

“General optical council” (goc) -further evidence for this council itself to be “struck off.” the day-2 fitness to practise transcript!

Abstract

At last! An honest journal serves the public. Regulatory bodies protect the public? Not always. Best known is US Food and Drugs Administration (FDA) corruption. Dr David Graham forced Merck Corporation to withdraw FDA approved VIOXX, (139,000 heart attacks -30-40% fatal.) FDA defended Aspartame claimed “non-toxic” in completely unknown total daily “expected usage” since 1974, against New Mexico’s and Hawaii’s attempted prosecutions. Contaminating multitudinous foods, consumption is unknown. Metabolites, formic acid (cyanotic) formaldehyde (genotoxic, neurotoxic) and methyl alcohol (blindness) are never safe. Grandma seizures are suspected. A worse, hidden problem exists with the UK’s General Optical Council colluding with corrupt medicine, far transcending aspartame poisoning, trivial comparably, condemning every man, woman and child; even the unborn to heart attack and early death. Insidiously, originating in the 1920s, corruption grew, becoming open war between the author’s nutritional Optometry, and NHS doctors risking imprisonment for perjury, threatening cooperative doctors in 2003, defended by the GOC preserving heart attacks and NHS disease dependent jobs, also protected by censored, peer reviewed banned scientific papers and ‘NICE.’

Method: Public notices challenged authority.

Result: BBC forced to report. Fitness to Practise prosecution. Erasure from register. Perjured medical allegations revealed. The “faction” thriller “*Call Dr Sydney J Bush*” exposed more corruption. Honest doctors enroll for Bush’s life extending University, CardioRetinometry Doctorate, to end *bypass surgery for scurvy*. Sequel requested. 200 very happy patient’s written

Testimonials: A supreme world authority’s book praising author Bush; Bush recommended for Nobel Prize. Praised by another Optometry professor flying from America supporting medical journalist Dr W Gifford-Jones MD.

Conclusion: Bush’s succeeding in first getting himself struck off the register, timed to require reinstatement by the GOC from retirement, enabled Stage 2. Now impossible to ignore continued GOC, NHS and BBC malfeasance and corruption. GOC causing death demands disestablishment and update.

Keywords: explanation of terms and previous relevant work that will be encountered in this subject, providing a quick introduction to heart, arterial diseases, and e.g. glaucoma, also established as another of many deficiency disease of vitamin C, that should be the proper responsibility of optometry but have been actively suppressed for profit by pharmaco-medicine acting together

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Abbreviations: GMC, general medical council; GPC, giant cell papillary conjunctivitis; HDL, high density cholesterol

Introduction

This paper should be read together with three others in the series all mutually explanatory. They are found by Google under Sydney Bush MedCrave and are . . .

i. *CardioRetinometry® Reveals Rarely Absent, Focal Scurvy, Pathognomonic of Unrecognized Ubiquitous Fatal Occult Scurvy, Unexpected Heart Attack, Thrombosis, and Stroke Deaths.*

ii. *CardioRetinometry® Solves the Riddle of the Retinal Arteriolar Reflex: A Review of Experience with a Contact Lens Wearing Population, with Life Extending Possibilities.*

iii. *Nutritional CardioRetinometry® Reveals “Not So Dry Eye” (NSDE) Focal Occult Scurvy, Pathognomonic of Coronary Disease, Retinal Atherosclerosis and Neural Atrophy?*

This fourth paper concludes a brief series, opening the way for a vast literature on the new science that is expected to introduce a paradigm change in Western medicine from disease dependency to prevention, with enhanced status and very considerable economic

advantages to all graduate primary health care practitioners, e.g., osteopathic, medical, optometric and chiropractic consequent on giving the public its preferred "prevention rather than cure."

Terms

Arteriolar Reflex, a bright white line appearing to be a reflection from retinal blood vessels, often also from veins, with no proven explanation until author Bush 2017 demonstrated that it is an extension of the reversible intraluminal blockages accepted as present in Hollenhorst plaque at bifurcation of vessels. This has been ignored and, mysteriously, treated as if it is something else for the next fifty years e.g., variously claimed to be reflection from ensheathment of vessels or from the blood column (Brinchmann-Hansen and Heier). These are unsustainable as any reading of Hollenhorst's original earlier paper might have shown the peer reviewers.

Ascorbic acid (AA)

Acid form of vitamin C unsuitable for intravenous injection. Now potentiated in liposomal form. Credited for curing 60 consecutive cases of Polio treated by Dr Frederick R Klenner in 1948-49, who all walked out of his hospital. Described by him in 25 scientific papers all of which have been ignored by pharmaco-medicine preferring to search for some other patentable antiviral whilst millions died needlessly.

Atheroma

Lipoprotein alpha oxysterols, with platelets and plasma components sealing endothelial cellular separation (diastasis) and linings of vessels like 'putty'. Seals glass into a window frame to prevent air leaks. Without Lp(a) our vessels would not be watertight. Animals that make their own vitamin C (the goat can make 100 grams per day) don't have Lp(a). They don't need it because they can make collagen quickly to seal the leaks. That is how high blood pressure and raised heart rate strain the system.

BBC

British Broadcasting Corporation. A non-commercial broadcasting corporation paid for out of taxes and shown to have been "bought" by pharmaco-medicine. After being invited to the TV studio for interview by Peter Levy, to follow the news, the invitation was cancelled by David Snelling, the Northern Programmes controller who did not deny author Bush's accusation that the BBC was corrupt. Original BBC Radio Humberside nine minutes live interview by Alex Comfort was at 7.09am Monday 23rd August 2010.

"Optician"

The name for the then primary journal of British Optometry.

Bypass

Coronary heart artery bypass graft of a leg vein into the heart, to restore blood supply to heart muscle instead of dissolving blockages with vitamin C. Crude surgery for what Nature can dissolve away, but vitamin C cures and prevents so many diseases, that disease dependent doctors dare not use and thus admit it. CardioRetinometry® author's coined, registered term, to protect the name of the new science against abuse by those who wanted to hide it from the public by a snowstorm of 2,000 virus bearing websites launched against it in 2000 to suppress vitamin C knowledge and the fraud of heart bypasses.

Definition

Because of 100% correlation of heart arterial blockages with microscopically easurable equivalents in the retina of the eye, we are able to adjust the blood chemistry to either increase or decrease them without surgery, drugs. Or damaging X-Rays and actually see it in weeks to keep a photographic record of your health. Diastasis: Separation of (endothelial) arteriolar cells risking 'ungelling' and aneurysmic weakening of vessel walls unable to resist internal blood pressure; Disc: Head or papilla of Optic nerve where myelination of nerve fibres stops and the retina begins. It corresponds with the "Blind Spot" in the visual field, which is insensitive to light, corresponding with a finger tip of the e.g., Right hand for the Right eye, at arm's length, horizontally offset to the Right of one's fixation point by about 20 cms, first described by Bjerrum, in the 19th Century. FTP: GOC Fitness To Practise Hearing. Register. Introduced with the GOC by Act of Parliament 1958, four years after Author Bush started practice.

Hollenhorst plaque. The accentuated white or yellow reflex seen at the bifurcations of retinal vessels first described by Hollenhorst in 1961 but recorded in representations of the fundus oculi over 100 years ago. IOP. Intraocular eye pressure measured by tonometry. NOT the prime cause of open angle glaucoma which is a risk "marker." The risk "factor" is scurvy. This is not publishable in *Optician* journal. The author's last "vitamin C" paper was rejected for its "slant." Like the GOC there is a need for a new journal and an entirely new GOC. First shown to be a deficiency disease of vitamin C by Virno et al. in 1966 confirmed by Bioetti immediately afterwards and ignored and suppressed ever since by Pharmaco-Medicine. These researchers used doses of ascorbic acid of 30 grams per day but shortly afterwards, Official Medicine decreed that 2 grams per day was the "Upper Tolerable Limit" and committed many people to blindness deliberately. This accusation is made because the only reason why the Rome University Eye Clinic embarked on the 30 grams per day was in the hope that the osmolarity of the vitamin at high but physiological strength, would succeed where all medications had failed to control the progressive blindness. Prof Erickson credit Prof Bush with curing her own glaucoma using the same prescription, in the book "Live Longer, See Better" which she wrote at Prof Bush's suggestion for the new doctorate in CardioRetinometry degree for qualified doctors and Optometrists. Unfortunately, the latter have shown no interest.

Klenner Dr Frederick R Klenner MD., FCCP., was the first to cure people with Polio in 1948-49 in Reidsville N. Carolina. With oral and injected vitamin C. His 60 patients all *walked* out of hospital. All the other treated by the other doctors either died or were paralysed for life. After lecturing the American Medical Association (Like Dr Bush lectured the >British Medical Association) He received no applause. Frustrated after publishing 25 scientific papers that were ignored, describing cures for every kind of snakebite and fever and insect and plant allergy, he stated "The doctor would allow the patient to die, rather than admit the power of vitamin C beyond the range of a vitamin. Lp(a) Lipoprotein (alpha) LDL = Low Density Cholesterol. No other animal has the amount in the bloodstream that humans have. The Biblical injunction to the Jews to remember the 7th day to keep it Holy and refrain from work, appears to be an extra safeguard for the cardiovascular system after God withdrew from humans, the life expectancy of Methusaleh's (400 years) and said (Genesis 6:3) that our days will be 120 years. CardioRetinometry from an early age suggests that this is to be expected.

MI: Myocardial Infarct. Loss of blood to a portion of heart muscle due to thrombosis in a coronary artery. Often immediately fatal. The most common cause of sudden death; NaAsc: Sodium L-Ascorbate only form that should be used for intravenous injection. NHS the United Kingdom's national Health Service. Described by Dr Walter Yellowlees as a medical service because it ignored the need for the fence round the top of the cliff, preferring to put increasingly Hi-Tech ambulances below. (Mackenzie lecture Edinburgh RCGMP 1978.). NICE: National Institute of Clinical Excellence. Selectively regulates from censored permitted research papers. It is a misleading name for a restrictive organization. NSDE "Not So Dry Eye" false "Dry Eye" cause of contact lenses being abandoned. The condition in which patients complain of "dry eyes" whilst possessing an adequate tear prism.

Optometrist: A registered protected name for an Optician specializing in the detection and correction of errors of the binoculars, both refractive and coordinative involving the extraocular musculature and the health of the adnexa, with the ability to detect, diagnose, and prevent diseases of the eye and the corpus humanus, especially in the case of deficiency diseases where systemic disease manifests in the eye (e.g. raised intraocular pressure, avitaminosis A (Bitot's spots) retinal atherosclerosis and systemic diseases, e.g. hypertension and incipient and chronic uncontrolled diabetes, all identifiable from the retinal microvasculature, and treatable as deficiency diseases by the Optometrist to prevent them. They range in nature from the detection, arrestation and even reversal of early (incipient) coronary arterial heart disease (thereby preventing coronary thrombosis, angina, peripheral circulatory failure and aneurysm) to the paralysis and risk of death from stroke. The vulnerability to these diseases and more e.g. cataract and glaucoma are well known. The degree of control and reversibility of such diseases or the tendency to such falls within the capability of the Optometrist, especially if trained and possessing the degree of Doctor of CardioRetinometry, who is expected to be instrumental in educating regarding and treating much eye disease, and referring to the medical practitioner, those beyond his ability to help.

PCT: The Primary Care Trust administering the NHS locally or regionally. This is a misleading name for a committee that cannot be trusted as events in Hull have proved. Pneumo-Tonometer: First supplied by American Optical Company in 1977 costing £6,500 with no support from the NHS or fee for its use, yet essential to protect UK population from blindness due to glaucoma. Author Bush published the first paper on a "Survey of 7,000 patients with non-contact Tonometry." In March 1979 ("Optician" Journal.) It disclosed approaching double the expected incidence of glaucoma. POAG: Primary Open Angle Glaucoma, the disease causing loss of sight primarily diagnosable in "low tension cases" only from demonstrable permanent loss of sight of characteristic portions areas of the visual field that can permanently reduce safety to drive vehicles creating "tunnel vision."

Scotoma: Old fashioned but effective glaucoma diagnostic - blind area of visual field; Tonometry: The procedure for measuring the internal eye pressure was practiced in 1955 author Bush, having abandoned medical studies to practice Optometry. He was the first UK Optometrist to practice Tonometry with a mechanical plunger type instrument purchased with the prize for best student to qualify in 1953 replaced in 1977 by the "air puff" non-contact tonometer. In March 1979 this was featured in the BBC News after he invested £6,500 in

the first electronic non-contact tonometer in the UK and published a paper on Glaucoma found in nearly 2% of 7,000 patients studied. Since the matters pertaining to this paper were first recorded, the latest development has been that medically qualified candidates are in the pipeline to qualify in CardioRetinometry to deliver Dr Bush's preventive care. The first is expected, with Dr Bush's training through the Cosmopolitan University and Institute of CardioRetinometry, to graduate with the extra doctorate in May 2017 and other are starting to register for 2017-2018.

