Medicolegal

The Gee case: a third expert gives evidence for Dr Gee

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Last week the court heard the evidence of a third endocrinologist called on behalf of Dr Sidney Gee in his libel action against the BBC. Dr Terence Wilkin, senior lecturer and honorary consultant in the department of medicine at Southampton General Hospital, told the court that he had treated obesity since 1979, both at Southampton and in his previous position as associate professor in endocrinology at the University of Montpellier in France. He had received his MD for a thesis entitled "Thyrotoxicosis: the influence of surgical treatment and the subsequent control of thyroid hormones."

Dr Wilkin described his programme for the treatment of obesity at Southampton General Hospital. He explained that the hospital had a metabolic ward equipped and staffed to take measurements very precisely and frequently. For each patient the minimum energy requirement, or the lowest energy intake that would maintain weight loss, was determined. Then the patient was put on a diet of 300 calories less than that figure. This was adequate to produce a weight loss sustained over a long period of time but not sufficient to induce the metabolic reflex and fall in serum triiodothyronine concentrations of which the court had heard in recent weeks. A number of patients had, over 18 months, lost 60 or 70 kg.

Michael Beloff QC, leading counsel for Dr Gee, asked Dr Wilkin about the symptoms allegedly experienced by Mrs Day, who had started taking Dr Gee's course of tablets on 6 October 1982. He said that Mrs Day had apparently made no complaint of any kind until 12 January. Dr Wilkin replied that if a person became thyrotoxic as a result of the administration of thyroid hormone any symptoms would be expected within a few days of starting the tablets. It was most unlikely that any of the symptoms she mentioned to her general practitioner's partner on 25 May, apparently 25 days or more after she stopped taking the tablets, were related to the thyroid hormone.

Mr Beloff said the BBC's case was that thyroid extract given in doses sufficient to increase the pulse rate to 120 beats/minute or more increased the risk to Mrs Day of cardiac death. Dr Wilkin said he did not think that any of the evidence he had read suggested that the amount of thyroid extract given to Mrs Day had in any way threatened her life from the point of view of cardiac death. He did not think the diagnosis of thyrotoxicosis could be substantiated at any time. There were symptoms consistent with it, but never the combination of symptoms on which the diagnosis could be made clinically. He had seen no evidence in the papers that established that Mrs Day was nearly killed by the treatment, or put into such a clinical condition as would justify that description, nor had he seen anything in the documents that suggested that Mrs White had been made thyrotoxic. With regard to Mrs Falconer, he said that in his view there were insufficient signs and symptoms that in combination could signify thyrotoxicosis.

Asked whether he considered that a condition of clinical thyrotoxicosis could exist without signs or symptoms, Dr Wilkin replied

that thyrotoxicosis was a clinical condition in which certain signs and symptoms were associated and a combination of these symptoms and signs when present in sufficient number constituted that diagnosis. More recently published reports had indicated that there might be changes in heart efficiency associated with a rising thyroid hormone concentration in the earliest possible stages of what might become clinical thyrotoxicosis, but no normal practising physician would be expected to have access to that sort of information and that sort of measurement.

In Mrs Malone's case, Dr Wilkin said, he did not think there was any suggestion of either clinical or biochemical thyrotoxicosis. The problem seemed to be one of quite severe and progressive obesity with which she was finding it exceedingly difficult to cope.

Dr Wilkin told the court that he treated patients for temporary hypothyroidism after surgery for Graves' disease with 80 µg triiodothyronine a day over 12 months, sometimes longer. In every group two or three had the drug withdrawn or the dose reduced, but taken overall they had not exhibited signs of clinical thyrotoxicosis. He said he still used the regimen and attached no danger to 80 µg. The patients in his study averaged 64 kg in weight. The dilution of thyroid tablets in obese patients was much greater.

Dr Wilkin said that thyrotoxicosis could not be properly diagnosed merely by reference to the serum thyroid hormone concentration. Thyrotoxicosis was a clinical, not a biochemical, state. It was not generally a life threatening condition. Most patients were quite able to wait one, two, or three weeks to see a consultant physician. It was no more serious or less serious if the cause happened to be exogenous rather than endogenous.

If the dose and the patient were properly monitored, Dr Wilkin said, there was no risk attached to administration of a suppressive dose of exogenous thyroid. He thought that perhaps thyroid hormone had fallen out of fashion because of abuse. There were several drugs that had fallen out of use and then come back into use again—digitalis and corticosteroids, for example. He considered there was no warrant for the charge made by the BBC that Dr Gee had been criminally or grossly negligent in the use of his drug treatment.

Cross examined by Andrew Rankin QC, leading counsel for the BBC, Dr Wilkin said he was suggesting that thyroid extract, where it was used prudently and well supervised, had never been a dangerous modality. What he thought had happened was that over the past 30 years it had been abused by a large number of people who had not used it properly, and as a result textbooks and pharmacopoeias now warned strongly against its use. He admitted that he did not know of anyone in the United Kingdom who used thyroid extract for obesity apart from Dr Gee. He himself had not, in treating obesity, used drugs of any sort.

Mr Rankin put it to Dr Wilkin that in an article on subthreshold dieting he had made the statement: "Thyroid hormone treatment, however, is potentially dangerous." Dr Wilkin said he agreed that it was potentially dangerous if it produced thyrotoxicosis to an extent liable to threaten the patient's health. In a young person it was not in itself inherently dangerous, but in some people who would respond adversely to thyroid hormone it would be dangerous.

Mr Rankin said that one of the striking things to anybody in this

case was: if thyroid hormones were effective and safe in the treatment of obesity why were they not indulged in? Dr Wilkin said there was still a very live interest and experimentation with thyroid hormones and it might be that when their application had been worked out more carefully they would come back into vogue for use by specialists. There were now very different types of treatment available, for example, for cancer of the bone marrow, which only specialists used because of the potential danger. If their use was widespread throughout the community of general practitioners there would be a catastrophe.

