GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (PROFESSIONAL CONDUCT)

Wednesday, 14 February 2007

Regent's Place, 350 Euston Road, London NW1 3JN

Chairman: Mr Richard Kyle

Panel Members:

Ms Joy Julien
Dr Ronald MacWalter
Dr Sheila Willatts

Legal Assessor: Mr Michael Seed QC

CASE OF:

EDEN, Julian Christopher Paul

(DAY THREE)

MR DAFYDD ENOCH, instructed by Messrs Field Fisher Waterhouse, solicitors, appeared on behalf of the General Medical Council.

MR ALAN JENKINS, instructed by Messrs RadcliffesLeBrasseur, solicitors, appeared on behalf of Dr Eden, who was present.

(Transcript of the shorthand notes of T. A. Reed & Co.
Tel No: 01992 465900)

I N D E X

THE CHAIRMAN: Good morning, everybody. A quick reminder about mobile telephones, please. Then, Mr Enoch, we are back with you, I think.

MR ENOCH: Thank you and good morning. Can I just mention that you have got a bundle 4, which deals with Patient A, who you heard about yesterday. Most of the relevant content of the email traffic, as you will have appreciated already is set out in the heads of charge because I have reiterated it in that document, but the email traffic such as we have it and the joining form are documents which are in that bundle. I do not think there is any question but that all this material is accepted as admissible and of its most of the email traffic records have been sent to us through Dr Eden's solicitors, and so there can be no problem about its provenance. That was just so you are aware that bundle 4 deals with that patient.

We are about to deal with Oliver Harvey and his purchase of Reductil, and bundle 5 is where the papers are regarding him. You might like to have that available to you. I have actually put 4, 5 and 6 all in one file because they are so thin. If anybody needs tags I have them.

My next witness will be Oliver Harvey, please, starting at heads of charge 29.

Can I also say that I have been provided this morning, after a request by me, with some email traffic and records from Dr Eden on Fiona Hutson, which we have never had before? I am having them copied at the moment.

MR JENKINS: We are copying them as well.

MR ENOCH: We are both copying them. They are clearly relevant for you to see and we will insert them at the appropriate time.

MR JENKINS: Can I add that we found some more on Dr Eden's old computer in relation to Fiona Hutson. Those are being copied as well.

THE CHAIRMAN: The only practical request I would then make is that they are hole punched beforehand.

OLIVER WILLIAM HARVEY, Affirmed
Examined by MR ENOCH

(Following introductions by the Chairman)

Q I am going to ask you about an investigation you undertook, but, first of all, what is your full name?
A Oliver William Harvey.

Q What is your occupation?
A I am a reporter for *The Sun* newspaper.

Q Are you still with *The Sun*?
A Yes, I am.

Q Were you with *The Sun* in 2003?
A That is right.

Q When did you start working for *The Sun*?
A In 2000.

Q What is your professional address?
A 1 Virginia Street, Wapping.

Q I think you undertook an investigation into internet prescribing in the latter part of 2003 in your capacity as an investigative journalist, is that right?
A That is correct.

Q I am sure I can lead on the fairly uncontroversial background, in fact I suspect all of your evidence is relatively uncontroversial: I think you used the search engine Google to see what you could find by way of websites from which you could buy prescription-type drugs?
A That is correct, yes.

Q The idea was to investigate it with a view to writing an article, which in due course you did?
A Yes, that is right, yes.

Q In any event, is it right that your first port of call was to try to find websites based abroad from which you would be able to import drugs into the UK?
A It was just to see exactly what you could buy; it was just start with Google and put in "buy drugs" and just see what you could get.

Q Was the first focus abroad or did it not matter?
A It was just that it was easier, the first thing – it was easier to do it from abroad, the type of drugs that you could buy.

Q Did you in fact make test purchase of medications from websites abroad?
A Yes.

Q Did you then focus on the UK to see what was available and purchasable from websites in the UK?
A Yes, I did, yes.

Q You eventually came to a website called Menscare, is that right, in the UK?
A Yes.

Q As is accepted now, you came to be consulting, as it were, through that website with Dr Eden?
A Yes.

Q We know that you were to purchase and receive Reductil slimming medication from him.
A Correct.

Q Just tell us the process you went through in order to do that, please?
A I simply went on to the Menscare website and had to ---

MR ENOCH: Are you referring to your statement now? Again, I take it there is no objection if you wish to refresh your memory from it. Thank you.

THE CHAIRMAN: I am sorry to interrupt but just to be clear, Mr Harvey, the Panel do not have your statement and will not have it so this is live evidence to us.

THE WITNESS: I went on to the website and filled out ---

MR ENOCH: You need to speak up, Mr Harvey.

A Sorry. I went on to their website and simply filled out a form where I had to give my body mass index, which on the original occasion that I did, I said I was 5'11" and 150 lb. It was a very brief medical questionnaire. It took just a few moments to fill out. In due course an email arrived which said I could not be prescribed Reductil because I must have a body mass index of over 30, so I simply went on the website again; filled out the same brief questionnaire but changed my weight to make me around 18 stone, I think, which gave me a body mass index of over 30, and it came back, "that's okay" so I paid £120 and received my Reductil.

Q Have you got a copy of bundle 5 in front of you, with "Oliver Harvey" on it?

A Yes.

Q In tab 1, is that the information that you provided in what you have described as the "brief medical questionnaire"?

A That is the information, yes.

Q In fact that must be the second form, dated 22 September, because we see there your weight is recorded as 18 stone, is that right?

A That is correct, yes.

Q If we turn over to tab 2, do we see there the email that you must have received refusing your initial request for Reductil, it is dated 19 September. So it looks as though on the Friday, because that was a Friday, in the late afternoon, you made your first contact. You received the email back on the Friday at 4 o'clock saying, "Your BMI is too low", is that right?

A That is right, yes.

Q And that is signed "Jackie" at Menscare, is that right?

A That is correct.

Q For the record, it reads:

> "Unfortunately on checking your BMI … which is a guide to healthy weight, yours calculated at 20.9. This is classed as healthy. We therefore would not be able to prescribe Xenical or Reductil to you, as you must be classed as obese and have a BMI of over 30".

So on the Monday you had another go.

A That is right.

Q So that was the next working day in fact?

A A That is correct, yes.

Q Did you use the same name and address?
A I did, yes, exactly the same. I think, from memory, I just used the form again, exactly the same, I just went, tick, tick, tick.

Q In any event, that alteration resulted in your being prescribed Reductil by Dr Eden, is
B that right?
A That is correct.

Q How much did you buy?
A I bought 28 capsules, 10mg capsules.

Q Who chose the amount and the dosage?
C A I think there was an option of ticking boxes and I ticked that one.

Q So you asked for a month's supply?
A Yes.

Q How was the delivery of the medication to be organised, as far as you could understand it?
D A They sent it to me.

Q Again, was this something that you were able to choose by way of option?
A Yes.

Q Did you have the medication in fact delivered to your home?
A I did, yes.
E
Q Did it arrive?
A Yes.

Q Did it arrive the next day?
A Yes, it did, yes. I was out so it was taken to the local post office for collection.

F Q Apart from you filling in the questionnaire and the email that we have seen refusing your initial request, signed by somebody called Jackie, was there any dialogue of any sort, electronic, between you and Dr Eden before you got these drugs?
A No, I did not even know of Dr Eden's existence at that point.

Q When the medication arrived did it come with its own internal information as all drugs have?
G A It came labelled with my name and the date and the dispensing chemist, who were ABC Drug Stores Limited in Portobello Road.

Q Did it come in a packet?
A Yes.

Q Were there any documents with it as far as you can remember?
H A There was some Menscare literature with it.

Q What sort of literature?
A I think it was stuff promoting other products of theirs.

Q Was there anything about the drug Reductil that you had been sent?
A Inside the packet there was, I think.

Q Can you remember what?
A Just the normal literature you would get with a prescribed drug.

Q On receipt of that did you go to the chemist to speak to them, the dispensing chemist?
A Yes, I did, yes. I went there and said, "Hello, I'm Oliver Harvey, can I see my prescription for this Reductil?" He at first declined to do that.

Q Do not worry about a conversation you had with him but you started off at the chemists to see what you could find out there about the doctor, is that right?
A That is right, yes.

Q Did you then go on to telephone Menscare?
A Yes.

Q Who did you speak to?
A Someone who gave her name as Jackie, who was the same name on the email.

Q Did you ask her to tell you who the prescribing doctor was?
A Yes.

Q Was she prepared to?
A No, she refused point blank, and I pushed it and she said no.

Q How did the conversation end?
A She put the phone down on me.

Q Were you concerned at that stage about the circumstances in which you had got these drugs? Yes or no will do.
A I was very concerned, yes.

Q I think you contacted the Royal Pharmaceutical Society, is that right?
A That is right.

Q And you published an article in *The Sun* on 27 October 2003?
A Correct.

Q You can be asked about that if it is thought appropriate. I am not going to. I think in due course you were asked to assist with information about this investigation and you did so assist, including this investigation. Is that right?
A That is right.

MR ENOCH: That is all I have. Would you wait there please, Mr Harvey?

Cross-examined by MR JENKINS

Q Mr Harvey, the article you wrote for *The Sun* set out all the types of drugs that you had obtained through the internet I think?
A Yes.

Q I do not know that the Panel need to see it, but would it be fair to say that it is written in *The Sun's* usual style, for those who are used to seeing *The Sun*?
A What do you mean by "usual style"?

Q "It took just ten minutes to get this lethal drug cocktail" I think is the way in which it is ---

MR ENOCH: I think that if comments like that are going to be made the Panel ought to see the article.

MR JENKINS: It is not a comment; I am just reading from the article.

MR ENOCH: "Usual style" sounds like a comment to me.

MR JENKINS: I am entirely neutral whether the Panel see it or not, but if Mr Enoch wants people to see it he can no doubt make copies.

(To the witness) You set out all the drugs that you managed to obtain over the internet.
A Yes.

Q What you told us, or what you were asked, was that you started by looking at websites abroad. How do you know if the are abroad?
A I did not start off by looking for websites abroad. As I said, I just used this global engine to search for the names of drugs, and buy, so it was not a case of looking for drugs to be bought but also they tell you where they are based, a lot of them, or you can see where the websites are registered and a lot of it was in places in the Pacific, and so on.

Q I understand. You were typing in the names of specific drugs that you were looking for?
A I think I just started off by "prescription drugs" and "buy." That is it.

Q You got drugs such as Rohypnol over the internet?
A Yes.

Q Others, antidepressants, Prozac, painkillers?
A Yes.

Q Of various types?
A Yes.

Q Let us deal with Temgesic. You got that from Thailand I think?
A Yes.

Q And the Rohypnol again from Thailand. Prozac you say you got from the South Pacific Islands of Vanuatu?
A Yes.

Q When you were applying for those types of drugs, the ones that we have just mentioned, did you fill in a questionnaire?
A Some of them, yes.

Q What were you asked in the questionnaire?
A Similar sort of things really. Very vague, very few questions.
Q Were there some websites where you did not fill in anything other than your name, the address to which the drugs were to be sent, and your credit card details?
A Possibly. I cannot actually remember that.

Q You cannot remember. I think you obtained various drugs for erectile dysfunctional problems?
A Yes.

Q Viagra, Levitra, Cialis?
A Yes.

Q You obtained them from this country I think?
A Yes.

Q Can I take you to the documents that the Panel have in the relevant bundle and, in particular, the questionnaire that you filled in for Menscare? What we have at the first tab of bundle 5 is the result of your feedback form, and that is how it is described. This one I think is the one which was where you misled them as to your weight. This was your second attempt?
A Yes.

Q You put your weight as 18 stone, but you had filled in a questionnaire indicating whether you had any allergies, an indication of your blood pressure and whether you had any eating disorder?
A Yes.

Q Anorexia or bulimia, and you were asked a number of further questions including, particularly, whether you were on any other medication?
A Correct.

Q I do not know if you recall. I think there was a box that you would have faced when asked about any other medication and there was scope for the person on line to write as much information as they wanted about other medication?
A Are you asking me that?

Q I am asking you.
A I cannot remember that, but possibly.

Q It is in the documentation that you have provided. Again, I have put a ring round something, but have a look at this, if you would. I am going to pass these documents over. (Same handed to the witness)

MR ENOCH: Is this the Menscare Encrypted Order?

MR JENKINS: No, it is not. It is what is described as 013, or OI3, which the Panel do not have.

MR ENOCH: Yes, that is the document. We will get it copied.

MR JENKINS: (To the witness) I think that is the form that you filled in?
A Yes, okay.

Q I have put a ring in pen around the list of products that you could select from?
A Yes.

Q That shows that it was one month's supply of Reductil that you were seeking?
A That is right, yes.

Q £120 was the cost on the website.
A Yes, that is correct.

THE CHAIRMAN: Just for the benefit of the Panel, Mr Jenkins, I have been handed the Legal Assessor's questionnaire. It has a box at the top indicating quantities, and that is being copied at the moment.

MR JENKINS: I can take you through it very briefly. There are boxes for you to indicate "yes" or "no" whether you are on any other medication.
A Yes.

Q That is in answer to the questions in the document that the Panel will presently have.
A Yes.

Q For medication, as an example, there is a box for you to enter whether you are on medication?
A That is right, yes, there is. I can see that now, yes.

MR JENKINS: Thank you very much. That is all I ask.

Re-examined by MR ENOCH

Q Have you got a copy of that form in front of you?
A Yes.

Q So there is a box indicating alternatives in terms of how many tablets you want. Is that right?
A Yes, that is right.

Q Who ticks that box?

A I do.

Q So if you chose to ask for four months' supply, you could tick the "4 Months" box?
A Yes.

Q We see there the boxes that you are asked to fill in. You give your height and your weight and the rest is "yes" or "no" with the addition of details if you choose to give them. Is
B that right?
A That is correct.

Q Then the credit card details.
A That is right.

Q Do you have a third page? Perhaps you can be shown that one. (Same handed to the
C witness)
A Yes, I have it now.

Q Just help us as to what that says please?
A

"Menscare Services
D

Thank you for placing your order for Reductil

NEW PRODUCT: Natural Penis Enlargement Capsules From Menscare."

Q So "Thank you for ordering Reductil" and then there is an advert for penis enlargement capsules. Is that right?
E A That is right, yes.

Q Then underneath that:

"Click here to return to Reductil website

You may like to Visit our Main Website
F Where you can purchase VIAGRA and other products."

A That is right, yes.

MR ENOCH: We will have that copied for the Panel. I will hand over to the Panel for any questions they may have.

G Questioned by THE PANEL

THE CHAIRMAN: Mr Harvey, at this particular time members of the Panel may also ask you questions. If they do want to do so I will introduce them, in particular to explain whether they are a medical or a lay member of the Panel. On my right, Dr Willatts is a medical member of the Panel.

H DR WILLATTS: Good morning, Mr Harvey.

A Good morning.

Q I may have missed this, but how do we, the Panel, know that Reductil was actually prescribed by Dr Eden?
A Because there is a ---

THE LEGAL ASSESSOR: Wait a moment before you answer that question.

B

MR ENOCH: He has admitted it.

THE LEGAL ASSESSOR: That is what concerns me. He has admitted it, but you have adduced no evidence of it and I am a bit worried, when you have failed to adduce a vital part of the case, although it has been admitted, about it coming out in Panel questions. Are you happy with that question, Mr Jenkins?

C

MR JENKINS: I am not unhappy.

THE LEGAL ASSESSOR: Very well.

MR JENKINS: Mr Enoch has the evidence available.

D THE WITNESS: Because after the investigation I approached the Royal Pharmaceutical Society who produced the prescription with Dr Eden's name on it.

DR WILLATTS: So there is, we can assume, documentary evidence. Can I just be sure, was Reductil the only drug you obtained through Menscare prescribed by Dr Eden?
A No. From Dr Eden it was, yes.

E Q From Dr Eden that was the only one?
A Yes.

THE CHAIRMAN: On my left Dr MacWalter is also a medical member of the Panel.

DR MACWALTER: I read on the Menscare ordering form that one of the boxes that you could check was "I Agree to the Waiver of Liability", "Yes" or "No", and on the form that
F was sent you agreed to this. What form of waiver of liability did you agree to?
A I just ticked the box.

Q So you did not actually read the waiver of liability?
A I think you have to read it to tick it, do you not? I just ticked the box.