The case for the urgent disestablishment of the present General Optical Council is presented with the recommendation that a new body be created, that serves a fully independent Optometry, no longer subservient to medicine, and updated to include an expanding role in public health to end coronary arterial type heart attacks, thrombosis, stroke, aneurysm, peripheral circulatory failure, and much more that it is confidently expected Optometrists with extra training will match and exceed the new skills now recognized by honest medical doctors as having been gained by Prof Bush in his new CardioRetinometry science, with Optometrists eliminating the need for cardiothoracic surgery for the simple deficiency disease they can identify, monitor and reverse, of Occult Scurvy. The problem facing the FTP hearing was simple. Politics changed it. It was a simple matter of risk to benefit ratio. It was completely ignored in the GOC FTP hearing of 2012 against author Bush. Not only was it ignored but, by claiming author Bush represented a danger to the public and had to be struck off the register the committee ignored over fifty obvious contradictions.

Principles ignored and abandoned by the GOC infected by medical dogma

At no point was the FTP committee prepared to balance any possible "risk" that Prof Bush's practice could pose to the public, especially in view of his holding the record for the identification of more glaucoma than any Optometrist in the UK, having been the first to introduce pneumotonometry and publishing his paper. This further advance By Prof Bush in Optometric health care was, instead viewed out of context with his 57 years of unblemished service and many advances introduced into Optometry all leading to improved health care. The GOC therefore is shown to have failed to give due attention and necessary consideration to the following required by the discovery of new science, urgently needed by the public

And answers are required as to why ...

- i. There was no proper assessment of risk to the public prior to the FTP hearing?
- ii. How wrong could the photographic evidence be?
- iii. Why was the GOC and its FTP committee intent of denying the findings of Michelson, Morganroth, Nichols and MacVaugh, regarding correlation of grades of retinal arterial disease with coronary arterial disease?
- iv. How important were the patients 200 written testimonials?
- v. Why was the satisfaction of Prof Bush's medical patients overseeing the development of the new science completely ignored??
- vi. Why were the optometric and medical authorities who flew from America and Canada ignored?

- vii. Why did the FTP committee never give weight to Prof Bush having been recommended for the Nobel prize for his discovery?
- viii. Why did the FTP ignore the evidence of the chairman of the British medical Association, Prof Bush's self declared highly satisfied patient of twenty years?
- ix. Why did the FTP committee not investigate how many satisfied doctors enjoyed Prof Bush's care and never objected to his notices claiming a cure for heart disease?
- x. How, if heart disease was being prevented at the incipient stage denied by the cardiologists, could there be any case to answer at all?
- xi. How, even if the heart disease were above Grade Zero on the cardiology scale and then reduced by CardioRetinometry, could the FTP justify its action in condemning this advance and risk doing more harm than good?
- xii. How, without a lay complaint, could this GOC action, be legitimate?
- xiii. Would Prof Bush not be in the position himself, of lying by omission if he declined to inform the public about this advance and its implications for prevention and cure of coronary arterial heart disease?
- xiv. Was Prof Bush, faced with threats and lies by the NHS Dr Butler and DrHancocks, not required by the need for honesty, to draw public attention to the matter in the only possible way remaining – through the windows of his practice?

An additional question remains that was not necessarily required of the GOC to answer but is of interest: Why did the local Hull Daily Mail, that faithfully reports lectures on domestic science and gardening, ignore this important meeting of doctors with Optometry on 2nd December 2009, when informed by Prof Bush, simply that the lecture had been given with no further details supplied? Would the editor not normally send his reporter to enquire in order to report it? Could the editor have been "asked" or even "ordered" by his very important NHS advertiser, not to publish this? Who else had a reason to keep the meeting secret?

Looking back on the events is it not now clear that the "striking off" of a high profile practitioner was purposed to act as a warning to the profession not to interfere with medical practice and the dogma that arterial disease is irreversible? In 1957 Dr George C Willis working in the Montreal's Queen Mary Veterans and St. Anne's Hospitals, selected 16 patients for an experiment with his new serial x-ray arteriography. It was a great success and Dr Willis published his results in 1954. Between 1954 and 2008 no researcher ventured to publish a similar paper in a major journal. We have had over fifty years of suppression. No funding for research and/or active suppression of efforts exactly as found with CardioRetinometry since 1999. Sixteen years in which author Bush has had to fund the entire fight against organized medicine which, by withdrawing his NHS contract, and then his registration, hoped to kill CardioRetinometry. This paper could be very long with a great deal of evidence presented and a hundred citations. The relatively recent work of cardiologist Dr Matthias Rath, and his photographs support the work of Dr Willis. It will be sufficient to provoke a full inquiry into the relationship between the general Optical Council and the General Medical Council; the relationship between the unique NICE organization, which is not at all nice because

it denies CardioRetinometry, and with the NHS corruption. It is sad that Dr Rath's X-Rays', like those of all cardiologists, can only show the reversals at risk of something like 2% more cancers. The reader should inform himself of the cures that are possible with vitamin C for many diseases claimed by medicine to be incurable. Much cancer, virtually all arterial disease, thrombosis, stroke prevention, no more coronary heart attacks except an occasional and temporary arterial spasm, and years of good health will not suit medicine or pharmacy wedded to disease. The new Medicine is Prevention: Real prevention, never before possible now becomes available, delayed by the GOC and NHS but it is coming as more practitioners are sickened of the corruption.

Who can stand seeing babies' legs chopped off due to preventable and curable meningitis? Who can tolerate famous entertainers thanking the NHS for getting them through hospital treatment for diseases, those same hospitals and the NHS actively caused? Who can tolerate the sickening collusion to sell newspapers of the game played between editors and pharmacy and the NHS not to mention manmade diseases without Which newspaper profits would plunge, unable to scream HOPE for this disease and that, knowing that every viral disease has already been cured by oral or intravenous vitamin C. Who is not sickened by children suddenly dying of anaphylactic shock, allergy that is preventable with adequate vitamin C and a harmless injection any school teacher can be trained to administer? Who is not sickened by people dying of carbon monoxide poisoning, when learning that carbon monoxide is instantly flash oxidized to harmless water and carbon dioxide, but there are no hypodermic syringes in the ambulances to enable on the spot treatment for victim, carted off in traffic and dying on the way to hospital or permanently injured in hospital because they refuse to or are ignorant of the best treatment with intravenous vitamin C?

The following questions require answers from the GOC and particularly those charged with the responsibility for its oversight. Taken so far as possible in their proper order The Questions all relate to the Fitness to Practice Hearing at which Prof Bush's goof name after 57 years of unblemished service, was restored to the register seemingly for the express purpose of enabling its then removal and the adverse publicity that is still seen worldwide on the Internet, thus presumably, aimed at damaging CardioRetinometry by attacking the credibility of its author. This was the ploy used by the decision making committee of the East Hull Primary Health Care Trust, now seen to be an ILL HEALTH care trust, dedicated if this case presented here is proved and accepted as dedicated to the preservation of ILL HEALTH.

Why was it not either emphasized or noted in the GOC record before the start of the proceedings of the Fitness to Practise hearing - - -

- i. That it was the GOC itself that had restored Bush to the register?
- ii. That Bush was in no need of registration being a full time teaching professor?
- iii. That 200 patients had testified to their satisfaction with Bush's care?
- iv. That the Council was incompetent to judge either the standards or quality of care given under the name of CardioRetinometry yet was willing to condemn it?

- v. That at best CardioRetinometry might represent a significant improvement in public health?
- vi. That at worst CardioRetinometry could do no worse than fail to diminish what NHS Hull had publicly stated on Buses and on the Internet, was the "above national average death rate for people in Hull"?
- vii. That the NHS *had promised "to cooperate with groups and individuals in addressing this problem."* That was a lie that author Bush proved. The NHS could do little more to obstruct author Bush?
- viii. That Bush had in fact demonstrated the principles of the care and how it was given, to the Hull Branch of the British Medical Association and that there is no medical argument whatever about the results or their benefit?
- ix. That the invitation had come from the doctors to address the doctors?
- x. That no doctor had suggested the photographic evidence was false?
- xi. That the cardiologists refused to attend although personally invited by the chairman?
- xii. That at the meeting at which Prof Bush lectured the British Medical Association for a full hour, no doctor had question his actions, suggested that the Optometrist was committing any crime or misdemeanor in giving extra care to his patients?
- xiii. Those doctors were his patients for contact lenses and were enthusiastic about the extra care that they themselves received?
- xiv. That Prof Bush was not asked if any of his medical patients for contact lenses, passing by the notice regarding heart disease cure, had commented on it?
- xv. That no doctor receiving Prof Bush's care did anything other than support and offers to help him?
- xvi. That indeed, he was lecturing the British Medical Association at the personal invitation of its chairman who was his patient and had seen the development of CardioRetinometry from the beginning?
- xvii. That if this doctor was satisfied why should the GOC decide that there was a case to answer for Prof Bush being a danger to the public?
- xviii. That the accepted route for publication of such developments in peer reviewed medical journals had been denied by medical policy leaving no alternative but a direct challenge to medicine seen by the BBC?
- xix. That there was not a single lay complaint from any member of the public or patient as required to avoid inter-professional rivalries?
- xx. That the only complaint came from members of the medical profession, who were not his patients? (This was emphasized at the funeral of internationally recognized dermatologist Dr CalmanKeskes when one doctor shouted out to all of them congregating after the service – "Here comes Sydney who wants to put us all out of work!"?)
- xxi. That in 2003 Dr Mark Hancocks had written untruths to the Council claiming falsely that Dr Bush did not have permission from Dr. Leen Witvliet to publish his name on information about CardioRetinometry but the Council failed in its duty to take action on this attempt to pervert the course of justice?
- xxii. Should it not have been entered in the record that the entire matter arose in 2003 because of a complaint to the primary are trust by a pharmacist, worried about losing sales of stations and had never been resolved by the GOC?
- xxiii. Should it not have been entered in the record that a previous objection to Prof Bush's recommending vitamin C had been thrown out by the GOC?
- xxiv. That in July 2008, Dr Sue Butler then head of the Hull NHS had insisted to Bush that he would not receive a new NHS contract unless he stopped telling patients that arterial disease is reversible?
- xxv. That this amounted to a demand that Dr Bush lie to patients?
- xxvi. That she had been warned by Dr Bush that this would be published in due course?
- xxvii. That she was handed in 2010, a copy of the book 700 Vitamin C Secrets with her demand to lie for the NHS on the back cover?
- xxviii. That Dr Butler was unable to sue for Libel because it was proved.
- xxix. That at the Fitness To Practise hearing she "Could not remember,"
- xxx. That at the FTP when Dr. Butler "Could not remember her threat" she should have been reminded by the solicitor to the GOC that her threat was printed on the back of the book 700 Vitamin C Secrets that was issued as evidence to every member of the FTP committee and to Dr. Butler herself the next day after it was published
- xxxi. That at the Fitness To Practise hearing when Dr Mark Hancocks was asked by Dr. Bush if he was an honest man, and he claimed that he was , but "could not remember" he should have been warned by the solicitor to the GOC that he was on oath to tell the truth?
- xxxii. Should he not have been warned that his untrue claim to the GOC in 2003, was on record when he alleged that Dr. Bush had not been given permission to publish Dr Leen Witvliet's name on his information?
- xxxiii. Should the FTP hearing not have been advised by the GOC solicitor that at the time the evidence that Prof Bush had been fully authorized By Dr Witvliet was in the record as submitted to the legal department of the Association Of Optometrists after which the GOC ignored the matter and did nothing.?
- xxxiv. Should Dr Hancocks have been warned by the solicitor to the GOC that he was on oath and that such a claim regarding his poor memory cast grave doubt on his own fitness to practice?
- xxxv. That only provocation by Dr. Bush in public notices, brought the opportunity to air the matter in a BBC radio interview in which the position was honestly and fully described on 23rd August 2010 at 7am?

xxxvi. That Dr Bush withdrew from the NHS before he retired?

xxxvii. That Dr Bush was and is entitled to practice CardioRetinometry without being a registered Optometrist?

xxxviii. That Dr Bush in claiming to "Cure heart disease" had established to his own satisfaction and that of his medical patients by their continued support, that he had the legal right to treat and reverse INCIPIENT coronary heart disease, before doctors admitted it existed, as correlated with the retinal vasculature at levels ignored as "normal" by the medical profession?

xxxix. That Dr Bush was effectively treating a disease that doctors claimed did not exist?

xl. That at the same time as doctors claimed it did not exist, it was and is killing as many people as cancer and is a prime cause of death before the age of 75 according to the British Medical Journals own statistics?

