

General Medical Council

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DETERMINATION ON IMPAIRMENT – 17. November 2011 FITNESS TO PRACTISE PANEL HEARING – Commencing 14 November 2011

Dr Gordon Robert Bruce SKINNER

Dr Skinner:

This is a review hearing of your case.

The Panel have reviewed your case as your registration is subject to conditions until 30 November 2011 in consequence of a direction by a Fitness to Practise Panel on 29 July 2011. The first hearing of your case was concluded in November 2007.

The allegations against you related to your treatment of four patients with thyroid conditions. The Panel in 2007 was most concerned that your rigid approach had put patients at risk of harm and that you had repeatedly breached the advice and guidance contained within 'Good Medical Practice'. Furthermore that Panel considered that you lacked insight and noted your refusal to comply with a request by your regulatory body for a performance assessment.

That Panel determined that your fitness to practise was impaired by reason of your misconduct and deficient professional performance and imposed conditions on your registration for a period of three years. You appealed this decision in December 2007 but that appeal was discontinued by consent at the High Court, and the sanction of three years conditional registration commenced in August 2008. The conditions imposed on your registration by the 2007 Fitness to Practise Panel were as follows:

1. You must notify the GMC promptly of any post you accept for which registration with the GMC is required and provide the GMC with the contact details of your employer.
2. You must allow the GMC to exchange information with your employer, or any organisation for which you provide medical services.
3. You must inform the GMC of any formal disciplinary proceedings taken against you, from the date of this determination.
4. You must inform the GMC if you apply for employment outside the UK.

5. You must only accept new patients for endocrine treatment if they have been referred to you by a fully registered medical practitioner. On a six monthly basis, you must provide to the GMC anonymised copies of patients' referral letters in a separate, paginated and indexed bundle (patients being identified by initials and NHS number).

6. Prior to initiating or varying any treatment regime, you must ensure that you have communicated your diagnosis and suggested care plan to the patient, his or her GP, and any other referring medical practitioner. On a six monthly basis, you must provide to the GMC copies of the letters sent to GPs or referring medical practitioners in a separate, paginated and indexed bundle (patients being identified by initials and NHS number).

7. You must keep a contemporaneous logbook of all patients seen in relation to work carried out as a registered medical practitioner. This book must identify the patient only by their initials and NHS number and the name and contact number of the referring practitioner, and should be initialled and dated by the patient. The logbook must indicate:

- in the case of a new patient, the reason for the consultation;
- in the case of all patients, the reason for any prescribing outside of UK recommended guidelines.

On a six monthly basis, you must provide the GMC with a copy of the logbook.

8. You must inform the following parties that your registration is subject to the conditions, listed at (1) to (7), above:

- a. Any organisation or person employing or contracting with you to undertake medical work;
- b. Any locum agency or out-of-hours service you are registered with or apply to be registered with (at the time of application);
- c. Any prospective employer (at the time of application).

A Fitness to Practise Panel convened to review your case in July 2011. However, after dealing with preliminary legal matters, the Panel found it necessary to adjourn the hearing as a result of difficulties regarding the GMC's expert evidence. In doing so, the Panel extended the conditions previously imposed on your registration for a further period of three months.

This Panel has now reviewed your case. It has considered, under Rule 22(f) of the GMC's Fitness to Practise Rules 2004, whether your Fitness to Practise is impaired by reason of your misconduct and deficient professional performance.

You have been represented by Mr Foster, Counsel, instructed by RadcliffesLeBrasseur, solicitors, and the GMC was represented by Mr Atherton, Counsel.

The Panel heard from the GMC's expert witness, Dr Thomas Akintewe, Consultant Diabetologist and Endocrinologist. His report reviewed the treatment of a cohort of 662 of your patients over the past three years. He confirmed the conclusions stated in his report, namely that you had complied with conditions 5, 6 and 7 of your registration.

However, in that report Dr Akintewe raised concerns regarding the prescription of thyroxine and Armour Thyroid by you to a small number of those patients who had, in Dr Akintewe's judgement, no clinical need for such a prescription.