Q I am asking you if that was the case. I do not know.
G A What I do is just tick the boxes. Even if it flashed up I did not read it. I just did it. It literally took two seconds to go tick, tick, tick, tick, go.

DR MACWALTER: Thank you.

THE CHAIRMAN: Mr Harvey, I am a lay member of the Panel. I am not quite clear where, in all of this, Dr Eden's name came to you. As I understand it from what we have been told,
H you received back an email which is behind tab 2 from somebody called Jackie?

A

A Yes.

Q In your evidence when you rang Menscare you spoke to a person called Jackie?
A Yes.

Q At that stage do I understand that you were trying to find out the name of the prescribing doctor?
B A Yes, I was, because obviously ---

Q At that stage you had no idea ---
A I had no idea. They would not tell me ---

Q -- who the prescribing doctor was.
A The chemist would not tell me and Menscare would not tell me.
C

Q What I am not clear about is this. You have mentioned in your evidence the name Dr Eden a number of times but I am not clear where the name "Dr Eden" came to you?
A It came from the Royal Pharmaceutical Society.

Q That was an assumption I was making because you said you spoke to the Royal Pharmaceutical Society, but it went no further. They told you what?
D A They showed me the prescription.

MR ENOCH: Sir, forgive me. It is my fault. Can I deal with this, because it is very easily answered, if Mr Jenkins is happy?

THE CHAIRMAN: Mr Jenkins, are you happy?

E MR JENKINS: I am entirely happy.

<u>Re-examined by MR ENOCH</u>

Q You saw the prescription?
A Yes.

F Q Because somebody from the Royal Pharmaceutical Society showed it to you and it had Dr Eden's name and stamp and signature on it?
A That is right, yes.

MR ENOCH: I am sorry, I should have made that clear.

THE LEGAL ASSESSOR: It is the document behind tab 1 in bundle 5.
G

THE CHAIRMAN: It is.

<u>Questioned by THE PANEL, Continued</u>

THE CHAIRMAN: (<u>To the witness</u>) The point that is being made is that behind tab 1 is the response to your second application where you put your 18 stone weight in and on that document there are others that have been pasted on before it was copied, or at least there is
H

one at the top that appears to have been, and then further down at the bottom there is a stamp. I am not clear whether that stamp was on that document when you received that email.
A No, it was not.

THE CHAIRMAN: Mr Enoch, all I can say is I do not understand this document that is behind tab 1.

MR ENOCH: Sir, I have not addressed my mind to this because he has admitted that he issued the prescription. Therefore, that fact is proved and I do not need to adduce technical evidence of this type.

THE LEGAL ASSESSOR: The problem with this document is that as a result of the matter being referred to the Royal Pharmaceutical Society by Mr Harvey they conducted an investigation and they seem to have got hold of a prescription, or at least this form that we see at tab 1, with Dr Eden's stamp on. That has come from the Royal Pharmaceutical Society because the other document to which the Chairman has referred is the exhibit label from the Royal Pharmaceutical Society.

MR ENOCH: Yes, which in turn has been got from the pharmacy by the Royal Pharmaceutical Society.

THE LEGAL ASSESSOR: And they showed it to Mr Harvey.

MR ENOCH: Exactly.

MR JENKINS: I must say I am entirely comfortable that all that has been clarified. There is a statement from a man called Mr Snewin who is at the Royal Pharmaceutical Society; you see his name on the exhibit label and there is a statement from him which Mr Enoch does not choose to read. I do not object; there is no difficulty with it.

MR ENOCH: Forgive me, it is not does not choose to read, he is abroad. That is why he is not a witness.

MR JENKINS: As I say, he can be read. What you will see is that this document was seized/produced from the ABC Pharmacy and there is an address.

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

Q If we can revert to Mr Harvey, after you had written your article you had a dialogue with the Royal Pharmaceutical Society.
A Yes.

Q You gave them information and they then subsequently provided you with various documents, including the one that we have back at tab 5.
A Yes, that is right.

Q You also produced as part of your witness statement something called a waiver of liability, which is a page from Menscare Services.
A Yes.

MR JENKINS: Sir, since it has been raised by one of the Panel I think you should see it. We will make sure it is copied and made available. It is OI2; we will copy that and make sure it is put in at the appropriate point. Thank you very much, Mr Harvey.

MR ENOCH: If there are no other questions from the Panel ---

THE CHAIRMAN: I have not quite finished yet. I am just considering my notes, Mr Enoch, because there has been a fair amount of input into this, if I can be clear.

Questioned by THE PANEL, Continued

THE CHAIRMAN: Just so you are clear on this then, Mr Harvey, Dr Eden in this particular case has admitted the facts in this and one of the ones that he has admitted was "make adequate arrangements for monitoring Mr Harvey's condition following the prescription". I know it is admitted, but did you attempt to contact them at any stage after that with regard to this prescription?

A No, only for a comment from Jackie, whoever she is.

THE CHAIRMAN: That is the end of the Panel's questions; do either counsel want to come back on this?

MR ENOCH: No.

MR JENKINS: No.

THE CHAIRMAN: Thank you very much, Mr Harvey, for coming. That is the end of your evidence, you are now free to go.

(The witness withdrew).

MR ENOCH: Sir, I am now going to move on if I may to the final case arising out of Mr Carrell's investigation on behalf of the *Independent on Sunday*, in respect of which you should also have a bundle numbered 6, charge 37. As I indicated yesterday, sir, it has been agreed between Mr Jenkins and I that this statement can be read, but you are not going to get copies because we have cut out quite a lot of irrelevant material about the subsequent publication of articles and so forth, and so I am simply going to read it because it would have taken too much cutting and pasting I am afraid to make it viable to copy.

MR JENKINS: I am sorry to interrupt but I am sure a copy can be made of what is going to be read for the shorthand writer.

MR ENOCH: That can certainly be done in due course, yes. For the Panel's information this gentleman's name is spelled C-a-r-r-e-l-l with the first name of Severin, S-e-v-e-r-i-n.

STATEMENT OF SEVERIN CARRELL

MR ENOCH: His statement reads as follows:

"1. At the time this statement was taken I was a senior reporter for the *Independent on Sunday*. I had held this position for about five years and had worked for the same

company for about six years. Before moving to the Sunday paper I spent a year reporting for the daily *Independent* newspaper. I am now employed by *The Guardian,* as its Scotland correspondent.

2. I had a fairly broad remit in my work at the *Independent on Sunday.* I covered issues such as health and consumer affairs, home affairs, the environment and defence. I was not a health specialist.

3. In 2004 I worked on a series of articles about internet pharmacies and prescribing, with a particular focus on the provision of bogus Viagra. In order to produce these articles I investigated the entire issue in depth. I was aiming to uncover the scale of the problem and risks faced by the public. During the course of my investigation I looked into a number of organisations.

4. The organisations I looked into were not selected randomly. I would describe my role as an investigative journalist as like unpicking a jumper. I have to look at all the threads and where they lead to. I came across Dr Eden and his company, E-med Private Medical Services, through my research into the wider story of internet prescribing in the UK and the role of UK registered doctors in it. I believe that I first came across a website, www.uk-clinic.co.uk, that offered medications online, and approached them. My recollection is that they told me of Dr Eden's existence. I then researched his background and looked into E-med.

5. I felt that Dr Eden and E-med/Uk-clinic were important parts of the wider debate on internet prescribing. My role as a journalist is to establish what the main public policy issues in a given field are and find stories to exemplify these. Dr Eden had set himself up as a pioneer of the field of internet prescribing and was publicising his service widely. He answered questions about holiday health issues in the *Independent on Sunday* for a period, and I understand that he also had a column in *The Guardian*. E-med as an operation defines many of the issues relating to internet prescribing. It is an example of how the area operates and the potential problems that arise from it.

6. On 3 March 2004, as part of my wider investigations, I used the Uk-clinic website to attempt to purchase erectile dysfunction drugs. On the main homepage were links to select for hair loss, weight loss and impotence medications. I selected a link to the Online Impotence Consultation. I completed Stage 1 of the consultation, which consisted of five questions regarding erectile function. [The Panel might want to keep one eye on the contents of the bundle at this point]. I responded to each question by selecting one of five possible answers. For example, question one was 'How do you rate your confidence that you get and keep an erection?' I selected 'Low'. I did not complete the form as myself but as someone who wants to obtain an erectile dysfunction drug might. I now produce a printout of the completed Stage 1 page.

7. After submitting Stage 1, I went on to Stage 2 of the consultation. I do not have a printout of Stage 2, but the questions and my answers can be seen from the printout of Stage 5 of the consultation. Stage 5 was the confirmation stage and I now produce a copy of my printout of it. From this it can be seen that Stage 2 consisted of a Health Questionnaire for problems with erection. There were a

number of conditions listed from 1 to 15 and fields in which to give details of any relevant health problems. I put 'none' in all the fields except field 13, 'Hospital Treatment' where I put 'broken leg and concussion'. Questions 16, 17, 18, 20 and 21 related specifically to erectile problems. I stated that the problem was that 'I just can't keep it up', that I had had the problem for four years and that my main concern was that it was affecting my marriage. Again, these were not truthful answers but answers that someone seeking this medication might give. Question 19 was 'Are you on any other medication (prescription or non prescription?)'. I answered 'none'.

8. The next stage, Stage 3, merely required me to fill in contact details. I filled in the form as 'Gregor Jackson', a completely imaginary character. All the other details shown were made up as well. The postcode is real but is not my own. I now produce a printout of Stage 3.

9. Stage 4 required me to enter an email address and give a password. Prior to beginning the online consultation I had set up an online email account in the name of Gregor Jackson, at the address gregjack101@yahoo.co.uk. This was very simple to do. I entered this email address art Stage 4. I now produce a printout of Stage 4. I then submitted the page and progressed to Stage 5 which contained a summary of all the information that I had provided, as described above.

10. The printouts of the web pages all have a time on the top right hand corner. The time on the Stage 1 printout is 2.24 pm and the time on the Stage 5 printout is 2.30 pm. I printed each webpage out and went to the printer to collect it before submitting it. The printer that I used was not very far from my desk and computer. I would say that it was no more than 10 steps away.

11. After selecting the 'Finish' button on the final page of the form, Stage 5, I immediately received an email from support@uk-clinic.co.uk to gregjack101@yahoo.co.uk. This email thanked me for submitting my online consultation and informed me that Uk-clinic doctors would review my form and send me a diagnosis by email. I produce a printout of this email. The email is dated Wed, 3 Mar 2004 14:30:26. Although the time on the email account and the printer are not synchronised, I would suggest that there was no more than about a minute's difference between them. This is because the Stage 5 page says 2.30 pm. I would have printed it then gone straight back to the desk to submit it. The email from Uk-clinic then arrived immediately and is also timed 2.30 pm.

12. Very soon after receiving the initial email from Uk-clinic I received a further email from support@uk-clinic.co.uk entitled 'Doctor diagnosis'. The email said that the condition 'is best treated in the short term with a number of different medication'. There was then a link to click on 'to see which will help you most' … This is dated Wednesday, 3 March 14:32.23. This is just two minutes after I received the acknowledgement email. I was concerned by the fast turnaround of my application.

13. On clicking the link in the diagnosis email, I was taken to a page entitled 'Impotence Products' which listed Viagra, Levitra and Cialis in different amounts of tablets of various strength tablets … I selected 4x50mg of Viagra at £69 and

A submitted the page. I was then taken to a page entitled 'Pre Payment Order Confirm'. I confirmed the order and was directed to a page called 'Secure Credit Card Payment' where I was asked to fill in my credit card details … I did not go through with the order, although I had been invited to purchase the drugs. There would have been technical and legal issues with me using a credit card to make the purchase. For example, I would have had to find a safe address for the drugs or prescription to be sent to. I made a judgement that a test purchase was not B required in these circumstances.

14. I was very concerned by the short amount of time that it took for my doctor diagnosis to come back and was intrigued to see if I would get the same result when ordering another drug. Hair loss treatments were also advertised on the Uk-clinic website and so I went through the online consultation process in relation to hair loss."

C

Unless you want me to, I am not going to go through the hair loss. I will not read that unless you want me to.

MR JENKINS: Yes, please.

MR ENOCH: The part about hair loss?

D

MR JENKINS: Yes, I think it is relevant.

MR ENOCH: Very well. It reads,

"There are four stages to this consultation. Stage 1was a questionnaire about previous illnesses as in Stage 2 of the erectile dysfunction consultation. I filled it E in as Gregor Jackson, this time citing the problem as 'hair line receding fast' and my main concern as 'it's changing the way I look'. Stages 2 and 3 were for contact details and personal details as with the erectile dysfunction consultation. I used the same details again, as can be seen from the printout of Stage 4…

15. I received the acknowledgement email from support@uk-clinic.co.uk at 14:48:59. As before, it said I would receive a diagnosis shortly by email. On this occasion F the diagnosis email did not arrive until 16:08:31, showing a far greater time lag in processing the application…

16. In order to give a more accurate picture of what I did and when, I asked the Independent's IT department to provide me with a printout of server activity for the relevant time period for my own work station".

G He produces the relevant printout for that.

"On the first page, my activity on IP address…can be seen",

and it gives a number.

"This was the IP address of the Uk-clinic website at the time, but I do not know if it H was the same now".

Then he gives a description of that, and continues,

> "It can be seen from this sheet that I sent 2.8Kb of data at 2:30:49PM. I believe that this was when I submitted the final page of the consultation. The next data is 5.34Kb seen as 2:32:59PM. I believe that this when I received the email diagnosis and linked to the order page.

17. On 4 March 2004, the day after I had completed the UK-clinic consultations, I spoke with the owner of Uk-clinic, Graham McAndrew, on the telephone. He told me that E-med dealt with the medical side of things and that Dr Eden did the on-line consultations. He explained that the consultation information gets submitted to their doctors straight away by email. The doctor then reviews the situation and accepts or rejects the consultation before sending the email back with the link to the order page. He assured me that it was not an automated system.

18. Soon after I had finished speaking with Mr McAndrew, I telephoned a number for E-med in London. I asked for Dr Eden and was told by a female employee that he was in South Africa, but on line at doctor@e-med.co.uk. I then emailed Dr Eden at this email address, explaining that I was a journalist from the *Independent on Sunday* and asking that he contact me urgently.

19. I did not receive a response to this email so I telephoned E-med again the following day, Friday 5 March 2004. This time I spoke to Aaron, the IT administrator. He told me that he had forwarded my original email to Dr Eden. He also gave me a further direct email address for Dr Eden, jules@e-med.co.uk.

20. I then spoke again with Graham McAndrew. He reiterated that a doctor reviews the consultation and makes a diagnosis based on them. He explained that the doctor gets an email saying that there's a consultation to be looked at on the site, and then logs into his personal section of the site to see all the information. He said that a second approval takes place once the credit card application had been put in. He called me back once more that day after looking at his website traffic records and told me that my consultation was received at 14:32. He also assured me that he had contacted Dr Eden.

21. On 5 March 2004 I emailed Dr Eden for a second time, but this time sent it to the email address jules@e-med.co.uk. I asked him a number of questions regarding his practice and he replied the same day, declining to comment. I responded, requesting that he answer my questions. I did not receive a response to this email so I emailed him again on 10 March 2004 to request a meeting.

22. Dr Eden did not respond to my request for a meeting and so on 11 or 12 March 2004 I went to his office at the Hospital of St John and St Elizabeth. As I was planning to publish an article about Dr Eden, it was important to give him a chance to discuss the matter. I was also interested to see where he was operating from. I waited in the corridor outside his office until his appointments with patients were over and I had an opportunity to see him. He invited me into his room…Once in his office, I introduced myself fully.

A

23. I asked Dr Eden how he was able to process the application for Viagra so quickly. He told me that he had been on-line while he was away and had seen it. He waved a bill at me from a hotel in Cairo with his charges for telephone usage and I was able to glance at it. As far as I can remember it just had a figure on it, which Dr Eden said" --

B MR JENKINS: Would you read out the figure, please?

MR ENOCH: Certainly. It is $453.32,

> "which Dr Eden said was because he was on line all the time whilst away. When asked, Dr Eden also told me that he personally read my consultation He then ended the conversation".

C That is the statement of Mr Carrell.

THE CHAIRMAN: Can I just come back on that? I deliberately did not interrupt you because you were reading the statement into the transcript, but it was quite hard, certainly for me personally and I am not sure about other members of the Panel, to follow through in some of those early dottings around between various stages. I am quite happy to wait and receive
D copies of the statement, and we would certainly like to have that because they dart in and out.