xli. That the public would not regard it as reasonable, to learn as Dr. Bush stated on BBC radio, that they can be suffering up to and including 49% blockage of all major coronary heart arteries and be classified as "normal" with no treatable disease?

xlii. That Dr Bush was able to equate this degree with Grade 2 of his scale and successfully prevent the atheroma becoming worse?

xliii. That Dr Bush could improve on that by actually dissolving atheroma?

xliv. That over half of his patients believed and were prepared to swear that it was the vitamin C that he was monitoring that was reducing their disease that doctors denied was there?

xlv. That the discovery was claimed by Dr W Gifford Jones to be a "Historic discovery worthy of the Nobel Prize" and he had himself benefited from it?

xlii. That Two American professors had flown to Hull to confirm the truth of the discovery?

xlvii. That one wrote a book for Optometrists about it?

xlviii. That this professor at the time of the pronouncement of the GOC's FTP findings, had also come to give evidence to the FTP committee?

xlix. That the chairman of the Hull Branch of the British Medical Association also approved of Dr. Bush's care and gave evidence to the committee accordingly?

l. That Dr Bush now teaches qualified medical practitioners of the USA and UK to complete the medical education they were unable to receive from medical schools funded in part by pharmacy?

li. That Dr Bush has since revealed a black hole in the medical archive where there are no papers on Scurvy?

lii. That Dr Bush has revealed corruption of the medical archive where papers on scurvy have been suppressed or rejected since 1958?

liii. That the General Optical Council has failed in its duty of care to study these public health related matters?

liv. That in striking Dr Bush off the register after 57 unblemished years of service, they failed to note that Dr. Bush, far from representing a threat, had actually held the record in the UK and Europe for the amount of glaucoma he discovered and was the first to not only start routinely measuring intraocular pressure but the first to invest £ 6,500 in the electronic tonometer?

lv. That Dr. Bush led the way without subsidy from the NHS and without a fee for this benefit to society?

lvi. That Dr. Bush was praised for his initiative in researching and publishing the results in 1979 by the BBC News?

lvii. That this effectively compelled all Optometrists to adopt the routine saving thousands from blindness due to glaucoma?

lviii. That Dr Bush, going where nobody had gone before, should not have been returned to the register against his will, should not have been struck from that register, now seen as an act of spite and political deterrence?

lix. That the GOC should be asked to explain why a practitioner was allowed to remain on the register and was not a danger to the public, who had actually caused blindness after failing to detect glaucoma very many times, the case being drawn to the attention of Dr Bush by another Optometrist offended by the injustice of the GOC's treatment of Dr Bush?

lx. That the GOC now be invited to respond to the above charges and admit it has proved unfit to serve the public by properly discharging its responsibility, its duty of care, and must accept its abolition to be replaced by a more honest and competent body?

lxii. That finally, the FTP hearing was weighted against Prof Bush also by allowing their witness Dr Frank Eperjesi to be in the room throughout and able to be primed on the material being investigated, This is alone grounds for a mistrial.

The discovery

Like others before it, the discovery was made whilst searching for something else. Glaucoma is a nasty, insidious disease, that people can have a long time before realizing that they have lost much of their side (peripheral) vision, essential for safe driving. A better and quicker way of diagnosing the condition was being sought, that would not require waiting for permanent visual field losses in a characteristic pattern to prove glaucoma was damaging sight. Author Bush even allowed himself to think that a Nobel prize might be awarded for a better diagnostic that avoided this risk. In order to achieve this retinal photographs were taken with progressively more expensive fundus cameras, none of which was capable of sufficient enlargement to detect the microscopic shift of the central artery and/or vein of the retina as they emerged from the disc of the optic nerve head as it entering the back of the eye and, like in a tulip, opening out to become the flower but in this case, the sheet of nervous tissue called the retina, like cling film sticking to the interior of a ping pong ball painted red on the inside.

Multidisciplinary scientists reading this may find the description either tedious or helpful. It had long been observed that in those eyes that were blind or nearly so, there had apparently been a movement of these vessels displacing towards the nasal side so it was called the "nasal shift." Enlargements using a photocopier with Polaroid® type prints were too coarse and the marriage of digital photography to fundus cameras was eagerly awaited. The first Topcon fundus camera to come to the UK was seized and Within 18 month's patience was rewarded with a change in the vessels that was completely different

from one that could be expected and was for a minute beyond explanation. As the patient became restless worrying, she was assured that everything was fine, whilst author Bush was hit by the thought, "what if all our teaching has been wrong?" The patient was handed over to the nurses and the author then dared to again address the thoughts that were starting to assemble in his mind. His immediate thought had been that if this was only explicable as a dissolving of intraluminal plaque, then it would have to be tied to Pauling-Rath theory of heart disease. He had then asked the patient if she had been taking the vitamin C advised to prevent infections and allergy. She had answered immediately that she had been taking a gram twice a day as advised.

The author then went to a quiet room and sat down to think before returning to study the before and after images. They were centered to be precisely overlapping, magnified highly and on flicker alternation showed that there was no movement whatever of the vessels, but a pronounced change within them. Again, the thought of a Nobel Prize for proving Nobellist Dr Linus Pauling's hypothesis kept returning. This discovery led to careful examination of all patients serving as a captive cohort willing to take extra vitamin C if it meant greater comfort and uninterrupted contact lens wear with less infections. Eventually another case and then more were discovered. Then after two years it was becoming automatic to find people's vessels losing the white reflex after a year on vitamin C and often a little improvement seen at 3 months. After nearly two years, and the absolute certainty from what they claimed and the photographic evidence, author Bush decided that there was no risk of another Pons- Fleischman debacle and decided to tell his medical patients who were immediately enthralled. Dr Witvliet was the first to pronounce the change as signifying life extension. We had no idea of the problems his enthusiasm was going to cause both of us.

References and final questions

References to this paper are shared with the previous three papers and do not need repetition. The events are described by the author as faithfully as memory and the documentation allow. The FULL transcript with important sections censored, is now hidden from sight away in the archives of the GOC behind a £2,000 barrier.

DAY 2 was the fireworks when I made it plain that this hearing had no interest in public health or medical suppression of the truth which in my humble opinion should have resulted in. No case to answer! Dr Eperjesi is shown to have no interest in what he is teaching Optometry students.

- What is the justification for hiding the transcript
- Could not, the transcript of the entire five days and the final judgment, of this vitally important GOC action, be easily and without expense, permanently on display on the GOC website?
- Does the GOC, for the very good reasons set out here, feel the need to protect itself by hiding the evidence?
- Are these matters not of the greatest possible importance to a public beset with what is seen now to be deliberately inflicted heart disease?
- Do the proven medical lies and threats not demand exposure to the public as is attempted here?
- Is the dogma of the NHS and GMC regarding minimal vitamin C not poison to public health?

- Should the wealth of Pharmaco-Medicine continue to made dependent on the ILL health of the public when real prevention is now possible with CardioRetinometry®?
- What is the argument against the reform of disease dependent doctoring?
- Can the policies of the GOC in limiting the advance of Optometry be tolerated having now been shown to directly threaten and be actually costing the lives of every man, woman and even many unborn children in the West?

Transcript of Day 2 !

FULL TRANSCRIPT OF Fitness To Practice Sydney J. Bush vs The UK GOC! BEFORE THE FITNESS TO PRACTISE COMMITTEE OF THE GENERAL OPTICAL COUNCIL GENERAL OPTICAL COUNCIL F (11) 21 AND SYDNEY JOSEPH BUSH (01-3828) SUBSTANTIVE HEARING Monday, 18 June – Friday, 22 June 2012 DAY TWO Tuesday, 19 June 2012

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Substantive Hearing: Sydney Joseph Bush (01-3828) Day Two Tuesday, 19 June 2012 [Hearing resumed at 10.00]

Ms Jones:

Good morning, everyone. I think we concluded yesterday with Dr Davies' evidence, and Mr Hamer was asked to consider whether we should receive R2 and I think it was CAD11 and there was a random page which we queried. Could you update us?

Mr Hamer:

Yes, of course, Madam. The Council have no objection to you receiving R2. I am grateful for you giving me an opportunity to think about it overnight. R2, your 47/49 additional questions, I am very happy for that to go in before the Council. It is not a document we particularly rely upon, but we are very happy for you to submit that as part of your case and I will obviously want to comment on it in due course.

Professor Bush: Which is R2?

Mr Hamer:

That is the document, Professor, you had attached to the book. So there is no problem on that. Dr Azubike raised page 286. We are slightly mystified. We think it should not have been there. It is a random page. It is in fact a document from Professor Bush. We think it was in the bundle in error. We don't particularly rely upon it. If Professor Bush wants to refer to it, I am quite content. It appeared to be attached to the evidence of one of the witnesses, although when she came to give her evidence she said it wasn't part of her email notice. Professor Bush may want to explain it either now or in due course. The other document was CAD11. We have tracked that down, and we have copies of it if David could distribute them. We suggest that they are inserted in at page 352(a) through to 352(i) and, hopefully, they will be hole-punched and can go in the bundles.

Mr Henley:

These will be referred to as C4. [Documents distributed]

Ms Jones:

Thank you.

Mr Hamer:

I am not going to take you through the document, Madam. It has been referred to by the witness and I leave it there for you to look at with your Committee.

Ms Jones:

Thank you very much for that, Mr Hamer, and if you would like to continue.

Mr Hamer:

I am not going to take you through the document, Madam. It has been referred to by the witness and I leave it there for you to look at with your Committee.

Ms Jones:

Thank you very much for that, Mr Hamer, and if you would like to continue.

Mr Swinstead:

Just before we go on, just so it is not overlooked, if R2 could be distributed as well. [R2 distributed].

Mr Hamer:

Our next witness, Madam, is Dr Sue Butler, and you will find her witness statement on page 1 in volume 1. DR SUE BUTLER, called and affirmed Examined-in-chief by Mr HAMER_____

Q. Good morning to you, Dr Butler.

A. Good morning.

Q. If you could address your answers to Professor Bush particularly, and also speak up because it is a large room and that would be helpful to everybody, so don't be afraid to shout. Are you Dr Sue Butler? A. Yes.

Q. Your professional address is not on the witness statement. Could you give your professional address?

A. I no longer practise.

Q. Your professional address at the time of these events.

A. My professional address at the time of those events would be The Maltings, Silvester Street, Hull.

Q. Thank you very much, and if you could go to bundle 1 and page 1, you will find a witness statement in your name. Do you have that?

A. Yes.

Q. Good. That is a statement dated 26 August 2011, and it runs for eight pages. Is that your witness statement and is that your signature on each of those pages?

A. Yes.

Q. Can I just introduce matters then; is it correct that from 31 December 2006 until you left the PCT on 31 December 2010 you were employed as the Medical Director at the Hull Teaching Primary Care Trust, now known as the NHS Hull PCT?

A. Yes.

Q. And is it correct that you also originally worked as a general practitioner? From 1982 you were a principal in a number of GP practices, and between 1992 and 1995 you were also a trainer and course organizer for GP registrars and did you first move into medical management when you became consultant in primary care development at South Leeds PCG, and in 2002 were you then seconded to a post as Medical Director to the Yorkshire Wolds 4 and Coast and East Yorkshire PCTs, and that post was then made substantive in April 2003. Is all that correct as set out in paragraph 2?

A. Yes.

Q. Is it also correct that as part of your role as it then was, as the Medical Director of the Hull PCT, you were responsible for the performance of independent contractors, including optometrists?

A. Yes.

Q. Could you then very kindly read into the record as your evidence starting at paragraph 4?

A. [Reads] "The PCT first became aware of concerns about Mr Bush in the winter of 2007 when a concern was raised by a practice manager about one of Mr Bush's services. This matter was resolved by the PCT Primary Care Contracts team. However, they informed me that there had previously been anxiety about the way in which Mr Bush promoted his services both in the window of his practice and in the "Yellow Pages" telephone directory. I discussed this matter with the PCT ophthalmic advisor who in turn discussed the issue with the General Optical Council ("the GOC"). The GOC advised that we should conduct a local investigation before referring the matter to them. On 20 May 2008, a member of the Public Health Science team received an email from Mr Bush requesting a seat on the 'PCT monthly meeting' as 'a practising optometrist researching the non-surgical, non-toxic reversal of coronary atherosclerosis with extreme relevance to obstructive coronary artery disease'. This request was referred to me as I was at that time Director Lead for the PCT commissioning of cardiovascular services."

Q. Just pausing there; that is page 10, if you could go to it, in our bundle, and that is an email dated 20 May running through to page 14. Is that the email you are referring to, Dr Butler?

A. Yes.

Q. Okay, so if you could continue?

A. "On 21 May 2008 an email from Mr Bush, which he indicated had also been distributed to all PCTs and the National Institute for Clinical Excellence ("NICE"), was forwarded to me from the PCT Assistant Director for Primary Care Commissioning. This email expressed similar views to those included in Mr Bush's email dated 20th May 2008 including his views regarding the use of retinal photography and vitamin C to diagnose and manage arteriosclerosis."