In relation to the prescription of thyroxine, Dr Akintewe stated that the reason for the referrals to you from GPs was the unease felt in prescribing when blood test results indicated thyroid activity within the commonly regarded reference range. Dr Akintewe held the view that although there were no formal guidelines on the acceptable reference range of blood test results to assist in ascertaining thyroid deficiency, there was a range within the UK to which practitioners were expected to adhere before instituting treatment. This range was broader than that used by you.

As for the prescribing of Armour Thyroid, which is unlicensed in the UK, he maintained such was not recommended by the NHS or eminent clinicians in the field.

Dr Akintewe was concerned about your prescription of thyroxine to patients who had general symptoms which could be caused by a multitude of conditions and which could not be confirmed by biochemical testing as being due to hypothyroidism. He therefore had concerns that thyrotoxicity in these patients might develop, leading to problems of osteoporosis and irregularities of cardiac rhythm.

In your evidence before the Panel, you confirmed that to your knowledge there were no formal guidelines as to the accepted procedure for medicating those patients with thyroid deficiency. You also commented that, although you do not disregard the biochemical evidence, you do not regard blood chemistry as absolutely indicative in diagnosis, and you feel it is imperative to take into account the clinical symptoms exhibited.

You confirmed that you had met your conditions and that they had shaped your practice and that you would, for instance, continue to see new patients only by referrals from other medical practitioners. In terms of your private practice, you confirmed that the Care Quality Commission has oversight of your practice and that you are aware of the dangers of prescribing thyroid replacement to patients. You went on to describe the safety precautions within your practice. You made reference to a patient symptom questionnaire, a prescription request form, a thyroid prescribing precautions leaflet, details of your prescribing methods and the follow-up procedures you have with patients and GPs. You also clarified that those occasions when you prescribe thyroxine to patients prior to ascertaining blood test results were

rare, usually either when a patient refuses a blood test or is so unwell that it is in their interest to commence immediate treatment. Moreover once the blood test results are available the diagnosis is reviewed. With reference to Armour Thyroid, you are of the view that it is of use in those patients that do not improve with thyroxine or have had a thyroidectomy. You commented that in all cases you initially prescribe at a low dose and progress in small increments, which in itself acts as a safeguard.

Mr Atherton, in his submissions on behalf of the GMC, outlined the nature of the facts found proved by the original Panel, highlighting the seriousness of the charge with particular respect to Patient B. That Panel found that your prescribing had been unnecessary, irresponsible, and not in the best interests of the patient, and had placed the patient at risk of harm. He recalled that no other doctor called to give evidence at your hearing in 2007 had agreed with your line of treatment, and noted that the previous Panel had considered that your rigid approach in denying the concept of biochemical thyrotoxicity showed a lack of insight and a failure to reflect upon your practice.

He conceded that you have complied with the conditions imposed by the previous Panel, and submitted that the essential question was one of ensuring the safety of patients.

He further submitted that, having received and responded to the report of Dr Akintewe, you have found it neither appropriate nor necessary to present any accumulated evidence in support of your course of practice, which is considered unorthodox, and not supported, by the main body of UK practitioners.

Mr Atherton went on to submit that, although the volume of testimonials and the extent of the personal support for you are impressive, more objective evidence of a system of monitoring, evaluation and feedback is required before this Panel can be satisfied that, in the absence of conditions, patient safety can be assured.

He submitted that there is still a lurking concern as to whether you have shown flexibility of thought, objective reflection and insight, and that consequently your Fitness to Practise remains impaired.

On your behalf Mr Foster reminded the Panel that the previous Panel had expressed concern that your rigid approach had put patients at risk of harm, and that your belief that biochemical thyrotoxicity was a misconception displayed a lack of insight. Furthermore the previous Panel had concerns that your prescribing of thyroxine had been without prior blood tests or regular reviews and monitoring.

Mr Foster submitted that there were no formal guidelines as to the accepted ranges for the testing for abnormal thyroid activity. He further submitted that there had been insufficient development in this field of medicine to conclude that the view held by Dr Akintewe was mandatory, and the lack of any formal guidelines was indicative of this. He also submitted that the limits recently revised in the USA were an alternative to those used in the UK and that the biochemical evidence should be

used as a support in dealing with the clinical presentation of a patient and not as the sole arbiter. Furthermore, Dr Akintewe had conceded that the variance in the patient results he had reviewed could be attributed to differing laboratory practices.