I was not clear. Are you saying that all the aspects referred to in that statement are included in Bundle 6?

MR ENOCH: No, not all of the documents referred to in his statement have been copied into Bundle 6. For example, the printout of the server activity. We thought it was unnecessary in
E light of the agreement that the consultation took approximately two minutes to answer.

THE CHAIRMAN: The documents that refer to the two minutes are definitely in here, are they?

MR ENOCH: I am not sure all of them are. The server printouts confirm that, but again, I do not think there is any dispute as to the timescale involved. I think head of charge 39 has been
F admitted and found proved.

THE CHAIRMAN: I understand that, Mr Enoch, but the Panel are now going to be presented with a statement which they may want to read through and try to corroborate documents in there. Admission is one thing. There may be other issues that come out of it, I know not. But going on from there, are the various other emails that are included in Bundle 6 obvious from that statement?

G

MR ENOCH: Can I make a suggestion, in the light of your question? I can understand it, if I may say so because in reading the statement myself it was difficult to follow from a person's point of view who has not read it before. What I will do, with your permission, is to copy all of the documents that he refers to in his statement, copy the statement, which has exhibit numbers in it so there can be no doubt what he is referring to at a given time, so you can have all of the documents.

H

THE CHAIRMAN: Clearly that will be helpful, but I go on to the second part of my question, to be clear whether there are any documents in Bundle 6 which are not referred to in the statement. I look particularly – I may have missed it because I was trying to keep up with them – towards the end where there are a succession of emails, one of which is from Dr Eden in which he says, "Many thanks for your inquiry". They do not have page numbers on them and it is obviously behind Tab 2, page 5. I was not clear whether you referred to that in the statement.

MR JENKINS: He did.

THE CHAIRMAN: He did. I am sorry if I missed it. All I am trying to be clear about is that all the documents that we have in Bundle 6, which we are entitled to read and may have read already, that their context is obvious in this statement.

MR ENOCH: They have all been referred to, I believe. For the avoidance of doubt, can I have the statement in edited form copied for you and, as long as Mr Jenkins agrees, I think the safest thing is to copy all the documents that he refers to in his statement. The difficulty is that it was only at the last minute we decided not to call him. Secondly, we do not want to burden the Panel with documents that will just confuse an issue that has already been agreed. In the light of your questions, sir, I think it best that I do copy those documents, including the server activity document.

MR JENKINS: I would object to that. He produces about 120 pages of material, including a lot of articles, some of which he has written and some of which have been written by others.

MR ENOCH: I have not read that part of the statement out so I would not be copying those obviously.

THE CHAIRMAN: Obviously you can agree between you what you copy and put before us, but I hope, Mr Jenkins, my questions make some sense. If they do not, then I am obviously not putting myself clearly. I know they are not directed at you but there are a lot of pages towards the end of Bundle 6 which I personally was not able to follow. I want to be clear that if the Panel read them, they are understandable in the context in which we are dealing with this.

MR ENOCH: Sir, can I address you on the documents you have in Bundle 6. What you have are the pages from Mr Carrell's logging on and applying for medication. That should be the first tab. All of those are taken from his activity on line. They are within what has been dealt with. As you know, the first pages relate to hair loss and the second pages relate to impotence.

THE CHAIRMAN: Without the statement it is slightly difficult but there was mention of Stage 2, was there not, in the statement, and I do not see a Stage 2 relating to on-line impotence in the consultation, for instance? It is slightly hard to follow.

MR JENKINS: I think the answer may be because he did not go that far.

MR ENOCH: You have to look at the result of Stage 2 to find out what this is.

THE CHAIRMAN: I may be confusing this whole issue. Perhaps you can agree between you what you can give to us which is in the statement. Clearly we are not looking for 120 pages if they are not relevant or refer to bits that you have taken out, but just to be sure that we can have a statement which refers to documents which were clearly with us.

MR ENOCH: What I will do is copy the statement and indicate where each of the documents in Bundle 6 are referred to in that statement. Can I do it that way?

THE CHAIRMAN: By all means. I suspect the Legal Assessor will want to give us a bit of guidance on this in a moment. Clearly he will have an opportunity to do so.

THE LEGAL ASSESSOR: I think the problem has arisen that the Chairman has identified, Mr Enoch, because you stopped reading – I was trying to follow from the unedited statement – at the end of paragraph 23. The documents to which the Chairman has referred at the back of the Panel bundle are produced in paragraphs 24, 25 and I think 27 of the statement. I am trying to marry up the exhibits in the original statement with what is in the Panel's bundle. You did not actually read the part of the statement that produced those emails at the end of the Panel bundle. If you can bear that in mind when producing your edited version so that these documents relate to something in the written statement.

MR ENOCH: Sir, we can do that now. I am going to be calling Dr Havelock next, who is the General Medical Council expert. You may wish to take a break now, perhaps an extended one, so we can deal with that exercise now.

THE CHAIRMAN: Let me just go back on a little bit of admin then. We were handed one document entitled, "Menscare Encrypted Order". This was from the previous witness. That will be C9.

MR ENOCH: Can I check how many pages you were given? Have you had the last page as well?

THE CHAIRMAN: We have the one entitled, "Menscare Services. Thank you for placing your order".

MR ENOCH: I am grateful. Dealing with the same topic, I said that we had the liability document. We will copy that during the break if one is to be taken now, and you will want to include that.

THE CHAIRMAN: The one I mentioned, "Menscare Encrypted Order" will be C9, and I will give successive ones successive numbers when we get them. I am quite happy to take a break now, not least so we can have a fair run at the next witness without having an early interruption, and I am happy to take a break until 11 o'clock to enable this to be done. If the documents are not complete by 11 o'clock I think we should proceed with the next witness, regardless. Others can be copying things in the meantime, otherwise we will go on for a long time. But were there to be any questions about understanding this statement and the following documents then I would wish to come back to this because it would only be fair on the Panel that they do fully understand this and that there is no confusion about it, despite the admissions because, of course, there is a paragraph at the end of these admissions which is not admitted, and it must indeed be totally relevant to the context we are talking about.

MR ENOCH: Can I also take the opportunity to hand out copies of the Fiona Hutson records?

THE CHAIRMAN: If it is agreed between the two of you, as far as I am concerned you can hand out anything providing it is relevant.

MR ENOCH: I think we were going to wait for additional ones. Forgive me; we will do it later.

THE CHAIRMAN: We will adjourn now for coffee. We will not be adjourning again before lunch after this. We will adjourn now until 11 o'clock, when we will start, whatever the copying situation is.

(The Panel adjourned for a short time)

THE CHAIRMAN: Mr Enoch?

MR ENOCH: Sir, we have spent almost all the break dealing with this and agreeing the form of the editing. The statement is just being copied. I would like Mr Jenkins to have a copy and to check it before I hand it out. I can hand it out now, it is a matter entirely for the Panel.

Can I tell you what I propose to do so that I hope the documents in bundle 6 become more clear, and I apologise and accept on the chin criticism that they were not clear and were not followable: I agree with you. One of the problems is that Panel bundle 6 is not paginated. I had not realised that and I apologise for that. I am going to invite you to paginate in due course. What I am going to do is to give you the edited statement and I am going to show you where every document is referred to in the statement, and you can make a note on the statement which page is being referred to, so you will know exactly where everything is. If I may say so, your learned Legal Assessor, as I should have know, was absolutely right when he said that there are a couple of documents at the end that actually are not referred to in the statement, but I will make that clear.

THE CHAIRMAN: We will deal with all of that at the end of Dr Havelock's evidence. I might hand bundle 6 back to you or your solicitor to sort out.

MR ENOCH: Yes, we can paginate them for you. We will certainly do that with pleasure.

THE CHAIRMAN: Let us proceed with your next witness.

MR ENOCH: Dr Havelock, please.

THE CHAIRMAN: Mr Jenkins, I understand that your expert witness is indeed here, as you told us yesterday he would be, and that is Professor Sheik.

MR JENKINS: Yes.

THE CHAIRMAN: Thank you very much.

PETER HAVELOCK, Sworn.
Examined by MR ENOCH

(Following introductions by the Chairman)

Q Would you give the Panel your full name and professional address?
A I am Peter Havelock, Pound House Surgery, Wooburn Green.

Q I think you have been a general practitioner since 1972, is that right?
A I have.

Q And you have treated thousands of patients in that time, and you have been an Associate Director in the General Practice Department of the Postgraduate Medical and Dental Education of Oxford University, is that right?
A That is correct.

Q And so through that you are involved in education, development, mentoring and standards assessment of GPs as well as other healthcare workers, is that right?
A That is correct.

Q And you have been a GMC performance assessor since 1997?
A Correct.

Q I think you have been asked to attend hearings such as this in the expert witness capacity many times, is that right?
A That is correct.

Q I think you have experience of at least three other cases involving internet prescribing?
A That is correct.

Q You have been asked, I think, to comment on the practices of Dr Eden arising out of his activities in relation to the cases that this Panel is concerned with, and you have had a look at all the material involving each of those cases, is that right?
A That is correct.

Q The first one that we are concerned with is the treatment of the patient Fiona Hutson. Do you have a copy of your reports in front of you?
A I do.

Q Would you wish to refer to those to assist your memory and to assist your evidence today?
A I would.

Q There is no objection raised.
A Thank you.

Q Can I just tell you, Dr Havelock, that in relation to Fiona Hutson, when you have been looking at her and her treatment, you have had no access to any of the communications that took place between her and Dr Eden, have you?

A A I have not.

Q You did in some of the other cases.
A I did.

Q But in this particular case you did not, although you did have her general practitioner notes?
B A Records.

Q Just so that you know, we have been given today communications between Mrs Hutson and Dr Eden, so if at any stage you feel that you want to see them, or any of them, because you think there is something missing, will you say so and we will attempt to assist you with that. It may well be, and in fact I anticipate, that you will not need them because all the factual matters arising out of her treatment are accepted, there is no dispute
C about it.
A Fine.

Q We know, and can you confirm from your analysis, that, in summary, Dr Eden prescribed 180 dihydrocodeine 30 mg and 90 diazepam every month from e-med between September 2002 and September 2003 to Mrs Hutson, is that right?
A That is what she described.
D
Q As far as those medications are concerned, is *BNF* information available to general practitioners about them in the *British National Formulary*?
A They are.

Q Just help anybody who is not up to speed on the what it is and what it is there to help GPs with?
E A The *BNF* is distributed to every general practitioner every six months, updated, and it has full details of drugs with their side effects, with their indications and their dosage.

Q So it is a sort of running, updated, first-base, look-up book for any GP to check on a drug?
A It is the one that is on every GP's desk, or should be so.

F Q Can you tell us, arising out of Fiona Hutson's case, first of all about dihydrocodeine?
A Certainly. Dihydrocodeine is an opiate analgesic which is in the same group as things like morphine and heroin and it is a drug used for pain, in pain relief. There are all sorts of warnings within the drug – in the *BNF* about its addictive properties or its tendency to cause dependence.

Q Does it tend to cause dependence?
G A It does tend to cause dependence.

Q And tolerance?
A And tolerance of drugs, so an increasing dose is sometimes needed.

Q When would long-term use of a potent opioid be appropriate?

H

A A Really in terminal care, because it is used in early stages of terminal care where the pain is increasing, but with a great deal of concern because it is used in chronic pain and it should be regularly assessed.

Q That was my next question: how important is it for somebody taking that kind of medication for more than a short-term period, how important is it that they be regularly seen and assessed?

B A It is very important, because of the potential tolerance and addictive factors.

Q What are the side-effects of dihydrocodeine?

A It can cause nausea and vomiting, constipation can be quite a problem with it and it makes people drowsy, particularly in high doses.

Q What is the recommended dose of dihydrocodeine?

C A 30 mg 4 to 6 hourly, when necessary.

Q Tell us about diazepam, please?

A Again, diazepam is an anxiolytic, it is part of the benzodiazepine group and used for reducing anxiety or the symptoms of anxiety.

Q What does the *BNF* say about how long you should prescribe it for?

D A It says that it should be limited, that it should be limited to the lowest possible dose for the shortest possible time because of the tendency that there is in dependency in this drug as well.

Q You talk in your report about specific advice given by the Committee on the Safety of Medicines: can you help us with that?

E A Yes, certainly. There is specific advice from the Committee on the Safety of Medicines that benzodiazepines are indicated for the short-term relief, two or four weeks only, of anxiety that is severe, disabling or subjecting the individual to unacceptable distress, occurring alone or in association with insomnia, or short-term psychosomatic, organic or psychotic disorders. Secondly, that the use of benzodiazepines to treat short-term mild anxiety is inappropriate and unsuitable, and, thirdly, benzodiazepines should be used to treat insomnia only when it is severe, disabling or subjecting the individual to extreme distress.

F Q So a two to four week course is the primary indication, is that right?

A That is the length of time it is recommended for.

Q Do we summarise it thus, that it is only to be used in extreme cases?

A That is right. I go back to it, that the lowest possible dose for the shortest possible time in cases.

G Q Specific cautions relating to diazepam?

A That it causes drowsiness and the effect of alcohol is enhanced.

Q Side effects?

A Drowsiness, light-headedness the next day, confusion and ataxia, particularly in the elderly, amnesia, dependence again, paradoxic aggression and sometimes muscle weakness.

H Q What dose is recommended?

A A They recommend, the *BNF*, 2 mg three times a day. If necessary it can be increased to 15 or 30 mg daily in divided doses.

Q We know Mrs Hutson joined e-med and filled in an on-line questionnaire, which I think you have seen, is that right?
A I have.

B Q And as a result of that she was supplied over a period of about a year with both dihydrocodeine and diazepam, and you note I think that in the on-line questionnaire Mrs Hutson mentions her chronic back-ache and panic attacks as well as her mother's terminal illness and difficulty sleeping, yes?
A That is correct.

Q I think you were aware of what she had said in her statement, were you not, as to the
C circumstances in which she had obtained these drugs, is that right?
A That is what I noted.

Q In which she reiterated the basis upon which she asked for diazepam and dihydrocodeine?
A That is correct.

D Q You also noted that she indicated that she had requested prescriptions several days early, did you not?
A I did.

Q And also her indication that Dr Eden had not sought to contact her or question her about that, or had any face-to-face consultation with her?
A That is right.
E

Q Did you have a look at Good Medical Practice to see how that assisted you in your analysis of his treatment of this lady?
A I did find it useful.

Q Tell us about that.
A Good Medical Practice, in paragraph 2, and I used the 2001 Good Medical Practice,
F which had recently been updated that:

> "an adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination."

In providing care, you should keep colleagues well informed and when sharing the care of patients and prescribing,
G

> "… drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs.

Q Later I think you refer to the part of the document under "Sharing information with colleagues."
A That is right, paragraph 45:
H

"If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects. If the patient has not been referred to you by a general practitioner, you should inform the general practitioner before starting treatment, except in emergencies or when it is impracticable to do so. If you do not tell the patient's general practitioner, before or after providing treatment, you will be responsible for providing or arranging all necessary after-care until another doctor agrees to take over."

Q I think you have had sight of draft allegations in relation to Mrs Hutson, have you seen the ---
A I have.

Q --- latest ones, have you?
A I have, dated January.

Q What do you say about the adequacy of the assessment of this lady's condition by Dr Eden?
A The questionnaire that she was given was very general and it did not include information about her history. It was just about general information rather than being specific.

Q Was what she told Dr Eden during the course of that information, so far as you are concerned, sufficient to give rise to his being in a position appropriately to prescribe for her?
A No, because a back ache requires a full history; can have a number of different causes and it needs an examination before coming to a diagnosis – it needs a diagnosis of what is being treated, and both these drugs were potentially dependence or abuse so a fuller history is absolutely essential.

Q What about face-to-face consultation, how important is that?
A Well it is really virtually impossible or impossible to do, to take a full history and examination without a face-to-face consultation.

Q Was there any evidence that you could see that he had done any sort of examination at all?
A No.

Q As far as you were concerned, how deficient was it to prescribe dihydrocodeine and diazepam to a person he had never met without having spoken to any of her treating doctors on the basis solely of the information in that form?
A I found that falls seriously short of normal general practitioner care.

Q Then what about the aspect of providing repeat prescriptions on demand over the course of a year?
A These are drugs that I described earlier than have potentiality for dependency and these regular prescriptions without any check up, without any follow up, just by the patient ticking boxes on the prescription form, was inadequate and seriously inadequate to care.