Q. Is that Exhibit 2 which we then find on pages 16 and 17 of our bundle?

A. Yes.

Q. Thank you.

A. On 22 May 2008, the PA to Dr Wendy Richardson, Director of Public Health for Hull, forwarded emails to the PCT from Hull City Council. Mr Bush had contacted them, advocating cardioretinometry services and stating that the failure of the medical profession to adopt this service had led to the deaths of tens of millions of patients. Mr Bush indicated that his email had been shared with journalists and MPs. Mr Bush was informed in an email dated 21 May 2008 from Hull City Council that he would be referred to the PCT and, in his response, Mr Bush expressed his negative views about the PCT in very clear terms. Mr Bush also stated his concern that when he had raised his views to the medical profession in the past, he had been the subjects of 'attacks' on his computers and those colleagues in the USA feared personal attack because of similar views."

Q. Pausing there; the emails you refer to as "SB3", do we find those at pages 19 to 25 in the bundle?

A. Yes.

Q. Continue with paragraph 8.

A. "I was concerned about the way in which the challenge to existing services was being expressed by Mr Bush and also about the level of concern expressed by Mr Bush about the risk to his work and his person. I felt that the style of communication Mr Bush was adopting could undermine the confidence of patients in existing services. Given the tone of his emails, including the possibly unrealistic concern he expressed about risk to himself, I was also concerned about his health. These were matters which could impact upon Mr Bush's suitability to be included on the PCT Ophthalmic Performers List and needed to be addressed through the PCT Professional Performance Procedures. As such, on 22 May 2008, I wrote to Mr Bush setting out my concerns including:

- o Mr Bush's advocacy of the use of Vitamin C to manage serum cholesterol. I noted that the PCT expected services for the prevention of ischaemic heart disease to be delivered in line with the nationally accepted evidence base and that it did not commission such services from optometrists;
- o Mr Bush's comments about the PCT in the "Yellow Pages" and on the video screens at his practice;
- o I outlined that I was concerned that the frustrations that resulted from others not sharing Mr Bush's passionate advocacy of Cardioretinometry may be causing Mr Bush stress that was affecting his health.
- o I invited him to meet me to discuss these matters further."

Q. Now, just pausing there, if you could turn to pages 27 and

28, is that the letter you are referring to in paragraph 9 of your witness statement?

o A. Yes.

Q. And if we just pick it up – we have read this previously, but I think it is right to read it with your being present-I just want to pick it up at the second hole punch and read down to the bottom of that page in which you expressed concern. You say: "Firstly your passionate advocacy of the use of oral vitamin C to reduce serum cholesterol. Of course we should all be open to new scientific evidence and to hearing and reflecting on scientific debate. For those of us working in the NHS the place for such debate is in peer reviewed journals and through organizations such as the National Institute for Health and Clinical Excellence (NICE). NICE is expected to publish a guideline on the management of serum lipids this year. The Joint British Societies published their guidance on the primary and secondary prevention of ischaemic heart disease in 2005. This guidance makes clear reference to the role of statins in reducing the risk of ischaemic heart disease. Nationally recognized guidance informed by careful and expert deliberation, such as that published by the Joint Societies, provides a benchmark against which clinicians should consider their own practice. Clinicians would be expected to provide a well argued case and associated evidence base to support practice which is significantly different from that advised in such guidance. I understand that you have a passionate belief that an alternative approach to lipid management should be considered. Currently I believe that such consideration should be through further research and academic debate. In particular it is not appropriate for patients to be advised to discontinue statin therapy. The PCT commissions specialist, primary and community services for the prevention of ischaemic heart disease. The PCT expects these services to be delivered in line with the nationally accepted evidence base. The PCT does not currently commission services for the prevention of ischaemic heart disease from optometrists." So that is the letter you wrote, and at the time you wrote that, did you consider it was an appropriate letter to write bearing in mind the circumstances as they then were to you? A. Yes.

Q. And, subsequently, did you have any reason to change the tone and structure of that letter?

A. The only comment I would make is that, subsequently, I came to understand from Mr Bush that I had slightly misinterpreted the work that he was advocating in terms of it being a different way of managing cardiovascular disease and not about lipid management, but the tone of the letter and the way in which clinicians should view changes of practice I would continue to adhere to.

Q. Thank you very much, and going back to your witness statement at paragraph 9 when you have under the first bullet points at page 2 of your witness statement you said that: "...services for the prevention of ischaemic heart disease is to be delivered in line with nationally accepted evidence." Am I understanding correctly that that is a reference obviously to NICE and the Joint British Societies?

A. Yes.

Q. Moving forward then, I think you actually met Mr Bush following this letter. This letter is 22 May, and I think you then met him a few days later. So if you could kindly pick it up at paragraph 10 of your witness statement.

A. "Mr Bush met with me in my office on 29 May 2008. I was concerned that he was continuing to discuss the issues from a commissioning rather than a professional performance perspective. Mr Bush did however agree to remove the messages that gave me cause for concern from the window of his practice. Mr Bush did not agree to an Occupational Health assessment. Following the meeting on 29 May 2009..." –

Q. That must be 2008. I think that must be a typing error, so we can all change that.

A. "Mr Bush emailed Medical Directorate administrative staff and myself referencing sources of evidence relating to CardioRetinometry."

Q. We have that at your exhibit 5, which is pages 30 to 37 of our bundle.

A. Yes.

Q. Paragraph 12?

A. "I wrote to Mr Bush on 5th June 2008 documenting our meeting. I proposed the following actions:

- i. I would discuss the issue of Occupational Health referral with the PCT Performance Decision Making Group
- ii. I would seek advice with regard to the evidence base he was citing; and
- iii. Mr Bush may wish to consider taking his ideas forward through a research rather than a commissioning route."

Q. Your letter then of 5 June, do we see that at pages 39 and 40?

A. Yes.

Q. This letter is written after your meeting with the Professor.

A. Yes.

Q. And in your first letter, going back to page 27, you said four or five lines from the bottom of that page: "In particular it is not appropriate for patients to be advised to discontinue statin therapy." Do you see those words at the bottom of page 27?

A. Yes.

Q. And then having had your meeting with the Professor, you write, on page 39 at the end of the third paragraph, this sentence: "In the meantime I must emphasize that you should not advise patients to cease conventional treatment which has been prescribed for the purpose of primary or secondary prevention of coronary heart disease." Why did you feel it necessary to write that and emphasis that?

A. wrote that because of two concerns. The first was that the PCT commissioned services for the prevention and management of coronary heart disease and did not commission those services from optometrists. Secondly, although, at that point, my stance was that I was investigating allegations that were made by colleagues and I have no view as to whether they would or would not be substantiated, I have met with Mr Bush and seen how passionately he advocated his views. Therefore, his approach led me to believe that he would wish to share those views with his patients.

Ms Jones:

Sorry, could you just repeat that last response, please, Dr Butler?

A. From my perspective, the PCT had taken a considered decision to commission services for the prevention and management of ischaemic heart disease, and did not commission those services from optometrists. Secondly, I was aware that I was managing allegations that Mr Bush was promoting advice to patients and the public that was contrary to best evidence and best practice as I perceived it, and having met him and seen how passionately he advocated his views, I considered it likely that he would continue to promote those views to patients and the public during our procedures.

Mr Hamer:

Carrying on with your evidence back to page 3, we have reached the last sentence in paragraph 12 beginning "The evidence review...". Perhaps you could just read that, please, into the record.

A. "The evidence review was commissioned from the PCT Public Health Science team on 12 June 2008."

Q. And then continuing.

A. "Mr Bush's responses to my letter of 5 June 2008 included detailed, and referenced, discussion of CardioRetinometry issues. I was concerned that he seemed unable to understand the Professional Performance aspect of our discussion."

Q. We have been through his response. I am not going to read it through to the Committee. You will see at SB7 a series of documents and emails and letters running through from page 42 to page 70 and, in particular, at page 44 through to page 48 would appear to be your letter of 5 June responded to by the Professor inserting comments as we go along through the letter. Is that correct?

A. Yes.

Q. Having sent off that letter, he wrote a follow-up letter himself at page 52 – quite a long letter in fact – through to page 59, dated 8 June. Again, it is in the bundle for the Committee to read if they wish to do so. Did you receive that letter?

A. Yes.

Q. Thank you very much. If we can continue with your evidence then at page 3 of our bundle, paragraph 14, Dr Butler.

A. "On 9 June 2008, I was copied into an email from the PCT Assistance Director or Primary Care Commissioning, which outlined the circumstances in which an ophthalmic performer would not automatically be offered a new contract when the new GOS contract was put in place later in the year. We agreed that while the matters mentioned above were subject to discussion and possible action by the PCT, it may not be possible to offer Mr Bush a new contract. At the end of June 2008, I discussed my concerns with the PCT's Performance Decision Making Group ("PDMG"). The PCT's PDMG decided that advice should be sought both from the GOC and from the PCT Occupational Health Service about my concerns relating to Mr Bush. I wrote to the General Optical council on 26 June 2008 setting out three main concerns:

O. Mr Bush's advocacy of the discontinuation of statin therapy and the use of oral Vitamin C to manage risk of ischaemic heart disease. As well as being outside the accepted evidence base, this seemed to be outside the expertise expected of an optometrist and could place patients at risk".

Q. Just pausing there, the next two matters I ought to make clear the Council do not rely upon them. They are not part of these charges

and, although Dr Butler, this is not criticism of you, although you included them in the letter and 10 they are before this Committee, they are not part of my case. So we will not need to read out those two matters, but the final paragraph in paragraph 15, I think it begins "On 2 July..." it might be a typing error, which should be "1 July". Perhaps you could just read those two sentences.

A. "On 1 July 2008, I wrote to Mr Bush advising him of the outcome of the recent discussion by the PCT's PDMG. The letter included copies of referrals to the PCT Occupational Health service and to the GOC."

Q. If you turn to page 72 in the bundle, do you see it is the other way around – at page 74 to 75, is that your letter to the General Optical Council of 26 June 2008?

A. Yes.

Q. And the first paragraph beginning "Firstly his energetic advocacy..." deals with what we have dealt with down to the words "...as a result".

A. Yes.

Q. And then the letter to Professor Bush of 1 July, which you have referred to in the witness statement, is at pages 72 and 73.

A. Yes.

Q. Continuing with your witness statement at paragraph 16.

A. "During July 2008, I received reports from the Public Health Science team and the Occupational Health service. The Public Health Science report was a review of the evidence cited by Mr Bush. In summary, the report indicated that whilst the literature provided demonstrated a considerable amount of debate amongst a small number of colleagues, it did not include peer reviewed evidence from leading journals. Such evidence is the kind of work that would lead to a possible change in clinical practice and this did not exist in respect of the material provided by Mr Bush."

Q. Do we see that report at pages 78 through to 88 in your bundle? That is the report of 15 July 2008.

A. Yes.

Q. Thank you. I am not going to take you through it. I have taken the Committee through it and we will come back to it in due course, but it is not necessary for you to read out to the Committee in your evidence. So paragraph 17, please, Dr Butler.

A. "The Occupational Health Physician advised the PCT that he did not find any evidence of health problems which would impact upon Mr Bush's professional performance or the way in which the PCT should manage proceedings concerning his professional performance. Also during July 2008, the PCT was contacted by Mr Bush's AOP representative seeking clarity regarding Mr Bush's NHS contract." 11

Q. That is the Association of Optometrists – the AOP?

A. Yes.

"These matters were discussed by the PCT's PDMG at their meeting on 26 July 2008. At their request, I met with Mr Bush again on 15 August 2008 to discuss the PDMG's ongoing concerns regarding his CardioRetinometry activities. As these concerns were now being managed through the PCT Professional Performance Procedures, this could have impacted upon a decision regarding the offer of the new GOS contract to Mr Bush. Before this meeting, I received a further

letter from Mr Bush expressing his willingness to work with the PCT to find a mutually acceptable way forward. On this occasion, Mr Bush was accompanied by his AOP representative. During our meeting, we discussed Mr Bush's lack of clarity, at that time, about next steps regarding both his contract and the PCT Professional Performance Procedures. We also discussed the appropriate scope of Mr Bush's clinical practice. Finally, we reviewed a letter that Mr Bush brought with him from one of his patients who was also a Hull City Councillor. I was surprised that he had discussed these confidential matters with a patient. I wrote to Mr Bush on 19 August 2008 to document our meeting."

Q. The letter, Exhibit 10, on page 90 and page 91 is a draft letter by the look of it. Is that the letter you are referring to?

A. Yes.

Q. It appears to be a draft, and then you continue at the end of this paragraph by referring to a Hull City Councillor, and could you turn to then page 93; is that the Councillor you are referring to?