Mr Foster submitted that there was a place for the prescribing of Armour Thyroid to those patients who had not responded adequately to thyroxine. Furthermore he contended that the use of unlicensed drugs was commonplace in the UK and not unique to Armour Thyroid. He went on to submit that the British Medical Journal article (*Thyroxine treatment in patients with symptoms of hypothyroidism but thyroid function tests within the reference range...*, Pollock M A et al; 2001; 323: 891-895) which was referenced in and used to support Dr Akintewe's report, had been a small study from 2001 and had not been followed up with work of a significant scale, despite you having agitated for this to be done.

He submitted that you have shown yourself well aware of possible complications in your treatments and in neither the evidence before the original Panel nor in relation to those patients reviewed by Dr Akintewe was there any evidence of patient harm. He also drew the Panel's attention to the numerous testimonials in your support. Therefore, in light of your reflection, insight and the safeguards you now utilise, he submitted there is no evidence to support the view that your fitness to practise is impaired.

In determining whether your fitness to practise is impaired the Panel has taken note of the Legal Assessor's advice. Particular reference has been made to the fact that neither party bears any burden of proof and that the Panel need only consider whether your current practice and beliefs still show disregard of your clinical responsibilities towards your patients and whether they demonstrate that you now have insight.

The Panel must determine whether there is any evidence of current misconduct or deficient professional performance, and whether you have shown sufficient insight into, and reflection upon, those matters which concerned the previous Panel. The Panel notes that you have provided much evidence to support the view that you have shown due reflection on the comments made by the previous Panel.

The Panel notes that the central issue in this case is the propriety of prescribing thyroxine to patients who are judged to exhibit symptoms and/or signs of hypothyroidism, but whose biochemical test results fall within a conventionally accepted reference range, which is generally interpreted as implying "normality".

It is not within the Panel's remit to pronounce on the correctness or otherwise of your approach other than by assuring itself that appropriate steps are being taken by you to ensure its safety.

However the Panel cannot fail to take notice of the fact that your approach to treatment, whereby both clinical and biochemical parameters are assessed, falls within the guidelines of 'Good Medical Practice'. In this respect your assessment of

your patients does not differ from Dr Akintewe. The difference of approach lies in the weight given to the respective clinical and biochemical findings.

The Panel noted that you continue to challenge the concept of biochemical thyrotoxicity, but is satisfied that you are fully aware of, and in no way deny, the fact that the administration of thyroid hormone can lead to levels in the bloodstream which can be dangerous. The Panel understands your position to be that you do not accept that raised levels of thyroxine in the blood are inevitably or necessarily associated with a toxic state.

The Panel is satisfied that the procedures you have in place to safeguard those patients referred to you are adequate. In reference to your prescription of the unlicensed drug Armour Thyroid, the Panel is content with your reasoning behind its prescription.

In reaching its decision the Panel has considered all the evidence before it. It notes that you have complied with the conditions on your registration for the past three years, that there is no evidence of patient harm nor any evidence of any misconduct or deficient professional performance. You have referred the Panel to many papers, written over many years, which have addressed the issue of biochemical testing for thyroid disease, and its relationship with the clinical findings. It is clear the issue is a complex one. The Panel is satisfied, however, that your ability to produce these references demonstrates both insight and ability to reflect objectively upon your practice.

The safety measures and follow-up routine as described by you have allowed the Panel to feel confident that patient safety is not disregarded by you. On the contrary you have shown awareness of the risks of your prescribing and have sought to communicate this to patients. The Panel is impressed with the reflection you have shown and your evident immersion in your specialty, and has noted your ready awareness of views opposing yours in this field. The Panel is confident that you will continue this reflection in your future clinical work.

This Panel has therefore determined that your fitness to practise is no longer impaired by reason of your misconduct or deficient professional performance.

Your conditions are revoked forthwith and you are now free to practise without restriction within the United Kingdom.

That concludes your case.