Q Let us move on please to Patient A, who you deal with next in your report. It is going slightly out of order as far as the heads of charge are concerned. Patient A is the young boy.
A I remember.

Q The teenage boy?
A Yes.

Q Who received propranolol and who in due course was reported to have taken an overdose of that propranolol?
A Yes.

Q Just help us with propranolol, please?
A Propranolol is a beta-blocker and its indications are those of hypertension, angina, myocardial infarction, arrhythmias, heart failure, thyrotoxicosis and under "Other Uses" it says:

> "Beta-blockers have been used to alleviate some symptoms of anxiety; probably patients with palpitations, tremor, and tachycardia respond best."

It blocks the effects of adrenaline.

Q What are the cautions and contraindications and side effects?
A There are a considerable number, particular in the elderly, and the significant one for Patient A was the contraindication to the drug, that he had any history of allergy or hay fever or asthma, because the effect of beta-blockers can worsen this.

Q What is the commended dose?
A 40 mg a day increased to three times a day if necessary.

Q You have read the emails from Patient A to Dr Eden, much of which is reiterated in the final heads of charge.
A Yes.

Q Which, in short summary, demonstrate that Patient A was, shall we say neutrally, very disturbed?
A Disturbed and vulnerable.

Q Therefore, what is your general view about whether or not Dr Eden should have taken on this patient at all?
A There seemed to be no reason. He was young, he was under the care of a specialist on regular care, he had a long history of mental troubles. This I think would be a very difficult patient to take on in a face-to-face consultation and certainly would be inappropriate for an internet consultation.

Q Knowing that he was under the care of a mental health team and knowing, for example, that the question of medication was an issue that had arisen between him and his treating doctors, as far as you are concerned was it responsible or in the best interests of Patient A for Dr Eden, without ever meeting him, to prescribe him propranolol?
A It was very irresponsible. This guy obviously needed a lot of other help other than medication.

Q Having been told by the patient specifically that he had a tendency to self-harm, is that a red flag as far as the provision of medication is concerned?
A Yes, it must be. Part of our responsibility is to spot that and stop self-harm.

Q How many red flags were there in the information given by Patient A? I am not asking you to give a number.
B A There was the fact he was young, he described throughout his emails the distress, his relationships, his previous self-harm, his wish to use/abuse drugs, including cannabis. A large number.

Q What should Dr Eden's attitude have been to sharing information with those who were already treating him?
A It would seem that that was the action that he should have taken, to let Mr A know
C that he cannot offer him drugs and inform his carers of the anguish, the problems that Mr A was having at that time.

Q How important is his age in this context?
A He is …

Q He was 16 at the time.
D A He is 16, he is under age, very vulnerable, and is not an adult. He needs some sort of other consent to doing this. It indicates his vulnerability.

Q To provide a repeat prescription of propranolol as time went on ---?
A It would be very inappropriate.

Q Could it, under any circumstances, be described as in his best interests?
E A No, it was never in his best interests to prescribe for him.

Q Help us with when there is the potential for him to take an overdose of drugs that he was being given. An overdose of any drug presumably is bad. Would that be fair or not?
A Bad, yes. It has risks. It is an inappropriate use of medicines, therefore bad.

Q Some drugs are more dangerous than others. Is that right?
F A They certainly are.

Q In short, were this patient's problems the type of problems that it was appropriate for Dr Eden to begin to deal with?
A Certainly not.

Q We are going to deal with the other patient whose initials are PL, and we call him
G Patient X. This comes in your second report.
A Fine.

Q I know you deal with the two journalists in your first report.
A Yes.

A Q I would like now to deal with the person who we call Patient X, who is the patient who received, over a period of just over two years, regular supplies of zolpidem and zopiclone from Dr Eden. Do you recall?
A I certainly do.

Q It is that patient, and I think you were asked to comment on this particular patient a little later than the others that we have just described?
B A That is right.

Q That is why you have a second report?
A That is why it is a separate report.

Q That is just to put it in context, because it arose a little later. We know that he received 43 prescriptions of zolpidem over a 26-month period, each for 28 tablets, and eight
C prescriptions of 28 tablets of zopiclone. The Panel have seen schedules and have copies of the prescriptions themselves and you can look at them if you want to; you probably do not need to. I think you received copies of the email traffic and records held by Dr Eden in relation to this patient. Is that right?
A I did, yes, earlier this month.

Q First of all, could you adopt the same approach as far as the drugs are concerned and
D help us with zolpidem?
A Yes. They really can be nearly taken together because they are very similar medications.

Q Sure.
A Again, they are a group of hypnotics, sleeping pills, and this is general about hypnotics, that before a hypnotic is prescribed the cause of insomnia should be established
E and where possible underlying factors should be treated.

Q How do you go about doing that?
A By talking to the patient. Then the *BNF* describes transient and short-term insomnia and that they should not be used, or they can be used for those only. Then:

F "Chronic insomnia is rarely benefited by hypnotics and is more often due to mild dependence caused by injudicious prescribing."

Q Let us just pause there. Chronic insomnia, I think we would all agree, was something that Patient X was saying he had?
A Certainly.

Q Was it appropriate to prescribe zolpidem and zopiclone for that, or not, according to
G the *BNF*?
A Not according to the *BNF*.

Q I think the indication is short courses. Is that right?
A Short courses, with control over them and limited prescribing.

Q How quickly does the literature indicate that dependency and tolerance can occur?
H A Within three to 14 days of continual use.

A

Q So in three to 14 days of continual use the *BNF* tells you, does it, that you can become tolerant?
A That is exactly right.

Q Just carry on with anything else you want to say about that please?
A The major point with long-term use is that withdrawal causes rebound insomnia and
B precipitates a withdrawal symptom, so it is another recommendation about the dependency.

Q Can I just ask you to keep your voice up a little.
A I am so sorry. They are grouped together, there are three of them together and they are non-benzodiazepine but they act on the benzodiazepine receptor. These two have a short duration of action, they are not licensed for long-term use and dependence has been reported in a small number of patients. Again, indications, short-term use only with a list of cautions –
C depression, history of alcohol/drug misuse, hepatic impairment and avoid prolonged use, and abrupt withdrawal thereafter, and of course drowsiness.

Q Let us just pause there and focus on that for a second. The cautions listed are depression?
A Yes.

D Q History of alcohol or drug misuse?
A Yes.

Q How important is it to establish somebody's history of alcohol use or misuse or drug use or misuse?
A It is essential.

E Q Hepatic impairment: I suppose that goes along with alcohol and drug misuse in a way, does it not?
A It can do, but other things can cause it. Not necessarily.

Q It tells you to avoid prolonged use?
A Yes

F Q Then:

"DRIVING. Drowsiness may persist …",

is that right, one of the possible effects?
A That is right.

G Q The effects of alcohol can also be enhanced?
A That is right.

Q What are the contra indications?
A Obstructive sleep apnoea, acute pulmonary insufficiency, respiratory depression, myasthenia gravis.

H Q What is that?

A

A Myasthenia gravis is an illness that is very uncommon. If affects nerve endings and causes weakness.

Q I am sorry, I interrupted your contra indications.
A That is all right. Severe hepatic impairment, psychotic illness, pregnancy and breast feeding.

B

Q Should you exclude those things before you prescribe the drug?
A They need to be done.

Q You see from the evidence, and we have heard from Patient X himself, that he was in contact with Dr Eden over a period of two years and you have seen the questionnaire in which he accepted that he did not tell the doctor the full story.
A That is correct.

C

Q We know that he received the drugs that he asked for initially and continued to receive them over a period of a couple of years.
A That is correct.

Q We also know that on a number of occasions he telephoned the doctor to say that he had lost the prescription and his recollection was that that had happened about a dozen times.

D

Can I ask you this: How would you react if a patient was telling you that he had lost his prescription and needed a replacement? How would you react if he did it once and then how would you react if he did it more than once?
A I think, firstly, it depends on the medication that is involved. If it was his blood pressure pills I would be less concerned than if it was his hypnotics or his sleeping pills or painkillers.

E

Q Assuming that we are dealing with a drug that has a tendency to dependency or tolerance?
A Then more than once is again a red flag to the possible dependency upon those drugs. It needs further discussion and further history and discussion with the patient.

Q What is your assessment, please, of the treatment of this patient, and if you wish to start by referring to *Good Medical Practice* please feel free?

F

A I think I have already stated the good medical practice that is involved with this.

Q It is the same paragraph.
A It is the same paragraph, paragraph 2, clinical care, and paragraph 45 about the treatment of a patient if you are not the general practitioner.

Q What do you conclude about the treatment of this patient? Was it appropriate,

G

responsible treatment, in the best interests of Patient X, or not?
A Certainly not.

Q As far as you were concerned, was there a full-enough history taken?
A There was not.

Q Should there have been a face-to-face consultation and a proper dialogue?

H

A Without doubt.

Q Should there have been an examination?
A An examination in this particular case is less important. It was an examination of the man's psychological history that was really important.

Q How do you feel about the fact that the prescribing was repeated over such an extended period?
A That is completely inappropriate.

Q No doubt you have come across the words "inappropriate and irresponsible" in these hearings before?
A I have.

Q As far as you are concerned, when you say "inappropriate" does that encompass "irresponsible", or not?
A It certainly does.

Q How important was it, not only in this case but in other cases, for Dr Eden, at the very least, to ask about or encourage the sharing of information with a patient's general practitioner, if they had one?
A I think in all these three cases we have seen there is an awful lot more going on in the patients than there is, as was demonstrated in the emails, and therefore the general practitioner, the person that knows the doctor (sic) needs to be informed and needs to be involved in these decisions.

Q If, as is suggested in this case, the patient is telling Dr Eden he does not have a general practitioner, and here is a patient whom we know lives in South Wales, what is your feeling about any advice that ought to be given about having a general practitioner, if any at all?
A It is very easy to register with a general practitioner, you just walk in and take your medical card and therefore the advice should be to register with a general practitioner".

Q Might that have implications about prescribing in the sense of whether he would have to pay for his prescriptions?
A If the general practitioner chooses to prescribe to the patient they would be free, or they would pay the prescription charge.

Q Let us, please, move on to the journalist who got slimming medication, Reductil, which is on page 8 of your first report, just to orientate you, Mr Havelock.
A I have it.

Q We know that this person obtained at his request 28 Reductil. What is Reductil and how does it work?
A Reductil is a centrally acting appetite suppressant – it works on the brain to do this – and it is used in some individuals to manage obesity, particularly with those patients with a body mass index (BMI) of more than 30 kg per square metre, which is defined as obese.

Q The National Institute of Clinical Excellence has issued specific guidance on Reductil, is that right?
A That is correct.

Q Which indicates that it should be prescribed in accordance with its summary of product characteristics, is that right?
A That is correct.

Q Under what circumstances should it be prescribed?
A Only in combination with lifestyle management and follow-up in patients who have had three months of lifestyle management advice, dietary advice and exercise prior to prescription.

Q What are the specific cautions in the British National Formulary associated with Reductil, whose other name is Sibutramine.
A Yes. Regular monitoring of the blood pressure and pulse rate initially and then every three months.

Q How often initially?
A Every two weeks for three months and then monthly for three months and then every three months.

Q That is the blood pressure and heart rate monitoring.
A That is right.

Q Why is that specific caution there for Reductil?
A Because it can put up the rate of the blood pressure.

Q Is that because of the way it acts, because it is centrally acting?
A Because it is centrally acting.

Q Would that apply, for example, to Xenecol?
A No, it would not. The same monitoring, the same advice would apply, but not the specific thing about the blood pressure and pulse.

Q Is that because Xenecol does not act centrally?
A That is right.

Q It acts as a fat-barrier.
A It acts as a barrier to fat, so this is specific for this drug.

Q So monitor blood pressure and pulse rate every two weeks for three months.
A That is right.

Q Then monthly for three months and then every three months.
A That is right.

Q Other cautions?
A Other cautions are renal impairment, sleep apnoea syndrome, epilepsy, hepatic impairment and the monitoring for pulmonary hypertension, but also family history as well because it is a drug that has quite a lot of problems.

Q In all of the literature available as far as weight loss is concerned I think it would be agreed – and you indicate – the first line strategy must be weight reduction through diet, exercise and lifestyle modification, is that right?
A That is correct.

Q Which should be monitored.
A That is right.

Q Before drug therapy is considered.
A That is right, for at least three months.

Q Thank you. Then the BMI should be calculated and a decision made thereafter, is that right?
A That is correct.

Q Just looking at your page 10, before commencing drug treatment what specific points need to be addressed?
A First of all the judgment about the risks of the individual from continuing obesity and whether drug treatment is appropriate for patients and co-morbidity, so diabetes or complications from the obesity.

Q How serious their obesity is.
A How serious their obesity is and if there are any effects of that obesity.

Q Whether the obesity has caused any other problems.
A That is right. The continuance of the drug needs to be balanced with other things: their lifestyle and the potential effects of the drug, so it is a continuing monitoring of that.

Q Just in case anybody does not know, just help us as to what the body mass index is and how it is calculated.
A The body mass index is a relationship between height in metres and weight and it is calculated as the weight in kilograms divided by the height in metres squared.

Q At the bottom of page 10 you help as to what *Good Medical Practice* has to say specifically about the treatment of obesity.
A Yes, this was from the GMC guidelines in May 1999.

> "If you are considering prescribing drugs for the treatment of obesity the following principles are good medical practice. It is essential that you:
>
> (a) Take an adequate history from the patient including details of the current medical condition or any medication which the patient is already taking;
>
> (b) Examine the patient before prescribing;
>
> (c) Satisfy yourself that the patient has understood what is proposed and consents to it, before you prescribe.
>
> (d) Follow the current authoritative advice on which preparations are considered to be effective and the safe administration.

(e) Do not prescribe in excess of the proper doses of such drugs; and

(f) Monitor the patient's health or any side effects which might be caused by the drugs."

Q Then you go on to quote from a GMC newsletter.
A Would you like me to read that out?

Q Yes, please.
A "*Good Medical Practice* also makes clear that doctors practising in most specialties should usually accept patients only with a referral from their general practitioners or other appropriate healthcare professional. If you are not the patient's general practitioner, but decide, exceptionally, to accept a patient for treatment of obesity or weight control without a referral, you must explain to the patient the importance and benefits of keeping their general practitioner informed, and seek their agreement to do so. You must inform the patient's general practitioner before starting treatment, unless the patient objects to the disclosure. Where the patient does not wish their GP to be informed, or have no GP, you must take responsibility for providing all necessary after care for the patient and if you propose to prescribe anti-obesity drugs you must ensure that the patient is not suffering from any form of medical condition or receiving any other medical treatment that would make the prescription of such drugs unsuitable or dangerous."

Q We know that in this case a form was filled in, which you have seen, initially indicating a BMI of less than 30 and then the form was re-submitted with the same details with the weight upped.
A That is right.

Q As a result of that form, which you have seen, Reductil was sent by return to Mr Harvey. We know that there was no face-to-face consultation and no dialogue between the patient and doctor whatsoever other than what was contained in the initial form.
A That is correct, that is as I understand it.

Q How do you feel about that?
A Totally inappropriate use of prescribing; poor management of the patient.

Q It perhaps does not need saying but one of the crucial factors is the examination in this case. As far as you could see was there ever an examination?
A There was no examination.

Q Finally, please, Viagra. We have heard this morning about this through a statement signed by Mr Carrell, which was read, who is a journalist. He obtained Viagra – he had a choice of which erectile dysfunction drug he wanted out of three, but it was based on a form that was filled in by him which has questions on it about his erectile dysfunction, which I think you have seen.
A I have.

Q What do you say about Dr Eden's management of this person's application as you put it for Viagra?

A A Certainly Viagra is a drug that is increasingly widely used. Erectile dysfunction can be caused by a number of different things, some quite serious conditions, some chronic diseases like hypotension and diabetes and penile deformity, so it is more of a symptom than a diagnosis and the treatment with this drug without a more in-depth history and by examination, at least blood pressure, would be inappropriate. This is an inappropriate use of prescribing Viagra.

B Q What cautions are associated with the drug, please? They are at the bottom of page 12 in your report.
A They are particularly those of hypotension ---

Q How do you measure that?
A This is in interaction with other drugs, particularly nitrites.

C Q So hypotension.
A Anatomical deformation of the penis and those who might have a predisposition to sickle cell anaemia, multiple myeloma or leukaemia.