A. Yes.

Q. And you say also in your witness statement you attach a letter from the Hull City Councillor, and your response then to Professor Bush on 22 August is at page 94.

A. That is my response to Councillor Wastling on page 94.

Q. I am so sorry. You are quite right. Thank you very much. Then we move forward to paragraph 22 in your witness statement.

A. "On 18 August 2008 I was copied into a letter from the PCT Primary Care Contracts Commissioning Manager advising Mr Bush that he would not be offered an NHS contract. This decision was based upon a letter Mr Bush had written to the PCT in April 2008 advising them that he was the subject of an investigation by the GOC."

Q. Is that pages 96 to 98?

A. Yes.

Q. Then we move to the next paragraph of your witness statement.

A. "Mr Bush replied promptly with a letter dated 19 August 2008 undertaking not to promote his views regarding cardioretinometry within GOS services and seeking progress regarding the offer of an NHS contract."

Q. We see that at page 100, I think.

A. Yes.

Q. Then we move forward a few months to November 2008, paragraph 24.

A. "In November 2008, I was advised of the GOC's decision not to investigate the matter which had led to Mr Bush not being offered a GOS contract. I understand that following this, an NHS contract was offered to Mr Bush which he declined to accept. There followed a period in which the PCT took no action in respect of Mr Bush, as he was not treating NHS patients as far as the PCT was aware and he had taken down the inappropriate notices at his practice. In an email dated 25 March 2009, Mr Bush advised me that he would be citing me in a new book he was writing and asked how the PCT might support his research."

Q. Is that the email at page 102?

A. Yes.

Q. Thank you. Could you continue?

A. "Contact details for the PCT research advisor were provided to him in an email dated 2 April 2009."

Q. Yes, we can see that. We looked at it yesterday. That is from your Personal Assistant, Roslyn Cargill. That is page 106, Madam. Dr Butler, if you can continue then with paragraph 28 of your witness statement.

A. "This renewed engagement with the PCT prompted me to seek an update with regard to Mr Bush's promotion of CardioRetinometry. In April 2009, following a request by the PCT to gather further information, the Professional Performance Support Manager took photographs of Mr Bush's practice window showing that Mr Bush was once again promoting CardioRetinometry and in a manner derogatory to the PCT."

Q. Do you exhibit a set of photographs as SB16, pages 108 through to 114?

A. Yes.

Q. Continue at the end of paragraph 29.

A. "Mr Bush had a practice website containing similar material and I attach extracts from this website, printed on 31 July 2009."

Q. We haven't actually looked at those, but is that at pages 116 through to 126?

A. Yes.

Q. For my purposes, Madam, it does not take the Council's case further, therefore, I haven't laboured the point in opening, but it is there in the material for you obviously to consider. However, in opening it, I thought it was best to concentrate on a number of issues. Then we move to paragraph 30 of your witness statement.

A. "In April 2009, I also received a copy of a letter from Mr Bush to a local GP, Dr Galea, in which he asked Dr Galea to consider reducing a patient's statin treatment."

Q. Could you turn to page 128, please? Is that the letter you are referring to?

A. Yes.

Q. Could you just help the Committee? Could you explain how this came about because this is a letter sent by Professor Bush to Dr Galea, so how did it come into your hands and did you speak to Dr Galea or what happened about it?

A. Dr Galea had expressed his concern in a telephone call.

Q. To you?

A. Yes.

Q. When was that? Was that before you received the letter or after, as best you can recall?

A. I am reflecting that my memory of these events is not clear. I became aware of his concerns either from my PA or from Dr Hancocks – I am not sure – and I had a telephone call from Dr Galea. I asked him if he could support what he was telling me and received this letter.

Q. From your recollection, could you give us the gist of what he was telling you?

A. His concern was that, from his perspective, this patient needed this treatment.

Q. This treatment being the statin treatment?

A. Yes, to manage their existing condition, and that it was a risk for them to advise them to stop the treatment and to either create a circumstance in which they might stop the treatment or a circumstance in which they were less confident in the treatment.

Q. Did he indicate how the possibility of stopping the treatment had arisen?

A. His view was because this information in the letter was also known to the patient. That is my memory.

Q. Thank you. You then continue at the bottom of page 5 of your witness statement, the last line, if you could just read that and continue please.

A. "Two other GPs, Dr Price and Dr Shaikh, also advised me of their concerns that individual patients had been advised by Mr Bush that Vitamin C would be more beneficial to them in managing their cardiovascular disease than the statin therapy they were taking. Dr Price and Dr Shaikh did not provide copies of the relevant patient records to the PCT."

Q. Just pausing there; did you at any stage speak to Dr Price or Dr Shaikh?

A. Yes, I spoke to both of them.

Q. Because what you are saying here is that "Dr Price and Dr Shaikh also advised me of their concerns." Are you able to assist the Committee with firstly how this arose? Here you are sitting in your office. How did this occur?

A. In two different ways. Dr Price was the Chair of our Professional Executive Committee. That is the Senior Committee of clinicians advising the PCT on their commissioning decisions, and so I met with him regularly. Dr Price was also a member of the Performance Decision Making Group and he was also a practising GP in Hull.

Q. Leaving aside his role – I am more concerned about him being a General Practitioner for these purpose-was he discussing matters with you regarding a patient or patients?

A. He was obviously aware of these concerns. I mentioned at the beginning of my evidence that a concern had been raised which was dealt with prior to these matters—that concern had actually been raised from Dr Price's practice.

Q. So this is another matter?

A. Yes, but he came to me and said that the matter was arising again. Further consideration was needed, and the reason he expressed that to me was that a patient, who was consulting with him, had talked to him about what had occurred during the consultation with Mr Bush.

Q. Did he relay what that was – the gist of it at least?

A. The gist of it was that the patient was questioning whether the conventional treatment they were taking to minimize their risk of ischaemic heart disease was the right one for him.

Q. What about Dr Shaikh? We do have one email from Dr Shaikh, in fact, in our bundle at page 374, and it is dated around this time. From

memory, I think it is May 2009. Yes. It is an email from Dr Shaikh at page 374, Dr Butler. Did you speak to Dr Shaikh?

A. Yes.

Q. Again, you said in your witness statement at paragraph 30-I won't read it out again – is this something which he raised with you or you were raising it with him?

A. As you see, the copies of the emails there were not directed to me but to a colleague who was at that time the Clinical Lead for cardiovascular disease, and had been for some time. Initially, he explained to me that Dr Shaikh had a concern and I had a phone call with Dr Shaikh.

Q. Tell us about that phone call with Dr Shaikh.

A. I asked him if he could explain more to me about his concerns and, again, my understanding was at that time that following a consultation with Mr Bush, a patient was suggesting that his prescription was not the right one or the best one for him with regard to his cardiovascular disease.

Q. Right. Then we move on to paragraph 31 of your witness statement.

A. "On 29 June 2009, I was forwarded copies of emails that had been sent by Mr Bush to East Riding of Yorkshire PCT, as well as, apparently, to an email forum, promoting cardioretinometry and citing myself and the PCT as an opponent of his views and also as the withdrawer of his NHS contract."

Q. Then I think at tab 19 – that is pages 130 through to 137 – you produced those documents, the emails.

A. Yes.

Q. We will move on then to the next paragraph, paragraph 32.

A. "On 24 September 2009, I was copied into an email from Mr Bush to the Chair of the PCT commenting very directly on the interactions Mr Bush had had between myself and the Medical Advisor of one of the PCT predecessor organisations."

Q. Yes, we can take this quite quickly. I think that is pages 139, 140 and 141. Is that right?

A. Yes.

Q. Then continuing at paragraph 33, Dr Butler, if you could please.

A. "During this time my PA had been trying to arrange a meeting with Mr Bush to discuss ongoing issues. Mr Bush requested advice regarding the matters that I proposed to discuss before confirming this meeting. On 13 October 2009, I wrote to Mr Bush regarding the PCT's concerns. I confirmed that the PCT was concerned that Mr Bush was acting beyond his competence as an optometrist and wished to arrange a meeting with him in accordance with the PCT's performance procedures. I also reiterated that the PCT's clinical commissioning was based on the guidelines and guidance produced by the NICE and the Joint British 16 Societies Cardiovascular Risk advice and that, in its current stage of development, the evidence that CardioRetinometry would improve upon this advice was not sufficient to influence PCT commissioning. I suggested that any local work in the area of CardioRetinometry should be progressed through research and reminded Mr Bush of the contact details of the PCT's

Research Advisor, Dr Davey. I also advised him, that given the tone of his recent emails, I had asked a colleague, the ophthalmic advisor, to take this forward on my behalf."

Q. Just pausing there; you have referred in paragraphs 33, 34 and 35 to your letter of 13 October 2009. Do we see that at pages 143 through to 145 in our bundle?

A. Yes.

Q. And at page 144 you refer to the notices in his window and just against the first hole punch, the last sentence there, reads: "You did remove the notices from your office window. I am advised that similar notices are once again being displayed." You have given evidence earlier to that effect.

A. Yes.

Q. Then on page 145 you say further concerns about your clinical practice have been raised, but it is the second bullet point I want to ask you about. You say here that: "Three general practitioners have contacted me to express their concern that you have advised their patients to cease or reduce medication that these patients were taking to lower their serum cholesterol levels. They were concerned that this advice was beyond the clinical competence of an optometrist and that it increased the risk that the patients concerned would suffer from cardiovascular disease." Could you tell us who are the three general practitioners you are referring to in this letter?

A. Dr Galea, Dr Shaikh and Dr Price.

Q. And is that the evidence you have been referring to earlier – this is a reference to that evidence?

A. Yes.

Q. Thank you very much, and then you continue by saying: "The concerns imply that you may be delivering services beyond the clinical competence of an optometrist...", etc. Is that a view which you held in your capacity as a Medical Director?

A. It was a view that I had reached after discussion with the PCT ophthalmic advisor.

Q. Thank you very much. Then we move on in your evidence to paragraph 36 on page 6. I am pleased to say, Madam, we are approaching the end now. I am conscious that we have been going an hour. I think probably it will take 15 minutes. I don't think more than that. I think the rest of this is purely reading, if that is alright with you and the Professor?

Ms Jones:

I think that is fine. Thank you. We will go until 11.15, and then we will take a break and come back for the cross-examination. Please continue, Mr Hamer.

Q. Thank you very much, Madam. Paragraph 36, Dr Butler, if you could just read that, please.

A. "I attach a copy of the NICE guidance on Lipid Modification and the Joint British Societies Guidelines on the Prevention of Cardiovascular Disease in Clinical Practice."

Q. I needn't bother to ask you to read those. You will find, I think, the NICE one at pages 147 through to 184 and the Joint British Societies Guidelines at page 186 through to page 247.

A. Yes.

Q. So we can move then to paragraph 37 of your witness statement.

A. "Cardiovascular disease is a lead cause of ill health and premature death in Hull. The PCT has established a number of initiatives to raise awareness of the factors predisposing patients to cardiovascular diseases and to encourage patients and members of the public to find out about their personal risk of cardiovascular disease. The PCT has commissioned services in a range of settings in which people can have their risk of cardiovascular disease assessed. People who are found to be at high risk are referred to their GP for treatment. On 26 October 2009, I received an email from Dr Christine Davey, the PCT research advisor, documenting her meeting with Mr Bush and her letter and attaching email correspondence following the meeting. The email mentioned difficulties in the discussion with Mr Bush and his apparent difficulty in recognizing the research structures and processes in place in the UK."

Q. I think that is your SB24 which we see through pages 249 to 253. Is that right?

A. Yes.

Q. I read those to the Committee earlier. I do not propose to read them through again. So if you could just carry on at the end of paragraph 38.

A. "On the morning following the meeting between Dr Davey and Mr Bush, I received a telephone call from Dr Davey's line manager advising me that she had found the meeting very stressful and that she would not be able to support the work that Mr Bush proposed. Mr Bush advised my PA that he would not attend a meeting with the PCT and wrote to me on 7 November 2009 stating 'that unless you are prepared to unreservedly offer me an NHS contract and pay compensation for the trouble you have caused and the financial damage you have done to my practice I see no point in any further contact with you and for the time being I do not wish to be associated with the false Hull NHS or its performers list.'"

Q. Just looking at that, could you turn to page 255 and is that the letter you are referring to? I am trying to find the date on it, but there are so many stamps over it I cannot see the date on it-7 November – but it certainly seems to have been received by you on the 10th , and if you go to the second hole punch there is the paragraph reading: "Unless you are prepared to unreservedly offer me an NHS contract and pay compensation for the trouble you have caused and the financial damage you have done to my practice I see no point in any further contact with you and for the time being I do not wish to be associated with the false Hull NHS or its performers list." Is that the quote you are referring to in your witness statement?

