levels over 30. This confusion is one of the millstones in the management of patients and none of the patients including Patient C and Patient D and of course Patient B had evidence of thyrotoxicity which negates the entire argument that these patients were at risk. Potential risk as suggested by Professor Weetman is entirely unproven; he

inexplicably chose to discuss a different set of patients namely patients with subclinical hypothyroidism while agreeing he had no experience on the cases under scrutiny. In fairness to myself, the text should be rewritten and the term biochemical thyrotoxicity which is a non-concept removed before this notion becomes entrenched as an accepted 'GMC endorsed concept' to the future detriment of patients with hypothyroidism.

3. The principle that a patient's level of thyroid replacement cannot be changed without thyroid chemistry is extreme although the opposite concept that you need not even see the patient which was realised by two of the complainants who had not examined the patient – is non-viable and 'Bad Medical Practice'. As an aside it is worth commenting that three of the complainants namely Dr Jordan (Patient B) , Dr Cundy (Patient C) and Dr Stewart (Patient D) appear to have fired off letters to the GMC without ever having seen the patient at all which is disgraceful. I am disappointed that the GMC would entertain such poor medical practice and unprofessionalism.

I hold with the principle that it is not always necessary to check thyroid chemistry prior to any change in a patient's medication unless there is reason to believe from the patient's history and examination that the patient might be thyrotoxic or still hypothyroid which cannot be adjudged from the thyroid chemistry; it is worth adding that this is how medicine was conducted prior to the introduction of thyroid chemistry following which thyroid chemistry assumed pivotal importance under a misconception of evidence based medicine where the most important evidence namely how the patient feels is now blithely ignored.

If this point is not accepted, then patients will continue to be undertreated often throughout their entire lives on the basis of crassly exaggerated possible adverse effects in patients who have returned to good health.

4. Patient B highlights another critical misconception. At the inception of the NHS, Mr Bevan advocated a shared care between the public and private sector. This relates in the particular to 10b page 4 concerning patient B where an arrangement wherein a private practitioner prescribes and the patient is monitored by the Family Practitioner is deemed to constitute 'failing to monitor adequately or not at all' on which precept every private and NHS practitioner is 'Guilty as Charged'. It is stated (curiously) that I continued thyroxine when the patient was biochemically thyrotoxic and had palpitations. It is tedious to reiterate but the patient was never thyrotoxic and indeed Dr Blair recorded a pulse rate of 60 per minute; 'palpitations' is rather a talk up of an episode of tachycardia which was reported by this patient and there is no contraindication to adjusting a patient's medication if indeed they are biochemically thyrotoxic (vide supra) and/or if they have had palpitations or tachycardia.

SUMMARY

It would be perhaps be personally advantageous to make ameliorating response to the allegations which are considered to be proven but would be an abrogation of professional honesty and potentially disastrous for the future health of our nation; it would be quoted as precedent of acceptance of ill-judged principles in the

management of patients with hypothyroidism. There is no such concept as biochemical thyrotoxicity and patients must not be continued in a state of hypothyroidism when there is evidence that they are clinically hypothyroid but the thyroid chemistry says otherwise I will state quite categorically that I am not concerned if the patient has low TSH levels and the patient seems in optimal health.

Patients have hypothyroid features which can continue and return at intervals during the treatment for example tachycardia or palpitations. This does not constitute overreplacement or overtreatment or irresponsibility or unprofessionalism or (most absurd) putting the patient at risk of harm. This latter calls into question the whole question of patient follow up where if (for example) one found that a diabetic patient's glucose was too high then that could be readjusted if considered necessary but the way forward now, it would appear, is to consider that the patient had been overtreated, a felony and thus a practitioner is in some way culpable. I urge that the Panel do not allow the concept that if a follow up consultation requires therapeutic re-adjustment this constitutes 'Bad Medical Practice'.

Professional integrity is absent. The Panel have been asked to adjudge on allegations made on three occasions by practitioners who have never seen the patients nor had the courtesy to address any concerns with my good self and yet these types of allegations - which are clearly unfounded - were entertained in full by the GMC; I ask that consideration be given to this unprofessional approach to peer review of medical practice.

Note keeping requires comment. Notes are for the personal attention of the practitioner and my notes were deemed satisfactory by the Healthcare Commission who inspect my notes at intervals. It does rather irk to have these notes criticised following complains from practitioners for example Dr Ince (Patient C) whose entire contribution was 'ISQ' and had not managed to take a pulse in a patient about whom she was asserting thyrotoxicity.

The totality of these complaints would appear to be nothing more that patient B had tachycardia during the night following which her dose was adjusted by the Family Practitioner and myself. This would seem perfectly usual and not a matter of concern; it is extraordinary that such an issue would even require the scrutiny of a Panel of the GMC.

I am very concerned that these principles which I have enunciated be written into 'folk lore' or, more specifically, transcripts of these proceedings partly for the future of medical practitioners who are gradually being put into an impossible position where they are damned if they do and damned if they don't and more importantly, for the patients wherein they will be not diagnosed or adequately treated through a servile devotion to thyroid chemistry – and this is the crucial point – which has never ever been shown to correlate with clinical wellbeing.

I say quite sincerely that I do not believe that there is any impairment of my fitness to practice. I have returned many thousands of patients to health with to my knowledge no detriment or significant adverse effect in any patient.

It may be an old fashioned out of date concept but I have tried to follow the principles of the Hippocratic Oath in the face of a changing tide wherein practitioners must now devote time and energy towards protecting their career - perhaps we cannot blame them – rather than focussing on what is best for their patients.