Q You mentioned cardiovascular disease.
A It is used in caution with cardiovascular disease.

D Q Which means what?
A Which means any heart disease, particularly those people who have angina, are taking nitrites.

Q How important is it to perform an examination to exclude those?
A The examination is important to define the anatomical deformation of the penis and other causes, but a lot of doctors probably would not examine before prescribing Viagra but
E they would certainly take a much longer and intensive history to find out about this.

Q What about psychological factors which might give rise to somebody's request for Viagra?
A It is this that is really very important. Sexual intercourse needs a lot more brain than it does ---

F Q Brawn?
A The penis, to a certain extent, and that needs investigating as to the cause. It might be a relationship problem, an anxiety, these sorts of things can cause erectile dysfunction. These need then discussing and examining within the terms of the history.

Q What is your conclusion then about the way Dr Eden came to the conclusion that it was appropriate to prescribe Viagra? I think it is accepted that from request to decision to
G prescribe was about two minutes?
A It was an inappropriate history, inadequate history and there were many other things that not sought. It was inappropriate to prescribe with that lack of information.

Q Help us, please, based upon your experience of reading the evidence in this case and other internet cases, where do you see the pitfalls and problems in internet medicine and prescribing?
H

A There has been a great increase in the internet for doctors, most of us now have the internet on our desks. The problem in internet prescribing is that of making an adequate assessment of the patient before prescribing. There is a great complexity in patients presenting to their doctors; it is not simple. The importance of proper communication and questioning, discussion, checking out ideas, sharing of information needs complex communication and this is not possible to do on a series of swapped emails. The decision to treat with a medication, to prescribe, comes way down that discussion; there are a whole lot B of places where patients can get advice, medical health advice, from the internet, from NHS Direct. They can get medication from their chemists, a lot of over-the-counter medication, so those drugs that are left to prescribe need complex decision-making and history-taking before prescribing.

Q Has there been any guidance that you have been able to come across, for example from abroad, that might help anybody who cares to research it with what they should be C doing in this area?
A There has been quite a lot of guidance from the GMC but there is also guidance from the USA.

Q Tell us about that.
A We are often told that the USA is the place where technology starts and we are getting it, so we can use the USA guidance as well.
D
Q You refer in one of your supplementary reports to guidance issued by the US Federation of State Medical Boards in 2003.
A Yes.

Q What do they have to say about it?
A
E
"Issuing a prescription based solely on an online questionnaire or consultation does not constitute an acceptable standard of care.

Q Just pause there. Read that again for us, would you?
A
F
"Issuing a prescription based solely on an online questionnaire or consultation does not constitute an acceptable standard of care."

Q Do you agree with that?
A I do most certainly.

Q Carry on, please.
G A It continues to say:

"A physician who prescribes medication via the internet must have established a patient/physician relationship. This includes, among other things, obtaining a reliable medical history, performing a physical examination of the patient, having sufficient dialogue with the patient regarding treatment options and the risks/benefits of treatment and having follow-ups with the patient where appropriate."
H

Q Appreciating, as we must, that at the time there was no specific *Good Medical Practice* GMC guidance on the specifics of internet prescribing, is there now in GMC guidance from 2006 some help on this?
A It is very clear.

Q What does it say about this area, please?
A About this area?

Q Yes. You have quoted it in your report.
A I did, in 38, 39 and 40. Would you like me to read that out?

Q Yes, please, because the Panel do not have copies.
A This is in the GMC guidance, the new GMC guidance, *Good Medical Practice*.

Q I am sorry, they do have it in their General Medical Council booklets.
A I suspect so, and it is 38, 39 and 40.

Q I am not going to ask you then to read it all out. What is the general tenor of it? It is paragraphs 38 to 41 inclusive, I take it.
A Yes, that is right.

Q Does it, in general terms, follow the American guidance?
A It does in general terms. What it does not state is categorically that it is poor medical practice to do it, but it gives so many recommendations where it could happen; where you have responsibility for the patient or deputising where you have established a patient's current medical conditions; adequate assessment to identify the likely cause of the patient's condition; ensure that there is sufficient justification to prescribe. If you are not prescribing continuing care for the patient, again reiterating things in 46 that we do -- the need for follow-up; the need to establish a dialogue; the need to monitor. There is a conclusion in paragraph 41.

> "Where you cannot satisfy all these conditions you should not use remote means to prescribe medicines for your patients".

THE CHAIRMAN: Mr Enoch, can I interrupt you? Can we be clear on this point which paragraphs we are talking about because 38 to 41 in *Good Medical Practice* that was issued in 2006 --

MR ENOCH: It is *Good Practice in Prescribing Medicines* not *Good Medical Practice*.

THE CHAIRMAN: Then we do not have copies of it.

MR ENOCH: Then we will get you copies. Let me just ask you this question, Dr Havelock, does the American guidance and what we now find in *Good Medical Practice*, as far as you are concerned, represent anything other than what has always been good common sense?
A I think it is a state of good common sense, the guidance we have had before from the news letters and previous General Medical Council guidance that we have had.

Q Give us an example of the type of consultation or advice giving that might be acceptable or appropriate for somebody like Dr Eden to be doing with somebody he has

never met on line. When might it be appropriate for him to be engaging a patient on line? Can you think of circumstances that might be acceptable?
A There are a number of circumstances like telephone help lines, advice about medications and treatment and health problems in magazines. That would be appropriate. NHS Direct.

Q Does an NHS Direct adviser ever have the power to prescribe?
A No, they do not, and it is consultations that do not end in a prescription. It could be advice to take some over the counter medications, but to prescribe you need to make a full diagnosis. This is laid out both in the American guidance and in the General Medical Council guidance.

Q What about something like blood pressure pills or antibiotics, something like that?
A Blood pressure pills initiating – there is a difference because a number of general practices will give repeat prescriptions for blood pressure pills – once the diagnosis has been established, once the investigations have been done, once the blood pressure has been monitored and the patient needed more medication. Antibiotics for a patient, say a woman with cystitis, might also be prescribed without seeing them. But this is in established patients where the history has been taken, where the records are kept and it is compared with the history up until now with a responsibility for continuing monitoring.

Q If the doctor has never met the person?
A If I had never met the person I would never prescribe.

MR ENOCH: That is all I have for you. Please wait there.

<u>Cross-examined by MR JENKINS</u>

MR JENKINS: What about telephone consulting?
A Telephone consulting is getting increasingly common with out-of-hours consultations and with emergency consultations. So telephone consulting from a general practitioner who has the patient's records can and is done in certain circumstances.

Q What about phoning up the local emergency service – where I live it is Camidoc (Camden and Islington) – where you can phone up a doctor who knows nothing about the patient and he may be speaking to a parent or the patient themselves and being told over the telephone what the child's or patient's symptoms are.
A Then on prescribing the doctor or nurse, because sometimes it is done by a nurse, will make an assessment of this and will give advice for over the counter medication. It is very rare, and since this case I have talked to a number of local doctors who have regular out of hours consultations, to prescribe without seeing the patient a drug that you cannot get over the counter.

Q The classical model of medical consulting is that the patient comes to see the doctor or, in cases of emergency or where the patient is too unwell to visit the doctor, the doctor will go and see the patient. That is the classical model.
A Yes, that is the classical model.

Q It is becoming a system under a great deal of pressure for various reasons. Would you agree?

A A Yes, there is pressure on the system.

Q Patients cannot always find time to go to a doctor at a time when they can get an appointment.
A I suspect that is right.

Q It is right, is it not, and the Government have made commitments which they have
B almost immediately failed to abide by? There will be circumstances where somebody wants to see a doctor, and see them today, but where very commonly it simply cannot be achieved. Would you agree?
A No, not very commonly. The majority of doctors can offer same day appointments. This is part of the quality guidance under which we work. General practitioners can always do same day appointments for patients that wish them.

C Q There will frequently be concerns that the patient may have where they want advice from a doctor rather than a prescription. Would you agree?
A I agree.

Q In those circumstances, using the classical model, a patient would have to make an appointment, perhaps lose time off work – sometimes half a day – to go and see the doctor, wait in the waiting room and seek advice from the doctor.
D A That can be.

Q Would you agree that if that scenario were conducted over the Internet, the advice the patient may be seeking could be provided within moments?
A There are all sorts of sources of advice for patients if they wish, and many doctors now, with their records in front of them, are offering advice to patients, but not prescriptions.

E Q What are the advantages of remote consulting? I include telephone and Internet, whether on line or through emails. What are the advantages, so far as you are able to judge, Dr Havelock?
A The advantages are convenience for the patient.

Q That is undoubtedly something which figures very highly in patients' concerns. Would you agree?
F A Patients' wish for convenience, yes.

Q Are there any others?
A You have got to ask if they are advantages to the patient for their health or which they would state.

Q Can you think of any others?
G A The advantage that some patients would wish to have anonymity.

Q For some patients it may be embarrassing dealing face to face with a doctor. Would you agree?
A It might be.

Q Whether there is a feeling that the doctor may be a bit creepy, or to explain personal
H matters such as problems – it is Valentines Day – sexual problems between partners or

matters of that nature, people will often find it easier to deal with the doctor remotely. Would you agree with that?

A No, I would not necessarily agree because I think sometimes it needs the right doctor to talk to them about it at the time. These are complex problems.

Q Whether or not the patient gets the right doctor may be a matter of chance. If they are dealing with somebody over the telephone, or perhaps over the Internet, would you agree that patients may face a rather lower level of embarrassment when talking about sexual matters or personal matters?

A They might well be.

Q When you see patients, if you are giving information to them explaining possible side effects, talking about decisions that they may need to make about their own healthcare or treatment that is available, do you give them leaflets?

A I can do. I quite often do. We can print them out and I do that maybe six or eight times a surgery.

Q Do most GPs do that, so far as you are aware?

A One of the most common computer systems has them already there. A lot of doctors do that.

Q I suggest it is actually quite rare for doctors to do that with patients within the course of a relatively brief consultation. Doctors will say what they think needs to be said and hope that the patient takes it all in. Would you agree?

A I would not agree that that was a generalisation that I have seen.

Q You are aware that quite a lot of research has been done as to how much information patients take away from a consultation.

A I am.

Q Frankly, it is nowhere near as high as people might wish.

A I am aware of that research and aware from that research that information patients take away is enhanced by a discussion of the patient's ideas around that information.

Q Do you agree that one of the advantages of the use of the Internet particularly and consulting with a doctor over the Internet, is that patients will receive written information from a doctor – they have to by the nature of email? They can take that away with them and look at it later, can they not?

A They can receive that, but they can get that information from the Internet without consulting with a doctor as well.

Q Not from the doctor they are consulting, surely.

A No, from the Internet.

Q I am talking about within the consultation. If a patient is consulting a doctor over the Internet about a particular problem, the patient by definition gets a written response to their concerns.

A That is right.

A Q It is something that they can look at at a later time, reflect upon, and there is a guarantee that the patient has all the information and retains it, that the doctor wants them to have.
A But it might be a language that they do not understand.

Q It might be.
A That is right.
B
Q But the doctor may, whether face to face or over the Internet, use language that the patient does not understand.
A Exactly.

Q If the doctor wants the patient to have information, if it is done on line, or if it is done through the Internet, there is a guarantee that the patient has and retains all the information
C that the doctor wants him to have.
A Guarantee only that the information is given.

Q Yes, of course. If the doctor gives information to the patient over the Internet, they get what the doctor gives them. Is there a difficulty about agreeing with this?
A No.

D Q The point is that, as against a face-to-face consultation, the patient may not understand it at the time and may not recall it later.
A But they have the opportunity, if they do not understand, to ask the doctor about it at that time and have a discussion about it. The effectiveness of that can be much greater than a printed leaflet. There is a lot of advice about leaflets, that they should not be given without discussion.

E Q Forgive me, I am putting to you what I hope are fairly straightforward propositions. Right?
A Yes.

Q The proposition I am putting to you is that if it is printed out for the patient and on their computer, they can go back and look at it at a later stage.
A Certainly.
F
Q If they are having an Internet dialogue with the doctor, if there is anything they want clarification about they can, just as in a face-to-face consultation, ask.
A Certainly.

Q How long are your consultations with patients typically?
A Ten or 12 minutes.
G
Q Would you accept that there are many doctors who, perhaps by reason of numbers, find that they compress patient appointments into shorter periods of time?
A Yes. I think the average is about eight minutes.

Q Doctors have to have strategies in dealing face to face with patients to ensure that those who can be dealt with efficiently are dealt with quickly so that they can perhaps spend
H

more time on patients where an examination is required or where matters need to be gone into at greater length.
A Yes.

Q Would you accept that over the Internet it is entirely possible for the dialogue to continue over a period of hours or days, at the convenience of the doctor and the patient?
A It is possible.

Q So there is scope, would you agree, for at least as full if not actually a much fuller dialogue for the patient consulting with the doctor than he would ever get in a face-to-face consultation?
A No, because you lose the whole non-verbal discussion, the interchange that comes in, in the sort of discussion we are having now. You lose that over the Internet. You can certainly swop information.

Q Can I suggest that there may be cases where a patient goes to a doctor and gets advice, whre the patient may want to discuss that with a relative or friend who is not actually in with the doctor?
A Very commonly.

Q So that situation requires that the patient goes away from the doctor, talks to the friend or relative and tries to recount to the friend or relative what it is that the doctor has said to them and one hopes that there will not be any Chinese whispers and things are reported accurately and fairly. But there is a risk of that, do you agree?
A Of course.

Q In the case of information being presented in written form to the patient, the discussion with the friend or relative would be fully informed, would you agree?
A If it adds to the information, certainly.

Q Let us say I went to the doctor to ask about certain forms of treatment and I wanted then to discuss that with my mother at a later stage, if I had the doctor's views all written down there is a guarantee that my mother sees the same information that I received. She knows exactly what the doctor was suggesting to me.
A It would be helpful.

Q Were you aware that in the United States there is encouragement for practitioners to look at the use of the Internet as a way of providing ongoing care for patients?
A I am well aware there is a movement to do that, yes.

Q From some of the official organisations; not just one or two practitioners, but from official medical organisations.
A Yes.

Q Would you agree that there are continuing advances in technology and perhaps with the use of cameras – we have seen a video link within this hearing – it is entirely possible to bring in much of the face to face contact that one might have in a face to face consultation with a patient?
A It might well be possible.

Q I do not know if you have ever conducted an Internet consultation with a patient.
A I have not.

Q Have you ever seen anyone else conduct one?
A I have not.

Q Let us agree that there are problems with the use of the Internet in that some people use the Internet to get access to things that they shoudl not be getting access to.
A That is correct.

Q Pornography might be one thing, and other types of unlawful material. But also people can disguise themselves in various ways.
A Yes.

Q Whether posing as a teenager when trying to talk to other teenagers or posing as a patient with certain problems when those are not true problems. Those are concerns that one needs to have.
A Yes.

Q What we know about this case is that four of the patients, we do not know about Patient A, have given misinformation or have lied about themselves when logging on line.
A Yes.

Q We do not know about Patient A because we have not seen his medical records, and I think you would agree that in circumstances where a patient has had a benefit to obtain by lying to the doctor then the doctor needs to exercise caution?
A Exactly.

Q That is true whether the patient is coming to see you in your surgery or whether you are dealing with the patient remotely over the telephone or on-line.
A Exactly, yes.

Q I think what you would say is that if you are dealing with a patient remotely you need to exercise additional care because you do not have, typically, the face-to-face sight of the patient; you cannot see whether they in fact are exhibiting the symptoms of withdrawal, let us say, but where they are claiming that they have a need for opiates or drugs of that kind, and you do not have the opportunity to examine them?
A (No audible response).

Q Let us agree that in prescribing drugs which have the potential for abuse, remote prescribing is unwise and inappropriate?
A We could agree that.

Q I do not know whether you are aware of the history that Dr Eden had, since 2001, been writing to the GMC for guidance, did you know that?
A From the most recent – your defence witness's report.

Q The panel will see the responses in due course, but would you agree that the guidance about remote prescribing or remote treating of patients has come quite recently, 2006.

A A Yes. The previous *Good Medical Practice* is very clear about remote in the way of looking after somebody else's patients, if you are not the general practitioner.

Q I understand, but the other documents to which you have referred and which the Panel have not yet been shown, *Good Practice in Prescribing Medicines*, that also is advice that dates from 2006.
A That is right.