A. Yes.

Q. It is dated. It is dated in the manuscript below that. There is his signature dated 7 November 2009. Then we continue at paragraph 40 of your witness statement, Dr Butler, please.

A. "As Mr Bush was currently only providing private services over which the PCT had no jurisdiction and had refused to meet with the PCT to discuss these matters, the PCT's PDMG decided that all of this additional information should be provided to the GOC for their consideration. They felt that if an investigation were to find evidence substantiating the concerns raised this would constitute a risk to patients in Hull and that they should therefore take any action they reasonably could to substantiate or refute these concerns."

Q. You then refer back to the General Optical Council. Is that pages 257 to 258 in our bundle? That is a letter, which we saw yesterday, sent by Liz Greenwood.

A. Yes.

Q. Continuing with paragraph 41.

A. "In February 2010, the PCT's PDMG recommended that, as Mr Bush had not provided NHS services locally for the last year, the PCT should advise him that he would be removed from the PCT Ophthalmic Performers List unless he requested otherwise. Mr Bush was advised of this by Maddy Ruff, the PCT Director of Commissioning, on 1 February 2010. Having not heard from Mr Bush, Ms Ruff wrote to Mr Bush on 29 March 2010 advising him that he would in fact be removed from the list."

Q. And we see Ms Ruff's letter, do we, at page 260 of the bundle, and a copy of it being copied to you, Dr Butler, as the Medical Director?

A. Yes.

Q. Right, we are moving to the close shortly. Paragraph 42?

A. "Following Mr Bush's removal from the list, concerns continued to be raised. Documents brought to my attention included a website that was discovered by a member of the PCT staff. The website's address was www.hullpct.co.uk, which is very similar to the PCT's website's address. However, the content refers only to Mr Bush's cardioretinometry interest.

Q. As far as the website is concerned, is that pages 262 to 267?

A. Yes.

Q. We have been working on it from a different page number – it appears twice in the bundle – we have been working on it at pages 379 to 384 because Mrs Greenwood gave her evidence first, and she referred to it. It is the same document. If you could just turn your eye across to 379 to 384, I think it is the same document as Mrs Greenwood produced.

A. Yes.

Q. So paragraph 43 I think of your witness statement we have now reached.

A. "There was also further concern about Mr Bush's practice following an email from a GP, Dr Mark Hancocks.

On this occasion, Dr Hancocks explained that he had concerns about Mr Bush's advice to one of his patients. Dr Hancocks explained in his email that, on 19 July 2010, a patient referred to as DH, had attended an appointment with him. DH explained to Dr Hancocks that Mr Bush had advised her to stop taking her statin medication, which had been prescribed to help prevent deterioration of her angina, and instead take vitamin C."

Q. Do we see that email at page 269 to your witness statement SB29?

A. Yes.

Q. And is that the same email that Mrs Greenwood produced at page 378, which we have been working on, again, yesterday?

A. Yes.

Q. In conclusion, are the facts in your witness statement and in the

Q. There are two kinds of cholesterol?

A. I am not a practising general practitioner at this time.

Q. Do you expect your general practitioners to know more than you do about it then, as you say? A. At this time now, yes, I would.

Q. It seems you don't have a very high opinion of your colleagues.

A. I said that at this time, now, I would expect practising practitioners to know more about cholesterol and its place in cardiovascular disease than I do as a no longer practising general practitioner.

Q. At the time, Dr Butler, when you said to me that I couldn't have a new National Health Service contract, you said something else to me, which you may or may not remember. Can you remember saying to me, "I will teach you to have respect for doctors"?

A. Absolutely not.

Q. You can't remember saying that.

A. Could I also just mention, Chair, that it's my memory, and my understanding, that I never said Mr Bush could not have a GOS contract, because that was not my decision to make. I did explain the circumstances surrounding that decision by the PCT.

Ms Jones:

Thank you.

Professor Bush:

Dr Butler, if Dr Fonorow came today, a passionate advocate of vitamin C, presumably you would tell him that you would tell him that you don't have confidence in his work?

Ms Jones:

Excuse me, Professor Bush, you need to establish if you are introducing other books whether Dr Butler has heard of or knows of the book, the doctor or their work.

Professor Bush:

But these have been circulated, haven't they?

Mr Swinstead:

I don't know whether Dr Butler has had any –

Professor Bush:

I'm sorry, I'm making the assumption that Dr Butler is familiar with this book.

Mr Swinstead:

I think you need to establish with her, as the Chairman says – Dr Butler, perhaps I can help: are you familiar with Dr Fonorow, do you know of Dr Fonorow?

A. I am aware of the existence of that book, I am not familiar with the contents.

Professor Bush:

Are you aware then that passionate advocacy for vitamin C goes back to Patterson, 1940. Patterson was a second world war surgeon in the Canadian Army, and it was he who first elucidated the connection

between atherosclerosis and localized an ascorbemia-are you aware of what I'm saying, do you understand what I'm saying?

A. I am aware from the information you sent me that a lot of people are taking part in the debate and have done for some time, about vitamin C and cardiovascular disease.

Q. Does it surprise you then, that Dr G C Willis – I've been talking about Dr J C Patterson – who was a general medical practitioner, you remember, he was the very first person to show, by x-ray, that coronary artery disease could be reversed with vitamin C, back in 1953. Serial arteriography in the causation of coronary angiography.

A. I am aware from reading what you sent me that that work took place and that people interpret the findings of that work differently.

Q. I couldn't catch what you said, could you repeat?

A. I am aware from what you sent me that that work took place, I am aware from the work done by my colleagues in the public health science team that people interpret that work differently.

Q. So then you are aware that the controversy started over 50 years ago?

A. Yes.

Q. And you may be now asking yourself, how can a controversy be maintained for 50 years?

A. I feel that there is no single answer to such a question.

Q. Can it only be maintained, do you think, if people have a passionate need, a passionate advocacy for the opposite for their own particular purposes, like profit-making? Too much knowledge is perhaps not good for the public.

A. I think controversy can be maintained by many things.

Q. What?

Mr Swinstead:

Controversy can be maintained by many things, was her answer.

Ms Jones:

Dr Butler, if you would speak as loudly as you are able, we would appreciate it greatly, thank you.

Professor Bush:

So when controversy surrounds a particular subject in medicine, like a particular application of a drug, or the effects of a hormone, you would expect, then, that there may be some truth, there is no smoke without a fire. This would be your attitude; there may well be some truth in this, if there's a controversy about a particular drug or its application, or some effect.

A. I don't subscribe to the saying that smoke always means there's a fire.

Q. What?

A. I don't believe the premise that there is no smoke without fire is an invariable help in making decisions.

Q. So, if you don't believe that there is no likelihood of a rumour having any worth – is that what you're saying?

A. I'm saying a rumour is a rumour – it may be a rumour, or it may turn out to be something different.

Q. You wouldn't give it any value?

A. I would want to know more.

Q. Is that why you are so passionate in your belief, as I take it, your belief in statins as a general medical practitioner. You believe in statins because you prescribe them widely, yes?

A. I believe that my prescription of statins is because I endeavoured to be an evidence-based general practitioner, which is slightly different from passionate.

Q. If you are so strong in your belief on evidence-based matters, can you explain to me why you continue to hold such passionate beliefs in the value of statins when today there has been no paper published proving any life extension properties with them?

A. I think my response to that would be that I practised in line with the evidence base, as discussed by colleagues in national bodies and nationally approved journals. I no longer practise and –

Q. So even if there is no evidence

Ms Jones:

Excuse me, Professor Bush, we agreed yesterday that we would let the witness respond, and then you would follow after.

Professor Bush:

I must apologize.

Ms Jones:

Thank you.

A. I was going to end that I no longer practise, and I feel it is probably inappropriate for me to offer opinions now, at this time, on best practise with regard to cardiovascular disease.

Professor Bush:

But even though you are not in practice I'm sure your advice is often sought, and you are entitled to your opinions. The fact that there has been no paper published proving any connection between life extension and statins doesn't deter you from continuing to hold your opinions about statins. You are passionate in your beliefs. A. I believe that I am here to describe as best I can what happened during the period of this paper. I am still a member of the medical register, but I do not have a licence and as such I do not offer medical advice to anybody.

Q. Thank you Dr Butler, I feel that you have said everything that I could possibly expect of you.

Ms Jones:

You have no further questions of Dr Butler?

Professor Bush:

No, thank you.

Mr Swinstead:

Can I just pick up one thing, just to establish with Dr Butler: the first book which you put, which I think was Dr Levy's book?

Professor Bush:

'Practising medicine without a licence', Dr Fonorow's book.

Mr Swinstead:

Not that one.

Professor Bush:

Matthias Roth's book.

Mr Swinstead:

No, the first one.

Professor Bush:

The first one was Dr Tomas A Levy's work.

Mr Swinstead:

Yes, Dr Levy – we never established with Dr Butler – sorry, Dr Butler – were you aware of Dr Levy and of that book, we never actually established that.

A. I think my answer has to be, I'm not clear. I remember the titles of the other books, and I remember seeing those in the information provided to me.

Mr Swinstead:

It's just that we established with the other books whether you knew of the authors and the books, but we didn't with that one so perhaps just have a look and see whether you knew of it and of Dr Levy, that's all, just to, as it were, square the circle.

A. I remember seeing the name of Dr Levy in the information provided to me by Mr Bush, I don't remember the title of his book.

Professor Bush:

Thank you. The main thrust of my questioning was to elucidate from Dr Butler that she is unaware of the evidence of three cardiologists to the effect that vitamin C is very closely involved with arterial disease.

Mr Swinstead:

Thank you.

Ms Jones:

Thank you. Mr Hamer.

Re-examined by Mr HAMER

Mr Hamer:

Just one question, Dr Butler: is there anything in the evidence you've given this morning in answer to Professor Bush's questions which leads you to want to change the evidence in your witness statement or to alter any of the letters which you have written?

A. No.

Q. Thank you.

Ms Jones:

Thank you very much. The Committee may have some questions for you now. Dr Azubike. Questioned by the Committee Dr Azubike: I just have two questions - the first one is to do with statins: I'm not quite clear, do you have any opinions on statins?

A. I feel that I am here to advise you of what I believe happened, and being asked about my opinion feels as if I'm being invited to be now an expert witness, which I am not.

Q. The question isn't for you to give an expert opinion, I just want to clarify the issue that Mr Bush was trying to put to you. So go back to the period of 2008, you have a view with respect to statins.

A. My view at that time would have been that they were an appropriate treatment for patients who were assessed as having certain risks of developing cardiovascular disease or who had already been identified as having cardiovascular disease.

Professor Bush:

Can I ask a supplementary question?

Ms Jones:

Now, one of the difficulties I think we have today is, I understand that you are answering DrAzubike's question, if you would face Professor Bush –

A. I beg your pardon, yes

Ms Jones:

We are all, I think – it's the usual patterns of communication. If you would face Professor Bush and summarize that answer, that would be very helpful, thank you.

A. I was saying that at the time that we met, I believed that statin therapy was appropriate for many patients who were identified as having a risk of developing cardiovascular disease, an assessed level of risk, or who had already been diagnosed as having cardiovascular disease.

Professor Bush:

May I come back with a supplementary question?

Ms Jones:

Once the Committee has asked its questions you may re-question.

Mr Swinstead:

Make a note of your question.

Ms Jones:

Dr Azubike, your second question, and as loud as possible, please.

Dr Azubike:

Doctor, if you go to page 2 of your witness statement, paragraph 9, it's the second bullet point, after "Yellow Pages", you described something to with video screens at his practice - my question is, did you actually see the video screens yourself?

A. I didn't see them myself, I did see pictures of them that were taken by a person I consider to be a trustworthy colleague, and I heard about them – sorry, I did see pictures of them that were taken by a person I consider to be a trustworthy colleague, and I heard about them from other colleagues.

Q. So they were stills from the video.

A. Yes.

Q. Thank you. Thank you, Chair.

Ms Jones:

Thank you. Mr Lomas.

Mr Lomas:

I have no questions.

Ms Hallendorff:

No, thank you.

Mr Reily:

Just a couple of questions about the NHS contract that – I just want to be absolutely clear about this: the first question is, was the contract that was offered to Mr Bush the standard mandatory contract that went to all optometrists?

A. That is my belief, but the business of offering those contracts, or the circumstances in which those contracts might not be offered, was managed by the Primary Care Contracting Team, with whom we were in communication. So that is my understanding, but I couldn't confirm it as a fact. I have no reason to suspect anything else. And in the same vein, really: what was the ultimate reason -

I just want to be absolutely clear - that that contract wasn't actually enforced, or came into force?

A. The reason the decision not to offer the contract was made by a member of the Primary Care Contracting Team, in the light of the letter that Mr Bush wrote to them, advising them of matters that were under consideration by the GOC. That was a separate matter from the business that Mr Bush and I were engaged upon.