Dr Wilkin agreed that in a practice where 90% of the patients were obese and therefore at risk of being diabetic it would be reasonable to do routine urine tests and to inquire into a family history of diabetes. It would also be reasonable to be mindful, in giving drugs targeted on the heart, of the possible damage to someone predisposed to a heart condition. He agreed that it was desirable that the NHS practitioner should know that his patient was getting atropine, amphetamine, and thyroid extract, and that there was a risk that a doctor without that information might give drugs that would interact with other treatment the patient was receiving.

Mr Rankin said that if witnesses who were to give evidence on behalf of the BBC were right about the effects of atropine, there was the curious situation with Dr Gee's treatment that those patients who had their thyroid glands put to sleep might have their sympathetic system stimulated by the excess of thyroid hormone and dexamphetamine and at the same time be given atropine, which blocks the para-sympathetic system. Assuming that to be so, he asked, would Dr Wilkin agree that it was a wholly undesirable form of treatment? Dr Wilkin replied that if all three drugs were active in the blood stream and producing clinical effects he thought it was undesirable. They would all tend to stimulate the rate of the heart.

On the possibility of thyrotoxicosis in Mrs Day, Dr Wilkin said

he was not terribly impressed with the figure of 156 nmol/l for the thyroid hormone concentration. The sort of concentrations he was used to seeing in patients with clinical thyrotoxicosis who required treatment were around 250 or 300 nmol/l.

Mr Rankin referred Dr Wilkin to an article by Bell that showed an increased heart rate in normal individuals given 150 and 200 µg thyroxine daily who were not clinically thyrotoxic. Dr Wilkin said he accepted that there were detectable and statistically significant changes, but the rise in heart rate was minimal. Mr Rankin asked whether it could be concluded from the findings that if giving thyroid hormones produced an increase in the individual's normal level he or she might sustain changes, for example in heart rate, even though on a laboratory analysis that individual would not be outside the normal range. Dr Wilkin agreed, but emphasised that the increase was a small one.

Asked about the case of Craig Chaplin, an 11 year old boy who received Dr Gee's drug treatment, Dr Wilkin replied that childhood was the least desirable time in which thyroid hormone should be used. He added that there would have to be some imperative need before he could justify giving a drug such as diethylpropion, which apparently had side effects that might suppress growth, in a boy entering his growth phase.

Moving on to Mrs Falconer, who died at the age of 34, Dr Wilkin agreed that she had manifested symptoms consistent with thyrotoxicosis. But her doctors had regarded her free thyroxine index of 200 against a laboratory high of 181 as "suggestive but not conclusive." He agreed that it was potentially hazardous to produce raised triiodothyronine concentrations in a person who was atheromatous. If it was monitored and the patient was not thyrotoxic, if the heart was not being overly stressed by the treatment, he did not see it as dangerous. But it was potentially dangerous because if none of these things were done the patient might one day wake up in heart failure.

Medicine and the Media

THE PUBLIC IS becoming sceptical about medical advice on diet. Bombarded with advice (much of it conflicting), made to feel guilty about eating foods previously promoted as healthy (butter, eggs), encouraged to be obsessed with "natural foods" (natural equals good), and told that the right diet will prevent everything from cancer to premenstrual tension, inevitably people are beginning to question the facts. The *Diverse Reports* programme "Eat Your Words" (Channel 4, 20 March) concluded that current dietary advice from doctors, particularly on fats, is based more on wishful thinking than science.

Clearly not intended as a balanced debate the programme gave little space to the "healthier eating" lobby: an unconvincing statement from the Health Education Council; a defensive minister of agriculture discussing the dairy industry; praise for the report from the National Advisory Committee in Nutrition Education (the NACNE report) simply because it offered quantitative advice; and an advertising man attempting to justify the Tesco healthy food campaign.

For the opposition Dr James Le Fanu attacked the undue emphasis on cross cultural and historical evidence for the link between diet and heart disease and emphasised the lack of evidence of benefit to the individual following a change in diet. He sees consensus reports such as that from NACNE as "pushing a line" and "scientifically corrupt." Perhaps such overstatement is in reaction to unproved assertions from the healthy food lobby.

The cautious wording from the committee on medical aspects of food policy (COMA report) was cited. One of its authors, Professor Michael Oliver, explained why the decline in ischaemic heart

disease in the USA could not be attributed to reduced fat consumption. The evidence for an association between fat and heart disease "falls short of proof" and the public "may be being conned." He advocated more research.

This was not a programme full of well tooled graphs. The serious arguments were interspersed with lighter comment. The *Guardian's* cookery writer cheerfully cooked high cholesterol food saying that eggs are essential for good cooking—although they may be bad for you if you eat 70 a week. Despite the doctors the British public still enjoys cream, and Randy's Donuts keep Randy in business in America.

The possibility that medically recommended diets may be harmful was raised, but there is little evidence on this. The programme also posed the intriguing question of what fuels the health food craze. Why in so short a time has corn become a national hero and butter an enemy? The question was unanswered, although there were dark hints at the influence of the healthy food lobby on politicians. (Apparently the Labour Party now advocates venison.)

Christine Chapman, who presented the programme, has done something to redress the balance of what is becoming an unbalanced public debate. And given a nudge to doctors to get more facts.—D J P BARKER, director, Medical Research Council Environmental Epidemiology Unit, Southampton.

CARLA LANE, author of *I Woke Up One Morning*, the new Thursday evening series on BBC 1, "has the gift . . . of writing in a human, funny and, occasionally, very moving way about what is