B

Q It is an expansion on the advice and guidance that the GMC had previously given?
A Correct.

Q Can I turn to the patients? I do not think I need ask you about Mrs Hutson, the first patient, in any detail, but you would accept that she did not tell the truth to her own doctor, Dr Cowan, and hid the truth from Dr Eden?
C A That is true.

Q She is the sort of patient, I think you would agree, who would present problems for her GP as well as any other doctor being asked to prescribe for her?
A Exactly.

Q The dangers there are that she may perceive there to be a benefit to her in distorting
D the truth or not telling the truth?
A That is right.

Q The dose that was prescribed by Dr Eden was six 30 mg dihydrocodeine tablets a day for a month.
A Yes.

E Q You are aware that she had been taking a significantly higher dose of that for years.
A Yes.

Q The highest dose that we have got recorded her taking in the years before she came to the internet was I think 720 mg a day on occasions, 24 tablets a day. The dose that Dr Eden prescribed was significantly lower than the 600 that she had been receiving for a significant period of time.
F A Yes.

Q Can I take you to Patient X, who is the next one with which the Panel are concerned? Patient X again misled Dr Eden.
A He did.

Q He was prescribed over a period of about two years. Have you seen the
G documentation in which a year or so into the prescribing Dr Eden was saying he needed to see the patient face-to-face?
A I do.

Q There was subsequently a meeting in June of 2005 after Dr Eden had insisted upon it, a meeting in London.
A Yes.

H

Q I do not think I need take you to what happened at that meeting. The Panel have heard one party's evidence, Patient X, and they will hear Dr Eden's evidence fairly shortly. I will take you to the documentation. Do you have the folder that deals with Patient X? It is folder 3.
A Yes.

Q Would you go to page 50, which is in tab 2? That is an email in which Dr Eden was saying to the patient, "I need you to come and see me".
A That is right.

Q The next email I am going to take you to is that at page 66. That is an email from Dr Eden, at the top of the page, saying to Patient X, "We will try something else", effectively, "In the short term lets try temazepam 30mg at night for a month". You would agree that temazepam should be used in the short-term?
A Yes, it is a hypnotic in the same way as the others.

Q What do you say of the suggestion, "I think you should see a sleep specialist as well" to this patient?
A I would not have thought a sleep specialist but certainly to go and see a generalist to get some help with his problem.

Q The response, the Panel will recall, is at page 59, in which Patient X said he found temazepam to be ineffective. Page 68, again the Panel have seen this briefly before. This is an email from Dr Eden saying that it is too soon for a subsequent prescription.
A That is right.

Q One sees the passage:

"… it is medically advisable that we also inform your NHS GP/Family Doctor that we prescribe".

You would wish to see that in circumstances such as this?
A I would wish to see that.

Q Page 80: again Dr Eden requiring a review of this patient and a face-to-face appointment.
A That is right.

Q Again, it is something you would wish to see in the circumstances.
A Yes.

Q Patient A, the 16 year old, we have emails in his case, and for that you will need to go to bundle 4. In the first tab you should have the questionnaire completed by this patient.
A I have.

Q On 27 August 2004 he submits a feedback form in which he gives his date of birth and one can see that he was 16 at the time.
A That is correct.

Q As one looks down the form there is an indication of his height and weight; that he was on incapacity benefit, and he indicates why, and he indicated that he did not want his GP to be informed. Patients have to be asked whether their GP should be informed if they are seeking treatment from another doctor, do they not?
A They do.

Q And if the patient says they do not want their GP informed that wish has to be respected as far as possible?
A They do, but it needs discussing as well.

Q I agree with that, Dr Havelock, and it may be that this case was not dealt with as well as it could have been, I know you say that, but as one goes on through the documentation, and I am afraid there is no pagination of the email tab for this patient but it might be best if we start from the back. A page marked "14 of 16" is the last page in tab 2, that is towards the end of Patient A's email. If you go further back, to 13 of 16, one sees the date of it, "Hi Dr Eden, again!" He is talking about the propranolol. The Panel I think will already have read what follows at the bottom half of page 13 and the rest of page 16. One sees at page 13 the email response from Dr Eden on Monday, 20 September.
A Yes, I have that.

Q
"… if you are looking to take these sort of meds, I think its best you see a consultant psychiatrist."
A Good advice.

Q
"We can refer you privately locally. Please advise."

If you go forward a page, please, it is headed 12 of 16, the Panel will have seen the intervening email at the bottom of page 12: "ok, it may be possible that I can come down to London soon" says Patient A, and above that is an email the following day from Dr Eden to the patient: "I think its best you see a private psych up there" and there is reference to how much might be charged: "If that's ok we could refer you here", and the name of an individual practitioner is given.
A That is right.

Q You would want to see in those circumstances Dr Eden encouraging this young man to seek specialist help.
A I would.

Q And he does?
A And he does.

Q He continues to do so I think. If you go to page 11 of 16, the email from Dr Eden:

"You've got to see a specialist, whether its in a retreat or otherwise in a hospital, if you are under 18 get your GP to refer you."

This is appropriate by way of a response from Dr Eden, clearly concerned for the patient and what he may be going through. One can do that from the other direction. If you start at the

beginning of tab 2 I think we have exactly the same emails, just in a slightly different format. Perhaps the first one we have not looked at:

> "No I need to see you for any psychoactive med, but I do think your GP is your best option."

The second Dr Eden email on that page we have seen, "you have got to see a specialist."

Q Would you agree that Propranolol is a relatively safe drug?
A I would, relatively.

Q The patient was asking for other types of medication and they were not being prescribed.
A Yes, that is correct.

Q That is significant, is it not?
A That was.

Q What we were told yesterday by the consultant psychiatrist who was then responsible for Patient A was that he could, if he had gone to an accident and emergency department, have been treated by a doctor who had not known him, he could well have been prescribed Propranolol by such a doctor if he presented with severe anxiety.
A He could, probably unlikely.

Q What we were told, can you agree, was that Propranolol is a drug that is frequently used in general practice?
A Not frequently but it is used.

Q Let me turn to the next patient, Oliver Harvey. We have heard from Mr Harvey this morning. What we have in his case is a document that you have in bundle 5, and this is a form that was completed and contains personal details which he gave about himself, on the first page, which has Dr Eden's stamp on it, and this we understand was the prescription that was issued, "1 x mth 10 mg Reductil ABC", which is the name of the pharmacy from where we understand it was dispensed. A history was taken in respect of that patient. You would want to see the patient's blood pressure taken by the doctor?
A I would.

Q Can you conceive of circumstances in which the patient's blood pressure, the information about the blood pressure could be provided in another form, perhaps by a patient going to their gym where there may be a nurse or some other suitably trained person to take the patient's blood pressure.
A Certainly.

Q Your concern is, I think, that there should be a base-line assessment ---
A Accurate, accurate base-line.

Q I understand. If it is not accurate it is no use, and you would want to see that patient followed up in the way that you have described to us, every two weeks, blood pressure.
A I would.

Q Is there any objection in principle to blood pressures being provided to the doctor by a third party, such as a nurse, whether it be a practice nurse, or someone at the patient's gym?
A No objection.

MR JENKINS: May I clarify: has the Panel been handed a waiver of liability document yet that is referred to?

THE CHAIRMAN: No.

MR JENKINS: I think we have copied it but we will do it later. We will not interrupt Dr Havelock's evidence to deal with that.

THE CHAIRMAN: We do have copies of the *Good Practice in Prescribing Medicines* 2006, that is ready to hand out.

MR JENKINS: I do not need to take Dr Havelock through that. What is important is that he post-dates all the factual allegations that we have to look at.

Q The last patient is Mr Carrell, who was a journalist with the *Independent on Sunday*, and who we know filled in some on-line questionnaires by misstating what his concerns were. There was a newspaper headline, I think over the weekend, saying that Boots the Chemist is thinking of prescribing Viagra or dispensing Viagra over the counter. Were you aware of that?
A I was.

Q What do you anticipate will happen if someone goes to Boots and says, "Can I have some Viagra please?" Will there be an examination?
A There will.

Q In the shop?
A Yes. That was what was stated in the paper, that the pharmacist would take their blood pressure.

Q Is that the extent of the examination?
A In Boots, yes.

Q Would you say that more should be done than just a baseline blood pressure?
A Not necessarily if the history is full and discussed, and certainly that is what they described the Boots pharmacist doing in this month's trial.

Q We are not projecting this into the distant future, are we? This is in the world as it is today.
A That is right.

Q If a patient comes to you and complains of erectile dysfunction, would you do any kind of examination of the penis at all?
A I would ask them about their sex life and how it has deteriorated, if there has been any pain, is there any difficulty and the problems they have with erections, and that would cover the issues around penile abnormality.

Q You cannot do a proper examination unless the man is erect, can you?
A You can get ideas from looking at the penis, feeling the penis.

Q But you do not criticise the prescription here because there was no physical examination of the penis, do you?
A I do not.

Q Can I suggest that it might not be uncommon if a man goes to his doctor and gives exactly the information that was provided by this journalist, that he has had problems over a period of years, that he has not spoken to anyone else, that he does not have psychological problems, that a doctor may well find himself prescribing Viagra for such a patient to see if that sorts the problem out?
A They might.

Q In those circumstances, for it to have been prescribed to a patient who gave the information that we have seen, I suggest it was not inappropriate or irresponsible for a prescription to be issued for this patient. I say "patient." He was not a patient.
A There was much more information that could be discussed for erectile dysfunction.

Q I agree, but that would be true of almost every consultation between a doctor and a patient. There might be much more that could be asked about or said?
A Yes.

Q Yes?
A Certainly.

Q What I suggest was that this was adequate as the amount of information that was provided to the doctor and that there may be many GPs prescribing face to face for a patient who, given exactly the information that was provided by this journalist, might go on to prescribe Viagra?
A I agree with you.

MR JENKINGS: Thank you very much. That is all I ask.

MR ENOCH: I have no re-examination, thank you. I will hand over to the Panel.

THE CHAIRMAN: Perhaps I should explain, Dr Havelock, that at this point there is no re-examination from the GMC but members of the Panel, as you are aware from previous occasions, can ask you questions and what I am just seeking to find out, by looking at them, is whether they do indeed have questions to ask of you. Quite a lot has been covered in this respect, and if there are a lot of questions – and I am just seeking to get some view – then I would be tempted to break for lunch at this particular point. Of course, you could not discuss this further during this particular time, and you would come back after lunch. I am seeking some sort of guidance as to whether there are several questions, otherwise it could be unending and lunch might then be way into the future. I sense that it would be sensible to take lunch at this particular point, in which case we will adjourn then until quarter to two.

MR ENOCH: Sir, I was going to ask you to adjourn until two because we have actually got quite a lot of work to do ourselves tidying up various things that we are going to be giving

A you, for example the Severin Carrell material. I wonder whether you would take a slightly longer break which will allow us, say, half an hour's work as well?

THE CHAIRMAN: Okay, but no more. I do not want to be ridiculous about this, but there is a limit to how long it can go on. Clearly, you want to achieve that before you conclude your case.

B MR ENOCH: Yes, and we just want to have a reasonable break ourselves. That is all.

THE CHAIRMAN: I understand. I am happy to go until 2 o'clock and we can all be back here at 2 o'clock.

MR ENOCH: Thank you.

C THE CHAIRMAN: (To the witness) You are still under oath, of course.

THE WITNESS: I do appreciate that.

THE CHAIRMAN: Thank you .

(Luncheon Adjournment)

D

Questioned by THE PANEL

THE CHAIRMAN: As I said before lunch, Dr Havelock, it is now the turn of the Panellists to ask you questions and I will introduce them. I am going to start on my right with Dr Willatts, who is a medical member of the Panel.

E DR WILLATTS: Good afternoon, Dr Havelock.
A Good afternoon.

Q I think you said, or Mr Enoch said on your behalf, that you have some experience of dealing with cases of internet prescribing?
A I have, in this role for the GMC.

F Q Supposing, or perhaps assuming, that I am in good standing with the GMC. Is there anything to stop me setting up a website and prescribing?
A I do not think there is. I know of no reason why you should not.

Q There is no other level of regulation that I would need to address before I just did it?
A I do not have information about that. I cannot see why there would be, but I do not know.

G

Q You referred us to some guidance on the issue of prescribing, but not prescribing in the absence of having had some exchange with the patient. Are there any written guidelines that would help me if I decided to set up such a website?
A Yes, currently there are the ones that we referred to, the American guidelines, and the most recent guidelines from the GMC.

H

Q They would tell me what I can do or I am allowed to do as well as what I should not do?
A Yes, it would give you – care with the things you can do and the things that you cannot do.

DR WILLATTS: Thank you very much.

THE CHAIRMAN: On my left, Dr MacWalter is another medical member of the Panel.

DR MACWALTER: I wonder if you could comment on the treatment that Mrs Hutson received. She received painkillers, dihydrocodeine and diazepam, from the internet service that was provided by the doctor in question. Did you think that this was an excessive amount of medication for a person with chronic back pain, as she claimed to have?
A I did.

Q Would you not agree that many general practitioners would have patients such as this on their lists to whom they would have to give continued prescriptions of dihydrocodeine and perhaps diazepam as well?
A Not probably for this length of time without review of why and to try other drugs that do not have the dependency aspect about them.

DR MACWALTER: Thank you very much.

THE CHAIRMAN: Also on my left, Ms Julien is a lay member of the Panel.

MS JULIEN: My question is a more general question about the medical questionnaire that has been used, the internet one.
A Yes.

Q Just bearing in mind that it is an internet medical service, if you like (I will call it that) you mentioned that you felt it was quite a general questionnaire and I just wonder how specific it could be, given that that is the medium?
A It reminded me of the questionnaire that many general practitioners would give to new patients about their health before their first consultation, so it was general about their health in general, not about specific illnesses which then need a different sort of discussion.

Q Are you saying you would have preferred to see more information about their illnesses, or what sort of specific information?
A More specific about the previous medical history, which for a general practitioner comes within the records.

Q Do you think that would be practical, given the type of service that it is, that it would be possible to do that?
A Probably not, because I feel that that sort of more specific individual information needs doing by discussion.

MS JULIEN: Thank you.

THE CHAIRMAN: Dr Havelock, I am a lay member of the Panel as well. Can I just go back to understanding your position here today. You come as an expert witness on behalf of the GMC, and just so that there is no doubt, your expertise is as a GP?

A Certainly.

Q You do not claim to be an expert in internet, on-line, medical work ---

A Not at all.

Q -- in any of this, although as I understand it you are now building up some experience of such proceedings as this, but you have not used the internet in this way yourself, your views are personal, you do not pretend to represent a greater body in this respect. Is that my understanding?

A Not in the slightest. I am here as a general practitioner.

Q That is how I understood it, but do I from the latter part of your evidence gather that you are … Let me ask it in a different way. Are you in favour of greater use of telephone or on-line medical work? Do you see it as inevitable? I was not quite sure where you stood on this at the end.

A Fine. I guess my background for many years has been on the doctor/patient consultation, both at home and in the surgery, and teaching and research upon that and what makes that effective. I am sure that the consultations will develop into telephone consultations as appropriately, and maybe internet consultations as appropriately, but as an adjunct rather than instead of the face-to-face consultation. For example, people are using the internet and telephones to follow up the patients they have already consulted with, that they have the records of, that they have made a plan to check as it is. We do in our own practice as well. "I saw you yesterday. You took the medication. How are you feeling?" rather than as an initiation of information and coming to a diagnosis and prescribing from it. Is that clear?

Q It is absolutely clear. What I am not sure though is – and forgive me for putting it this way, and others will jump to their feet if they are unhappy with it – whether you are living in the real world in this respect. If you take Sunday, almost anywhere, you are making a telephone call to a number that is in the practice booklet that encourages you to ring – some of this was covered, I accept that, but I just want to be clear on where we stand on this – and prescribing is happening.

A I think it is happening, and I say "think", but I have surveyed, since I had the information, that rarely is prescribing happening without the patient being seen. Advice is being given, advice to go to the pharmacy and pick up over-the-counter medication, but a prescription in limited circumstances is offered out of hours. I myself do not do out-of-hours at the moment, but that was certainly my experience of doing out-of-hours and the experience of five, six doctors I have referred to over the last three or four days about out-of-hours. Very rare to prescribe without seeing … Maybe follow-up medicine which they have already had and maybe lost the prescription, within certain circumstances, and maybe for one or two conditions, one of them I mentioned earlier, urinary tract infection in a female.