Q. Then ultimately he was offered a contract, I understand?

A. Yes, that's my understanding, in fact I was copied into a letter advising him of that.

Q. And to be absolutely clear, why wasn't it taken up?

A. I don't know.

Q. Thank you.

Ms Jones:

hose are our Committee questions. Mr Hamer?

Mr Hamer:

Shall I go first, and then Professor Bush.

Ms Jones:

By all means.

Mr Swinstead:

I think maybe it's appropriate while Professor Bush has his question in mind –

Mr Hamer:

Right. I only have one question.

Ms Jones:

Professor Bush, would you like to put the question we halted you with a short time ago? Further cross-examined by Professor Bush

Q. Dr Butler, I mentioned to you at the time of our meeting in July that I had 150 testimonials to the effect that people had seen their

arterial disease being reversed and you subsequently wrote to me saying that it's a difficult problem for me because I was faced with the impossibility of being truthful – I assume you meant that I was faced with the impossibility although you didn't say so – of being truthful, and true to my principles, and if I denied that arterial disease was reversible, having 150 testimonials from people to the effect that they had seen that it is reversible, so I assumed you were aware of that when you wrote to me and said that you understood that I was in a difficult position.

A. I remember you advising me on more than one occasion about the 150 testimonials. I couldn't be clear about the dates I came to know about them without referring to my statement. I think the assumptions about my thinking in commenting about that, I can't comment on assumptions that I may or may not have made. Thank you. Can you tell me why it is, Dr Butler, when you were invited to attend my lecture on 2 December 2009 to the British Medical Association, that you didn't attend, in your position of great responsibility as Director of Hull Primary Care Trust?

A. I can think of a number of answers to that, but the honest answer is, at this distance, no, I can't tell you.

Q. Do you think perhaps that if you had attended that lecture and seen with your own eyes how people's arterial disease was being reversed, that it might have changed your thinking about how to take this matter forward? Mr Swinstead:

The difficulty with that one is that you're asking the doctor to say what she might have thought if she'd seen something and she had attended, and I don't think she can say that because she didn't go, she didn't see it and therefore she would be at best speculating, and it may be impossible for her to say, because she wasn't there. Do you understand the point, it's putting her in a very difficult position.

Professor Bush:

I was asking the question simply because, as I already said, as Medical Director of the Primary Care Trust I thought she had a duty to the public to attend.

Mr Swinstead:

Well, that's a different point. The question you were just asking her was, if she had gone, would she have changed her mind, and that's not a question she can answer because she wasn't there.

Professor Bush:

With a duty to the public to attend in your highly responsible position, why did you not come?

A. I have already said, at this time I cannot remember.

Q. Dr Butler, are you aware of the research of Dr Karl Folkers, who was instrumental in introducing statins 30 years ago?

A. Not in detail, no.

Q. So you are unaware that Dr Folkers' primary discovery, after bringing statins to the market - you don't know what he stands for? I remind you, he stands for discovering the inhibition of co-enzyme Q10. Can you tell me what the significance is of that?

A. I don't think that is an appropriate question.

Q. I'll remind you that co-enzyme Q10 is essential for the heartbeat; it is intrinsic in the generation of the electrical stimulus for the heartbeat.

Mr Swinstead:

Professor, I think you are putting matters that we might put to the expert, but not to a witness of fact. I think you are moving away from what I understood you were going to ask her about which is why she didn't come to the meeting on 2 December, which is a matter she can deal with. You are now putting matters which I don't think are necessarily within her area of, she's not an expert; she is a witness of fact.

Professor Bush:

As the mouthpiece, so to speak, of this position of great responsibility, I'm leading to a very important point here.

Mr Swinstead:

May I suggest you make your point to her.

Professor Bush:

Okay. I will explain to you that co-enzyme Q10 is essential for the heartbeat, the heart muscles' production of co-enzyme Q10 declines naturally with age and eventually you die because you don't make enough. Statins affect that process, which may possibly be the reason why we have no satisfactory literature supporting the general prescribing of statins as a life extension mechanism. Can you explain why it is that when the statins which are so widely prescribed, on the assumption that they are going to benefit people, are not excluded as a cause of death when people die who are taking statins, because there is a serious risk that deaths are due to natural causes?

Mr Swinstead:

That's now a very, very long question – can you put it very simply? I think the point - correct me if I am wrong Professor – the point is this: the Professor is suggesting to you that because statins have the effect of not prolonging life but possibly shortening it, there should be a warning about statins, that's effectively what you're saying?

Professor Bush:

There should be a warning that they inhibit the co-enzyme Q10 and can cause sudden death.

Mr Swinstead:

That's the point - can you answer that?

A. I have a concern, Chair, that I can only answer that indirectly, and I'm not clear –

Mr Swinstead:

I think you can only answer to the best of your knowledge and ability. Nobody's asking you to go outside your knowledge, ability and experience as a retired doctor.

A. My concern about this conversation is that even when I was a Director at the PCT and I was there by virtue of having been a general practitioner, it was not my role to form personal opinions. There were a number of clinical leaders working for the PCT, each of whom had special interest and special expertise, and I never perceived my

discussion with Mr Bush to be one about my personal views on the management of cardiovascular disease.

Ms Jones:

One moment, Mr Hamer – I'm not sure that we've finished. Professor Bush, are there any final questions of this witness? Professor Bush:

I'm sure that as a general medical practitioner you cannot fail to be aware that rhabdomyolysis is a cause of sudden death and affects about one person in 1000 taking statins?

Mr Swinstead:

Do you know that, can you answer that point?

A. I'm not aware of the exact figures, I am aware that there are side effects of statins causing significant muscular damage.

Professor Bush:

Do we assume now, do we take it from you that, like most practitioners you are thoroughly aware that rhabdomyolysis causes sudden death in about one person in 1000 taking statins. But were you aware that inhibition of co-enzyme Q10 actually affects everybody, not one person in 1000, but affects the heartbeat of everybody – were you aware of that?

A. I think my honest answer is, I am not sure if at that time I was aware of that or not, referring to my previous comment that my purpose and my role was not personally to determine best evidence about cardiovascular disease.

Q. Dr Butler, if you were once more the Medical Director of the Primary Care Trust, can I take it that you would order that an inquest be held whenever anybody dies by taking statin drugs –

Mr Swinstead:

I think you first have to establish whether or not it's her responsibility to order an inquest in any case. Dr Butler, was your responsibility when you were Medical Director of the Trust to order in that role an inquest? A. No. Should I have any concerns, it would be my responsibility to share them with the coroner, concerns of that nature. It was never my responsibility to order tests.

Mr Swinstead:

There's a distinction of responsibility here, and with respect, Professor Bush, I think what Dr Butler has been indicating is that there are two separate things: she has knowledge and experience as a general practitioner, now retired, she has a position within the Trust which, with great respect to her I think she is saying is administrative as much as it is medical, therefore I think you can only go so far with your medical questions, if I can put it that way. Do you understand? I am not trying to stop you, but I think she is saying a number of times, there are limits to her ability to answer your questions.

Professor Bush:

I think we could stay the rest of the day with questions about cholesterol and low cholesterol diets and plasma cholesterol. Do you personally subscribe to the view that low plasma cholesterol is more healthy than high plasma cholesterol?

A. For some people.

Q. I'm asking generally, if you had the choice, would you prefer to have so-called high cholesterol or low cholesterol?

A. I think that's a complex question. To reach a conclusion about that at this time, I would refresh my knowledge before answering that question

Q. Presumably whilst you were Medical Director at the PCT you were wholeheartedly supporting the evidential standing of NICE?

A. When I was Medical Director of the PCT, I was promoting evidence-based practice as recommended by national professional and scientific bodies.

Q. So you were satisfied that there is evidence that higher cholesterol is more dangerous than low cholesterol according to NICE?

A. I think that would be a generalization of the NICE guidance, which would skip over a lot of the detail in there.

Q. Does it surprise you to know that in Russia a finding by a person's general medical practitioner that he has low cholesterol is not a subject for rejoicing but a view of early death?

A. That's neither surprising nor not surprising; it is new information to me.

Q. Are you aware that when the cholesterol level falls spontaneously for no apparent reason that it is pathognomonic of early death?

A. No.

Ms Jones:

Do you have any further questions, Professor Bush, or do I hand over to Mr Hamer?

Professor Bush:

Can you explain, Dr Butler, why you refused to answer my several invitations to care for the medical doctors in Hull in order to save them from the risk of coronary thrombosis? This was at the same time appealing to my greatest critics to find fault with my work and a glorious opportunity for you people to justify yourselves as regards the negative attitude you were taking to my work. Can you explain why, with that golden opportunity offered to you, you declined even to reply to my invitations?

A. I think I had made my position clear that my discussion with you was not about the appropriateness or not of certain treatments.

Q. Dr Butler, when you referred me to Dr Davey –

Ms Jones:

Excuse me, Professor Bush – she hasn't finished.

A. It was about professional responsibility in managing clinical decision-making.

Professor Bush:

Dr Butler, when you referred me to Dr Davey, I'm sure you were meaning to be helpful. Were you aware that Dr Davey's knowledge is limited to reviews and they in turn are limited to what is allowed to go into the peer reviewed journals?

A. I referred you to Dr Davey because she was the Research Manager for the service with which the PCT worked to support research, and her role would be to provide you with advice as to how you would be able to participate locally in research work supporting your interest.

Q. That completes the questions I want to ask.

Ms Jones:

Thank you very much. Mr Hamer. Further examined by Mr HAMER

Mr Hamer:

I just have two questions if I may, Madam, and the first one arises out of the answer you gave to Dr Azubike's question: you said that at the time you met Professor Bush in May/June 2008 you believed statin therapy was appropriate treatment. Is that based upon your letter of 22 May 2008, page 27 of the bundle, when you are referring to the statin treatment by NICE and the British Societies?

A. That was based upon work that I had done with both general practitioner and consultant advisers to the PCT in order to enable the PCT to specify services it wished to commission, so the detailed expert clinical input was theirs.

Q. And you mention in this letter that NICE and the British Joint Societies provide a benchmark against which clinicians should consider their own practice, and that included statin treatment in that?

A. Yes.

Q. So, is it correct that your understanding is that the NICE and the Joint British Societies' guidelines provided the accepted and proper standards for the management of cardiovascular disease for treating patients?

A. Yes.

Q. Thank you very much.

Ms Jones:

Thank you. Thank you, Dr Butler, for your evidence; you are now released as a witness. Mr Hamer, do you have further witnesses? [The witness stood down]

Mr Hamer:

I have Dr Eperjesi.

Ms Jones:

Thank you.

Mr Hamer:

This is my last witness.

Dr Frank Eperjesi, called and Affirmed Examined-in-chief by mr hamer

Mr Hamer:

Are you Dr Frank Eperjesi?

A. I am.

Q. And are you giving evidence here as an expert witness in the specialist field of optometry?

A. Yes.

Q. Can we just get your qualifications: if you could turn to volume 2, page 403? Are you the senior university lecturer and researcher in optometry at Aston University, and are you a registered optometrist?

A. Yes.

Q. Let's turn to your professional qualifications, your curriculum vitae at page 411 in the bundle. Amongst your curriculum vitae did you obtain a degree at Aston University in optometry, followed by a PhD, and also are you a Fellow of the American Academy of Optometry – is that correct?

A. Yes.

Q. We see your clinical professional experience in the middle of page 411: from 1990 to 2011 were you 21 years post-registration experience in primary care optometry practice, and it says here that you had worked in corporate practice, for example, Boots the opticians, Vision Express and Specsavers, in addition to independent practice, hospital practice and owned and worked in your own practice for 10 years between 2000 and 2010- is all that correct?

A. Yes.

Q. And from 1990 to 2000 were you ten years as a visiting lecturer, visiting clinician, teaching, carrying out research in optometry at Aston University, specializing in clinical investigation, especially of the retina, and ocular disease?

A. Yes.

Q. From 2000 to present, are you an academic member of the staff at the University, and specializing in the clinical investigation of ocular disease and rehabilitation of vision loss?

A. Yes.

Q. And from 2007 to date, continuing professional development lecturer for the American Academy of Optometry, and is it correct that you have published 31 clinical articles in referred journals, and 30 scientific articles in referred academic journals?

A. That might be slightly greater now, because this was put together in September 2011, so I think I've had a couple more –

Q. Alright. Are you the author of four text books, which you give there, or have you written any more since? A. No, just the four.

Q. Four. As an expert witness, it says at the bottom of page 411 you have been involved in 20 civil cases, all of which have been settled out of court, 23 General Optical Council cases – that's before the Fitness to Practise Committee and so forth –

A. That figure of 23, again I think there are two more since this was put together.

Q. Two more. And working on behalf of both the General Optical Council, on behalf of the complainant and also have done work for the Association of Optometrists on behalf of the registrant? A. Yes.