Q I think most of the rest of my questions are just a clarification on the various patients and I am not going to look to you to turn to them. Patient A, who was the propranolol patient, my impression was that this patient was apparently very open. Are you saying that, on the evidence that we have seen, there was enough evidence, enough information given to assess the vulnerability of this patient?

A A Yes, certainly for me reading his emails I think that I could assess his vulnerability.

Q Could an overdose of this particular drug be fatal?
A In appropriate dose, but probably not in the dose that he took.

Q When we were dealing with Patient X – I know these are not in the right order – the zolpidem and zopiclone ---?
B A Yes.

Q On one of those, I was not quite clear which one it was, you used the phrase I think, "It's not licensed for long-term use."
A I do not think I said "licensed." This is from the *BNF*. I think the recommendations are it should not be prescribed long-term:

C "*Chronic insomnia* is rarely benefited from hypnotics and is more often due to mild dependence caused by injudicious prescribing …

Hypnotics should **not** be prescribed indiscriminately and routine prescribing is undesirable."

But it is different from licensing.
D

Q I think you did use the words "not licensed" and I do not think I would have written them down off my own bat.
A Okay.

Q I just wanted to be clear if that was the case, what that meant?
A Fine. This is a quote from the *BNF* and it says – I am right there – that these three
E drugs, zaleplon, zolpidem and zopiclone, have a short duration of action. All three drugs are not licensed for long-term use.

Q What does that mean?
A That means that they should be prescribed only as they have been recommended by the *BNF*, except in circumstances where the doctor is very clear. Not licensed means that the manufacturer and the pharmaceutical … say how this drug should be used and how it should
F not be used and they recommend it should not be used for long-term use.

Q I will not pursue you any further, but licensing just seems to me to be allowed to be used or not allowed to be used, rather more than recommended?
A There are circumstances, and I cannot now recollect, when non-licensed drugs can be used, but there are circumstances and I am afraid I cannot answer that question.

G Q Going on with the same patient, this patient came for a face-to-face consultation?
A Yes.

Q At such a review which you have made it very clear you think should happen, indeed in most cases it if has not happened before, what would you expect to happen at that review? I am going to follow it with the question of how long, therefore, do you think such a review might take? I realise you cannot be specific about it.
H A Yes.

Q A "not less than" sort of feeling, but what should happen at such a review?
A Throughout the treatment of these drugs over a longish period of time, realising that they should not be prescribed over a longer period of time, and concerns, as I answered in my evidence earlier, that they might have been misused by lost prescriptions, that this review should be in detail of Mr X's drug use, and why, and what his plans are. It should cover a whole area about the gentleman himself, his use of the drugs and why he is still going on with them, in the same way as one would with a potential addict.

Q Understanding the limitations of this question, are we talking about a fairly quick review and this is the first occasion people have met, or are we talking about, given the type of person this person is, or appears to be, a fairly lengthy consultation?
A By its nature it would have to be lengthy. It is not a quick review.

Q I think that is helpful, for me anyway. Then we went on to Mr Carrell, the journalist ---
A Yes.

Q -- whom we did not see, and the question as far as he was concerned, of Viagra. I was not clear as we got to the end of that whether you considered that what happened to him and the treatment he got via the internet was inappropriate or not?
A I think it could be described as just adequate rather than inappropriate. It should have been done by recommendations, better, more information, coming to a proper diagnosis of erectile dysfunction, but I would concede that a number of doctors probably do not do that as well.

Q I want to be clear on this.
A Yes.

Q My question was: Was it inappropriate?
A The answer to that must be no.

Q It was not inappropriate.
A It was appropriate.

Q Earlier on you linked appropriate and irresponsible together. Does that mean you answer the same way; was it irresponsible? We understand these are your views.
A Was it irresponsible? Yes. It was really very borderline and I would wish to do an awful lot better than that, though I suspect that a number of doctors would behave in that way and therefore it was not irresponsible.

Q You are aware of the way the heads of charge go in these sorts of things. Was it not in the best interests of the patient?
A It was not in the best interests of the patient.

Q Those are the only questions I have got.

Further re-examined by MR ENOCH

Q Could you look at page 13 of your report, please, which deals with Dr Eden's management of the application for Viagra that we have been discussing.
A Yes.

Q Can I ask you to focus on what you consider to be proper practice rather than what you think some other doctors may have done, all right?
A Certainly.

Q There may be an awful lot of bad doctors but let us focus on what is good and what is not good, all right?
A Yes.

Q I want to be absolutely clear about this, please. Do you consider that to prescribe Viagra over the internet to a person you have never met, on the basis only of information that he has filled in in a questionnaire of the type you saw, do you consider that to be appropriate in the absence of any meeting or examination?
A No, I do not.

Q Do you consider it to be responsible or irresponsible?
A Irresponsible.

Q Do you consider that to be in the best interests of the patient or not in the best interests of the patient?
A Not in the best interests of the patient.

Q Why?
A Because erectile dysfunction is a symptom rather than a condition and it needs further examination of the history and the causes and further examination to establish why this patient has erectile dysfunction.

Q Do you understand the way you have been asked about what Boots might be being about to do, however relevant that may be? Do you understand that one of the things that is to happen is that the person is to be getting his own Viagra face to face from the person who is giving it to him?
A I am sorry, could you just say that again.

Q It is the idea that somebody goes in person to buy Viagra for themselves; is that the idea?
A In Boots?

Q Yes.
A As far as I understand it.

Q You gave evidence about the idea being for the pharmacist to take the blood pressure ---
A And the history.

Q And the history. How important do you regard the question of taking the blood pressure?
A Taking the blood pressure is important because it does affect the blood pressure and the taking of Viagra can alter the blood pressure.

Q As far as the questionnaire that was filled in online is concerned, are the questions that were in that questionnaire the sort of questions that might appropriately be asked?
A They are the sorts of questions, it gets into the areas, but it does not have the ability for follow-up questions and discussions about the issues.

Q I just want to be clear about where that leaves us because you can understand the Panel may be a little bit confused.
A I can understand that, I apologise.

Q Setting aside what you think some doctors may do, was it appropriate what happened with this person who was pretending to be someone who wanted Viagra.
A It was not appropriate.

Q I want to move on to some different topics, please. The Chairman asked you about your assessment of Patient A's treatment based on the information before the Panel. I do not know, I may be second-guessing the Chairman here, but it may be that you have seen more of the email traffic than the Panel have and in fact I discovered this morning that the early emails which actually form the subject matter of the heads of charge have not found their way into the bundle, and I have had them copied to hand out now so that we have the complete email traffic for Patient A. I apologise for that, but I did not prepare the bundle; that is all I can say about it. Could I ask that that be handed out now, please?

THE CHAIRMAN: You can, and it will be C10. What I am not clear about, Mr Enoch, is whether the Panel now need to read this before you take your question.

MR ENOCH: I do not think so because none of it is controversial. I have drafted heads of charge 14 to 18 on the basis of these emails and they have all been admitted and found proved. There is no difficulty with it, it is just that you do not have copies of them in your bundle. You ought to have done and I expected you to have but you did not, and I apologise profusely for that. You will see that there is some duplication; that is inevitable because they have come from different sources but, for example, can I just show you the first one, which was the initial email prior to the completing of the questionnaire which you will see at the top is timed at 11.56 on August 27, 2004 and forms the subject matter of head of charge 14 which has been admitted and found proved, and there you see it in all its glory in the actual email. Over the page on the next page you see Dr Eden's response, which again is in the heads of charge. I am certainly not going to ask you to read though all those now; you can do it at your leisure, and I am not going to take Dr Havelock through it.

(To the witness): Just to be clear, Dr Havelock, you saw all of the email traffic.
A I did.

Q That we had and we gave you that had taken place between doctor and patient in this case. I am going to leave that there for now. You were asked by the Chairman also about propanolol and you were asked whether an overdose of propanolol would be fatal. Your answer was "Yes, but not in the quantity he took".

A A Depending on the dose.

Q If somebody took a lot of propanolol, would it make them significantly ill at least?
A It is likely to.

Q Finally, I want to ask you about this, please, and it again arises out of one of the Chairman's questions. It is about what happens out of hours in a normal GP situation. Have
B I understood the position correctly, tell me if I have not. If it is on a Sunday, the GP surgery is closed.
A That is correct.

Q Every GP's surgery has to have some sort of emergency number, is that right?
A That is right.

C Q If you ring your general practitioner out of hours or on a Sunday, or in the middle of the night in the week, there will be an emergency number given for you to call.
A That is right.

Q Which will almost always take you to either a doctor on duty or a nurse of an NHS Direct-type triage scenario.
A That is right.
D

Q You will speak either to a nurse or a doctor about what is wrong with you.
A That is right; sometimes if people need phoning back a message is taken and they are phoned back.

Q Quite, you leave a message and the doctor phones you back.
A That is right.
E

Q Anybody who has got children knows exactly what I am talking about. Does prescribing ever happen in those circumstances over the phone, other than in the very rare ---

MR JENKINS: I wonder if it can be done without giving evidence.

MR ENOCH: I am asking a question, does prescribing ever occur other than in the rare
F circumstances you have alluded to already?
A I admit I have not done out of hours prescribing for a long time, but in my survey of six doctors who I phoned it happens very rarely.

Q Would it, could it and should it ever happen, for example, if somebody was saying I want some propanolol or diazepam or zolpidem or anything like that?
A No.
G

Q In ordinary circumstances if somebody out of hours tells a story which suggests to the doctor that they need to be prescribed something powerful, what would they be advised to do by the person they are speaking to out of hours?
A Either come into the centre – because they are always based in centres – or if it can wait until seeing their own general practitioner in hours.

H

Q If a doctor needs to see you is there always a doctor available, either at a centre or one that will come out?
A Yes.

Q Thank you very much. Finally this: you have been asked about what you meant by "licensed" or what the *BNF* meant by a drug that is licensed and your answer was, effectively, that there are occasions where unlicensed drugs are given.
A Yes.

Q Is it sometimes called "prescribing off licence"?
A That is right.

Q Would that be common or would that be an exception to the rule?
A Very uncommon.

Q That is all I have, thank you very much.

THE CHAIRMAN: Mr Jenkins, do you want to come back on anything?

MR JENKINS: No, thank you.

THE CHAIRMAN: Thank you very much, Dr Havelock. That is the end of your evidence; you are of course perfectly liable to stay if you want to, if your team want you to, but you are equally free to go from the Panel's point of view.
A Thank you very much.

(The witness withdrew)

MR ENOCH: Sir, there is one other matter I need to attend to, if I may, which is the handing out of and explanation of Mr Carrell's statement that we discussed this morning. I will ask for the edited version to be handed out, which I hope Mr Jenkins has had a chance to check.

MR JENKINS: I have indeed.

THE CHAIRMAN: This is entitled "Statement of Severin Carrell" this is C11.

MR ENOCH: Thank you very much. Could I ask the Panel to have at its fingertips bundle 6. What we have not done is paginate tabs 1 and 2 of bundle 6, but it may be that the Panel can do it as they go along, there are only about 20 pages involved.

THE CHAIRMAN: Was there one other handout that we were going to have?

MR JENKINS: There is, the waiver.

MR ENOCH: There should be two in fact, there is the waiver of liability document and the Fiona Hutson records. I am not quite sure how far we have got with that.

THE CHAIRMAN: We will come to it. If we have them now we might as well hand them all out.

MR ENOCH: Certainly. (Documents distributed). Whilst that is being done the Panel may like to take bundle 6, and just in the bottom right hand corner behind tab 1 number pages 1 to 15 which is the number of pages behind tab 1.

THE CHAIRMAN: You are going to lose me, Mr Enoch. I am sorry to hold you back but I have now got two more documents coming over my shoulder. The waiver of liability we will call C12 – I accept it has not necessarily come from your side – and the further documents relating to Fiona Hutson we will call C13. Whilst we are on this, the package I received first which we called C10 arrived with me and was not stapled together. It is also not paginated and I just want to be clear that everybody has got the same amount, that papers have not slipped off or anything. I have no idea how many papers we were supposed to receive then and how much you are going to rely on them.

MR ENOCH: I make it 19 at the first count.

THE CHAIRMAN: I have 19.

MR ENOCH: Can I move on to Severin Carrell.

THE CHAIRMAN: Yes, that is C11.

MR ENOCH: If the Panel members could very kindly have bundle 6 available to them, behind tab 1 there are 15 pages and it may be helpful to number them 1 to 15 in the bottom right hand corner and behind tab 2 1 to 12.

Dealing with what is being referred to in that statement, could I ask you to turn to page 3 of the statement and you will see the reference at the top of that page to SC3, which is the completed stage 1 of the erectile dysfunction consultation document. That document you will find at pages 6 and 7 behind tab 1. Then if you look at paragraph 7 of the statement you see the reference three lines down to stage 5; that is at pages 10 and 11 of tab 1. It might be useful to write against that on the statement the page reference.

Then in paragraph 8 of the statement you see reference at the end to SC5 which is a printout of stage 3, that is at tab 1, page 8. In paragraph 9, stage 4, four lines down, tab 1, page 9. Paragraph 11, the middle of the paragraph, the printout of the email, exhibit SC7, that is tab 2, page 1. The next paragraph 12, six lines down, SC8, tab 2, page 2. Paragraph 13, SC9, four lines down, tab 1, pages 12 and 13. SC10, referred to a couple of lines later, tab 1, pages 14 and 15. Paragraph 14 is reference to the hair loss treatment forms, Stages 2 and 3, SC11, Tab 1, pages 1 to 5. Why they were not at the beginning of the whole bundle I simply do not know.

Can I ask you to move on to paragraph 18 of the statement, the second part of it, at page 7 at the top? There is a reference to an email which is at Tab 2, page 3. Then paragraph 21,

> "On 5 March I emailed Dr Eden for a second time".

That is Tab 2, page 4. His reply, Tab 2, page 5, two lines down. Then,

> "I responded, requesting that he answer my questions",

Tab 2, page 6. Then an email to request a meeting at the bottom of Tab 2, page 8. The rest of the documentation in the bundle is not referred to in the statement; it is referred to in bits that have been cut out because they were later events. There is no objection to you reading them. They just put things into context.

I hope that that explains what each of the documents that you have in your bundle are, how they fit in and so forth, and I can only apologise again that that was not clear earlier.

THE CHAIRMAN: Just so there is no doubt in the future, paragraph 23 of my copy has something obliterated and then written on the top of it. I assume that the obliteration was in error and what is written on top was what was written underneath.

MR ENOCH: It is not, but it is a summarised version.

MR JENKINS: It makes it plain.

MR ENOCH: Otherwise the sentence would not have made grammatical sense.

MR JENKINS: You can be content that I am happy with the way it has been done.

MR ENOCH: Sir, that is the case for the General Medical Council.

THE CHAIRMAN: I turn to you, Mr Jenkins, but I have been given a hint that there might be some legal argument.

MR JENKINS: Yes, can I tell you the substance of what I want to do. I am going to call Dr Eden and I am going to take you through his CV. I am going to take you through his correspondence with the General Medical Council from 2001 and thereafter. Then I am going to ask him all about e-med. What I was proposing was that I should take you through what happens if one logs on to e-med. You may or may not have done that; I do not know. But I would like you to see the process of what happens if anyone does log on to e-med.

There have been certain changes to the website over the years and I would like you to hear what those changes have been. I cannot take you through the experience of what it was like in 2003 to log on, because I cannot do that now. There have been some changes to the website but I hope it would be of some benefit to you to see how the website operates. As far as the experience of the person who has logged on and is logging into the website is concerned, that experience has changed very little from the time that each of the patients with whom you are concerned logged on. They fill in information. They fill in questionnaires. They give details of themselves and what have you.

There are certain features of the website that are just the same as they were for the patients. That is what I would like you to see. Plainly at this stage of the proceedings it is for you as a Panel to hear evidence to help you decide one way or the other the outstanding heads of charge. I would choose, if it were open to me, to go a little way beyond that so that you hear evidence as to what the website currently contains. I do that because, plainly, within the course of the hearing you are going to have to decide whether the doctor's fitness to practise is impaired and, if so, whether any sanctions should be imposed, and I would prefer to call Dr Eden just once, rather than call him again.

I also have, as you know, Professor Sheikh, who sits alongside me, and I would like to ask his view of the present approach taken towards certain types of patients by e-med. I would like to call him after I have called Dr Eden, so you have seen Professor Sheikh hear the evidence Dr Eden has given. Professor Sheikh comes from Scotland. IF it is possible I would like to call him once and once only. It is possible it could be broken up so that I just deal with the factual questions pertinent to these patients, the ones where there are still outstanding allegations. Then at some future stage of the case I could go back, call Dr Eden again and ask him about the changes that have been made since the various patients with whom you have to deal were dealt with. But that would be a course that involves a fair bit of repetition. It would mean I have to get Professor Sheikh back down so that he can hear the evidence of the changes that have been made, and then call him a second time. I would not choose to do that.

Mr Enoch tells me that he objects to me eliciting now, at this stage of the proceedings, what changes have been made to the website and the way in which patients are dealt with. His objection is, as I understand it, founded upon the proposition that you only have to decide the outstanding heads of charge at this stage. Mr Enoch, you will know, in the course of his case, through Dr Havelock, has told you about the 2006 guidance given by the General Medical Council. You have been given *Good Medical Practice*, the most recent version, which of course post-dates the treatment of these patients. You have been given the most recent document on good practice in prescribing, which again post-dates Dr Eden's treatment of each of these patients.

Mr Enoch did that for perfectly understandable reasons: because he wants you to see the present position. That is what I seek to do. I do not anticipate it will be a major diversion at all for you to be told what changes have been made to the website whilst I am going through matters with Dr Eden, so I would seek to do that in the course of his evidence.

That is the course that I propose. It would not be unusual for the Panel to hear slightly more evidence at this stage from the practitioner, or on the practitioner's behalf, and you as a Panel would be able to sift through those parts of the evidence that are given which are relevant to the factual heads of charge that are outstanding and those that might be relevant to a later stage of the proceedings. That is what I propose to do. Again, Mr Enoch has done something similar. I suggest it would be entirely appropriate for me to give you the up-to-date position, just as Mr Enoch has done.

THE CHAIRMAN: Before I turn to Mr Enoch – obviously he will have an opportunity to respond – can I be clear, when you propose to effectively demonstrate e-med to us, will you be able to be absolutely clear which bits of what we see today in 2003 were not as we see them today.

MR JENKINS: I hope to be absolutely clear, yes. Whether or not I am absolutely clear is, of course, a matter for you, but I hope to be absolutely clear.

THE CHAIRMAN: Mr Enoch?

MR ENOCH: Sir, a very reasonable application put, if I may say so, in a very attractive way, as is Mr Jenkins' custom. I do not want to be the villain of the piece and I do not want to cause inconvenience to anybody, can I make that absolutely clear? But the rules contemplate a separation of stages. They do so for a reason. They do so to focus the Panel on the

appropriate decision-making that they have to undertake at a particular stage in the proceedings.

I think Mr Jenkins, in his application, concedes in terms that he is asking you to allow more evidence to be adduced at this stage than the rules contemplate. I think he has made that pretty clear. I do object to that, I am afraid, not because I wish to cause him or Mr Sheikh or anybody else inconvenience, but because it would be inappropriate for you to be distracted at this stage by matters which are essentially matters of mitigation relevant to stage three. There is ample authority. I need only mention the case of *Campbell*, with which no doubt this Panel are more than familiar, which is quite clear that matters of personal mitigation should not be heard at this stage. That has been gone over time and time again.

What this website is like in 2007 is not in the least bit relevant to what was going on in 2002-2003. We know that there have been changes. We know of one from Karl Landeg, the warning that appeared two months afterwards. It would be very easy for the Panel, if I may say so, being human – though they are a professional Panel, human nonetheless – to be drawn into what they see on the screen now. We have very clear, unequivocal evidence about what the situation was then. We have the printouts and all of the records that have been in Dr Eden's records in relation to these patients. You can see precisely what form needed to be filled in then, precisely how it was filled in and every single email that was exchanged thereafter, including the repeat prescription form and the advertising material that went along with it.

What you can see now, including fairly major changes that may have occurred since these complaints were made, are not going to help you in any way shape or form to understand what the position was then. It can only serve to cloud the issues. It is clearly designed, quite understandably but at the wrong stage, to cast the doctor in a better light in the sense that he has improved matters and changed things as a result, no doubt, partly because of what has happened and what has given rise to this case.

Mr Jenkins suggests that I have adopted a similar approach and done a similar thing by introducing 2006 General Medical Council guidelines. That is completely wrong, if I may say so with respect, because all I sought to do was, through my expert witness without objection from Mr Jenkins, to try to make clear what should have been common sense to any general practitioner back in 2003, and I asked him what guidelines were available then. He talked about the American guidelines, which have been no more than enshrined in the *Good Medical Practice* guidelines that were published subsequently. So my adducing evidence about 2006 guidelines has got nothing to do with and is not analogous to in any way what Mr Jenkins is seeking to do on his client's behalf now.

I have no doubt, and I entirely accept, that it is done for proper motive, and to save time. But looking at the saving time practicality point, I ask rhetorically why on earth cannot Professor Sheikh give evidence on both issues tomorrow, at both stages if necessary. He could give evidence before Dr Eden on the changes at stage two were it to be appropriate, and would not need to be delayed very long at all.

That is all I wish to say. I emphasise that I am not trying to be difficult. Normally I would do everything in my power to assist in the practicalities, but I do so having carefully thought about it. There are not that many heads of charge that remain outstanding in terms of factual

allegations and it is very important that the Panel be allowed to focus on them. This is irrelevant material.

THE CHAIRMAN: If I understand clearly what you said, you believe that this should go towards stage three. So you see it as personal mitigation and not contextual mitigation.

MR ENOCH: I think I am reading into your question the rhetorical question: is it relevant to stage two?

THE CHAIRMAN: You did in the latter part mention stage two and I just want to be clear which part you think it goes towards.

MR ENOCH: I would say stage three, because in order to determine stage two you equally do not look at personal mitigation, for example, or things that have been done since. You focus on what is in the heads of charge.

THE CHAIRMAN: Mr Jenkins?

MR JENKINS: Sir, my understanding of the case of *Campbell* is that it relates purely to personal mitigation rather than to the practitioner's practice. I wonder if I can ask a question of Mr Enoch from across the room, as it were. Is there any objection to the Panel being given a tour, to logging on to the website with Dr Eden's help and going to the secure pages, which otherwise they may not have access to?

MR ENOCH: Again my answer is: what is the relevance? That is my answer in rhetorical question form. How does it take matters any further than by looking at the printouts we have got? What is there on the website now that elucidates or amplifies material that is there to assist you in deciding the factual outstanding heads of charge?

MR JENKINS: Sir, I am going to take you to the rules, I am afraid, if I may.

THE CHAIRMAN: I think you have to because my next turning will be to the Legal Assessor. So I think it is appropriate that you do that now.

MR JENKINS: I do so with a slightly muted apology. Can I take you to Rule 17? Rule 17(1) reads as follows:

> "A Fitness to Practise Panel shall consider any allegations referred to it in accordance with these Rules and shall dispose of the case in accordance with",

and various sections of the Medical Act are listed. Rule 17(2) sets out the order of proceedings at the hearing, so we have reached (h):

> "the practitioner may open his case and may adduce evidence and call witnesses in support of it".

That is what the rule says. It does not limit the evidence that I can call. The Panel are considering the allegations that are listed on the Notice of Inquiry. That includes the statutory allegations and includes the allegation that Dr Eden's fitness to practise is thereby impaired.

So there is no restriction on the evidence that I can adduce or call witnesses in support of at this stage. Can I take you later on in the same document to the rule that deals with evidence, Rule 34? Rule 34(1) sets out that, subject to paragraph (2),

> "A Committee or a Panel may hear any evidence that they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law".

Rule (2) is,

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

It would be my submission that to take you on a tour, if I can call it that, using the internet, that is plainly relevant. It would certainly be admissible in any criminal court in England or Wales, and you should find it part of your duty to make due inquiry into how the internet works in this case. I suggest you should find it fair and relevant to the case before you.

How could you properly deal with the case otherwise, without following the route that each of the five patients that you have heard of had followed? There is actually quite a lot of information on the website, and I suggest if you are to approach this case you should at least know what is available. It would be very unfortunate if a Panel in these circumstances disqualified itself from making due inquiry as to what route the patients had gone down; what information was available for them on the website, and what information they saw, or might have seen, about Dr Eden, because there is information about him on the website as well.

There is quite a lot of information on the website and I suggest that it really should be part of your task to learn what is available; not read every web page but at least to know what is there.

Mr Enoch objects to Dr Eden being able to say at this stage what is new, what has changed, so he is then obliged to say, "Well, you should not allow yourselves to go on a tour" because it would be nonsensical for you to go on tour to know that this is the position today and you not being allowed to be told, "Well, this was not there two years ago, or three years ago, or four years ago." I say you should certainly find it within the scope of your inquiry to see what is on the website. Again the general approach is exactly as it was for each of these patients. Certain aspects of it have changed but I say it should properly be part of your inquiry to take the tour, if I can use that expression.

I repeat, Mr Enoch has brought you up-to-date; he has told you about guidance from the GMC that post-dates Dr Eden's treatment of each of these patients.

Can I invite you to approach the case by imagining a slightly different scenario? Imagine you were inquiring into a case where a doctor had treated a patient in a way that was said to be inappropriate and the doctor was giving evidence on his own behalf about how he had treated the patient, would the doctor be forbidden or not allowed to say, "Well I have subsequently learned that the way in which I was treating the patient then is wrong, I have studied some

books (or been on a course or something of that nature) and I now accept that I did not treat the patient quite as appropriately as I should have done". If Mr Enoch is right in taking objection as he does the doctor would not be allowed to say that in giving his evidence before the Panel at this stage.

I agree entirely, it may well be that if the doctor in that scenario had been on a course that that may be relevant at a later stage – I would say the second stage rather than the third – but that should not be a reason for disbarring the doctor from giving his evidence in one go at this stage of the proceedings.

That is my response to Mr Enoch's objection.

MR ENOCH: I think I am probably entitled to reply just on the rules being put before you, if I may.

It was said that the right of the defence to call evidence on behalf of the doctor at this stage is not limited in any way. Rule 34(2) of course does limit it. It limits it to evidence that would be admissible in a criminal court, subject to the overriding principle of due inquiry subject to advice from the learned Legal Assessor, and so your first port of call must be whether or not it is admissible in criminal law, and the basic principle of whether it is admissible in criminal law is is it relevant? Is it relevant to the issue that you have to determine? That is my principle objection. I say it is not. If it is not then the only way you can admit it, because it is mandatory that you shall not unless – if it is not admissible in criminal law, the only route by which you could admit it thereafter would be if you were satisfied that you had to admit it in order to make due inquiry, and that could not possibly be the case, in my respectful submission, if you thought that it was irrelevant to the issues you had to determine.

That is all I say about that particular rule. I do not say anything about anything else; I do not think I am entitled to.

THE CHAIRMAN: I will turn to the Legal Assessor and ask him for his advice.

THE LEGAL ASSESSOR: The question is, you have been directed to Rule 34 and the uppermost words must be "fair and relevant", and what went on when these patients contacted Dr Eden on the website is, of course, very relevant, and it would be unfair – but it is always a matter for you – in so far as it might sound as I give this advice that I am telling you what is fair and unfair, I do not intend to, that is a matter for you – but it would, as a general principle, be unfair to exclude relevant evidence that a doctor on trial for impaired fitness to practise wished to adduce part of his case.

As far as the differences between the website now and then, providing you have evidence as to how it differs now from how it was then, that would assist you in knowing exactly what these patients and journalists encountered, providing the differences are made clear to you.

My advice to you is that a visit to the website would be in accordance with the best evidence principles because one should always rely on the best evidence. Printouts, as Mr Enoch points out to you, would not be entirely in compliance with the best evidence principle when you could actually visit the website, in so far as it is still the same. These are documents that were printed out at that time and you do not know what other pages may or may not have

gone between in the various engagements between the patient and journalist and/or the doctor.

It is not uncommon, indeed, it has my experience over the last three cases where I have been the Legal Assessor, lengthy and complicated cases, not entirely dissimilar to this, for stage one and stage two, the evidence before the Panel to be mixed, and it is quite clear I can give you directions – and, of course, I retire with you when you consider your findings of fact – I can advise you at any stage as to what is not relevant to that stage and is relevant to a subsequent stage in the proceedings.

It is entirely a matter for you whether you think it is appropriate to hear evidence now, some of which it would appear (but it is a matter for you) is relevant to the finding of fact, and some of it may be relevant at stages two or three if you get that far. But, of course, you may not at this stage hear evidence that is purely personal mitigation but the rules do not preclude you hearing evidence of a mixed character which could go to either stage or stage two: it would preclude you hearing evidence which is exclusively for stage three at this stage, but the decision, I emphasise must be yours.

THE CHAIRMAN: Do either counsel want to come back on that advice?

MR ENOCH: No.

MR JENKINS: No.

THE CHAIRMAN: Can I just come back to my question, Mr Jenkins: the way you intend to explain to us, if you are allowed to bring up the website, what it was like when these events took place. This is based upon what you understand from questioning Dr Eden?

MR JENKINS: I have got a document which carries dates on various changes to warnings put on the website and I am proposing to show you that.

THE CHAIRMAN: In that case, the Panel will consider this in private.

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

STRANGERS HAVING READMITTED.

DECISION

THE CHAIRMAN: Mr Jenkins, the Panel has considered your application to demonstrate the e-med website as part of the defence case of Dr Eden and adduce evidence relating to its operation. You also indicated you would wish to question Professor Sheikh, your expert witness, on matters which might also include issues usually expanded upon at later stages of the proceedings. It has noted Mr Enoch's objection that the evidence in both respects would be irrelevant and should properly be considered at stage two or three of these proceedings.

The Legal Assessor has given the Panel advice in relation to Rule 34 of the Procedure Rules and indicated that the Panel must consider the wording of this rule carefully:

The rule states:

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

(2) Where evidence would not be admissible in criminal proceedings in England, the Committee or Panel shall not admit such evidence unless, on the advice of the Legal Assessor, they are satisfied that their duty of making due inquiry into the case before them makes its admission desirable."

The Legal Assessor stressed the importance of fairness and relevance.

The Panel considers that it is a professional Panel and, with guidance from the Legal Assessor, will be able to separate evidence to be used at all stages of the proceedings. With regard to the accessing of the website, the Panel consider that, providing you make clear how the website looked at the time these incidents took place, it will assist the Panel to look at it as it is now. This is in accordance with the "best evidence" principle, as advised by the Legal Assessor.

In relation to the evidence of Professor Sheikh, the Panel has concluded that it will be able to separate any evidence that he might give in relation to stage two of the proceedings regarding impairment, from the evidence in relation to stage one. However, it wishes to make clear that, in accordance with the case of *Campbell v. GMC* [2005] EWCA Civ. 250, it will not accept evidence relating to stage three, that is to say personal mitigation in respect of any sanction, at this stage.

The Panel has concluded that it would be both fair and relevant to admit the evidence in accordance with how you outlined its presentation, and is satisfied that, in making due inquiry into the case before it, the admission of website-based evidence is desirable. The Panel has also concluded that it is acceptable in the circumstances of this case to receive Professor Sheikh's evidence, including evidence that may relate to stage two, at this stage.

The Panel therefore accedes to your application, Mr Jenkins.

There are copies of that to come out, and there are two matters of housekeeping I would like to deal with now. I have realised that at no stage have we actually handed out *Good Practice and Prescribing Medicines 2006*. We have those copies and will issue them now. (Same handed and marked as C14).

I propose that we adjourn now. Let me make clear, before you rise, Mr Jenkins, this is primarily to allow you to talk to Dr Eden to ensure that the various differences can be clearly identified when you come to it. However, I wish to make clear that we will start at 9.30 and expect to begin at 9.30.

Are there any points you want to raise?

MR JENKINS: Sir, no. Can I check that the Menscare services waiver of liability has gone before you?

THE CHAIRMAN: It has.

THE PANEL SECRETARY: It is C12.

MR JENKINS: I would benefit, sir, if you were to break off now. I have my own housekeeping to check, and I have all my "C" numbers in order, and I hope we can move on at 9.30 tomorrow.

THE CHAIRMAN: Mr Enoch, are you happy?

MR ENOCH: Yes, sir.

THE CHAIRMAN: We will adjourn now until 9.30 in the morning.

(The Panel adjourned until 9.30 a.m. on Thursday, 15 February 2007)