Q. Thank you. I won't read it out, but there is a list of honorary posts and memberships of learned societies. So your report here, of 8 September, we see at page 403. Just before we go into it, just so the Committee know what they have, at 414 is a supplemental report from

you, in which you have reviewed Professor Bush's book, which is this one, '700 Vitamin C Secrets',

A. That's correct.

Q. We'll come to that in a moment but you say on the second page, 415, that you've read Professor Bush's book, but there's nothing in the book as far as you could tell that would make you want to change your main report.

A. That's correct.

Q. In addition to that, at page 415A, I think you have also read one of the other books which Professor Bush has referred to, which I think is this one, by Owen Fonorow, 'Practising medicine without a licence'.

A. That's correct, but I don't have that in my bundle, my report.

Q. No, but you are saying that –

Mr Swinstead:

Mr Hamer, forgive me, you referred to a page 415A.

Mr Hamer:

Yes.

Mr Swinstead:

That is not a page that I think anybody - I certainly don't – I don't think the Committee have that.

Mr Hamer:

I have some spares of 415A and B.

Mr Swinstead:

I think we'll need copies for the Professor and –

Mr Hamer:

Right, there are eight copies of 415A and 415B – these are your supplementary reports of 8 June 2012.

Mr Swinstead:

Make sure the Professor has one, certainly the witness.

Mr Hamer:

Yes. [Copies are distributed]

Mr Swinstead:

iProfessor, that is the document everyone has just been handed, it's page 4

Mr Hamer:

And this is your supplementary report of 8 June 2012, reviewing this book, 'Practising Medicine without a licence', is that correct?

A. That's correct.

Q. I'll come to that in a moment, but you end up by saying there is nothing in this book to make you want to alter your main opinion.

A. That's correct.

Q. There's another book that you reviewed, and I'll call this 415B

Mr Henley:

his will be C6.

Mr Hamer:

Thank you very much, Mr Henley. That's on another book which is this one by Hickey and Roberts.

A. Yes.

Q. And again, I think you reviewed that and end up by saying in conclusion there is nothing in the reports which requires you to change your opinion.

A. That's correct.

Q. So let's go back, then, to your main report, and take you through that, if I may. You cite at paragraph 8 various issues to be addressed, and there are eight of them – I won't read them word for word – but they are the role of the optometrist in assessing the appearance and/or condition of the eye; whether optometrists are competent or expected to detect health problems; the use of Professor Bush's term, 'CardioRetinometry'; and then (iv) the role of optometrists in advising patients and recommending treatment in respect of the primary or underlying condition, which has presented itself via a condition of the eye. Then (v), (vi) and (vii), your opinion on the use of vitamin C, and so forth. Let's just go through the paragraphs of your report-I want to start at paragraph 10. In paragraph 10 you say that in carrying out an eye examination an optometrist is expected to look for eye signs that may be indicative of a general health problem, for example, fatty deposits on and around the eyelids are indicative of high levels of cholesterol in the blood; burst blood vessels in the conjunctiva could be indicative of high blood pressure; cloudiness in the peripheral margin of the cornea could indicate high levels of cholesterol in the blood; episodes of blurry vision could indicate diabetes; bleeds in the retina could indicate diabetes and/or high blood pressure; increases in the width of arteries in the retina compared to the width of veins indicates high blood pressure; particulate blockage of the arteries could indicate cardiovascular disease and/or coronary health disease. You say that your opinion is based on knowledge of the curriculum at United Kingdom optometry schools, continuing education and training, continuing professional development and clinical experience. Is that your opinion in relation to the role of an optometrist in assessing the appearance -Yes, it is. When an optometrist carries out an eye examination it provides an ideal opportunity to look for general health problems, so what I have listed there are a few examples of the signs that an optometrist would look out for during an eye exam, as possible indicators of a general health issue.

Q. Then we move to paragraph 12 where you say that optometrists are educated and trained during a BSc Optometry programme, in the pre-registration period, to recognize signs in the eye that are indicative of general health problems, for example, GOC Core competency 6.1.13 requires a recognition of ocular manifestations of systemic disease, and so forth, and you say that that opinion is also based on your experience and knowledge. Is that correct, that optometrists are expected, having regard to their training, to detect these sort of problems?

A. Yes.

Q. Now we turn to paragraph 14, the use of the word 'CardioRetinometry' – is that something which you are familiar with?

A. It wasn't until I saw the advert that Professor Bush had placed in The Optician magazine, a full-page advert. I can't remember all the details of the advert, but that word was within the advert, and I remember thinking that's a new term that I hadn't previously seen.

Q. Yes. You say in your report, at paragraph 14, the first time you came across his term was when you saw it in one of Professor Bush's advertisements for a doctorate in CardioRetinometry, about three months ago, so that would be three months before September 2011.

A. Yes.

Q. And it's not a term you've found in any of the key ophthalmology or optometry text books, or in any of the optometry or ophthalmology dictionaries?

A. That's correct, yes.

Q. You also say in your report it's not a word that you could locate on the world's most comprehensive database for research findings.

A. That's right. I put the word into this database and –

Q. I was going to say, what did you do to try and find the word?

A. The database is called PubMed, and it contains the vast majority of the world's research literature – I put the word into there, and it didn't come up with any hits, as it were.

Q. And you say that as far as you can determine, it was a word that was coined by Professor Bush.

A. Yes.

Q. Just pausing there, we now have Professor Bush's book, and if you could turn to page 169, we can see the word 'CardioRetinometry' against paragraph 347, and that says it's a name coined by the author and first published by the author in December 2002. So does what is said in his book seem to support what you are saying in your report?

A. Well, the book seems to suggest that the word has been around a lot longer than I was aware, but it's possible that I just didn't see that publication in The Optician in 2002. It is a journal I subscribe to, but it's possible I may have just missed it at that time.

Q. But it does appear from what Professor Bush is saying in his own book it's a word termed by him.

A. Yes.

Q. And when you wrote your report, you hadn't had his book, I don't think.

A. No, I didn't have the book at that stage.

Q. Very well. Then we carry on in paragraph 14, you say that, "It seems to refer to the proposed improvement in the calibre of retinal arteries following a period of vitamin C consumption as determined by observation of retinal photographs. Optometrists do examine the calibre of retinal arteries during ophthalmoscopy, and if the caliber looks abnormal then they would refer the patient to a medical practitioner". That's correct, is it?

A. Yes, it is correct.

Q. And you also say they may also look at the calibre of the arteries after the patient has been treated for cardiovascular problems, and then you say this: "Optometrists do not use artery calibre to monitor their own treatment of a cardiovascular disease

simply because optometrists are not trained or qualified to treat cardiovascular disease."

Those last words, that optometrists are not trained or qualified to treat cardiovascular disease, is that correct?

A. Yes, it is.

Q. And you say that your opinion is based on "knowledge of the curriculum at United Kingdom optometry schools, continuing education and training and continuing professional development and clinical experience".

A. Yes.

Q. Then you draw attention to what we've looked at previously which is Section 26 of the Opticians Act of 1989, and you say that that states - and subject to the Legal Adviser - that would be my reading of the statute in its general interpretation although the Legal Adviser will obviously advise the Panel as to the correct interpretation of the statute. But you state that your understanding is that Section 26 states that "an optometrist has to refer to a medical practitioner once a disease has been detected. If an optometrist detects an eye sign that is suggestive of a cardiovascular problem, then the optometrist is obliged to refer the patient to a medical practitioner for treatment and advice, the only advice the optometrist should give to the patient is that they should make an appointment with their GP to discuss the general health problem". As an optometrist, is that your understanding of current practice of the law in this area?

A. Yes, it is.

Q. And you repeat that optometrists are not trained or qualified to offer any other form of advice or treatment, based upon your previously expressed knowledge of these matters.

A. That's correct.

Q. So then at paragraph 18, you repeat that optometrists are not trained or qualified in the treatment of cardiovascular problems, and then you say this also, in particular: "using vitamin C or any other form of nutrition". It would be your opinion that they should not treat cardiovascular problems by any means. Is that what you stand by?

A. Yes, it is.

Q. And you say you do think it is appropriate for optometrists to offer advice on diet and nutritional supplements in the case of age-related macular degeneration, in otherwise healthy patients. Over the page, at paragraph 20, we are now dealing with the extent to which it's appropriate for optometrists to discuss matters and you say you "think it is acceptable for optometrists to discuss conditions or treatments where the primary source of the condition is not the eye prior to referring patients to medical practitioners. Some patients may find it useful or comforting to have some information about their condition and/or prospective treatment". So up to that point you are quite content, are you?

A. Yes.

But then you say this:

"I do not think it is acceptable for optometrists to discuss conditions or treatments where the primary source of the condition is not the eye without referring to a medical practitioner. If a person has a condition that requires treatment then that patient should be referred to a medical practitioner for that treatment". That's what you stand by?

A. Yes.

Q. Now, dealing with the evidence of other professionals, you say at paragraph 22, "There is no evidence base to suggest that vitamin C has any effect on the calibre of arteries in cardiovascular disease". Is that what you still understand to be the position?

A. Yes.

Q. By this you mean that "there is no conclusive proof in peer reviewed academic journals to that effect. Therefore I do not think Professor Bush's views/recommendations are acceptable practice for an optometrist". You still stand by that?

A. Yes.

Q. Could you just keep your report open, but turn, if you could please, in volume 1, to page 78, which is the report obtained in July 2008 by Dr Butler from the Clinical Policy Support Manager at Hull – do you see that document?

A. Yes, I do.

Q. Have you had an opportunity to read through this?

A. Yes, I have.

Q. Various points are made in relation to the evidence base of other material on particularly page 80, where the author of this report is reviewing works by, for example, Professor Steve Hickey and Dr Roberts, and so forth, and Dr Gifford Jones. What I want to ask you is this: is there anything in this with which you disagree, or is that very much in line with what your own opinion is?

A. I thought this was a well-written piece of information, very informative, which agreed with my own views.

Q. Thank you. Right, we can put that away. There is certainly nothing in that document which warrants you to change your opinion or your report in this case?

(End page 40 of original) No, there isn't anything in that document.

Q. Thank you very much. We'll go back to your report. We've dealt with paragraph 22, I'm now on paragraph 24, when we're actually dealing with the advertisements that were displayed in the practice of Professor Bush's window. Paragraph 24 you say, "As there is no evidence base for an effect of vitamin C on the caliber of arteries and that this seems to be the treatment that Professor Bush is advocating to patients" you say it is your opinion that the claims in issue (viii) were inappropriate and unprofessional, and issue (viii), which goes back to page 406, you see issue (viii), paragraph 8(viii) on page 406, the appropriateness of Professor Bush's claims that he can cure heart disease and "real heart attack prevention", do you see that?

A. Yes.

Q. Then at paragraph 26 of your report you say with regard to issue (iii), that was paragraph 8(iii) page 405, use of the word 'CardioRetinometry' – you say in paragraph 26 of your report that by using this term, it is your opinion that Professor Bush's conduct has not, on simply the use of that word, fallen below the standard expected of a reasonably competent optometrist.

A. Yes.

Q. So the use of that word on its own wouldn't trouble you unduly?

A. Not at all, no.

Q. But it's not that on its own with which we are concerned in this case.

A. No.

Q. So then you say, with regard to issue (iv)-and issue (iv) is the top of page 406, Madam-the role of the optometrist in advising patients and/or recommending treatments in respect of the primary underlying condition, you say this: "If it is accepted" and this, of course, is a matter on which the Panel will have to come to a conclusion, "If it is accepted that Professor Bush has been advising patients and/or recommending treatment in respect of the primary or underlying condition which has presented itself via a condition of the eye" then it's your opinion that that would be in breach of Section 26 of the Act, and also various provisions of the Code of Conduct of the General Optical Council. (End p.41) Yes, that's correct.

Q. Obviously it's a matter for the Panel ultimately, and if the evidence goes the other way then the conclusion goes the other way, you are saying.

A. Yes.

Q. Similarly with regard to issue (v), which is the use of vitamin C, "If it is accepted that Professor Bush has been advising patients on matters of nutrition, particularly in the use of vitamin C, for the treatment of eye-related conditions, and particularly conditions not related to the eye but in respect of which symptoms manifest in the eye", then it is your opinion that that would be in breach of the Code of Conduct of the General Optical Council.

A. Yes.

Q. And we see the Code, Madam – I don't propose to go through the Code with the witness, but the Code changed – the 2005 Code is at page 400 in your bundle, and the 2010 Code precedes it at page 394. The only difference - and I have checked it through – there are a couple of words changed, but they don't make any change to the substance of it. The only difference is that the 2010 Code includes now items 18 and 19 on page 397. The 2005 Code was 17 items, as we see on page 400, and that ended with number 17, numbers 18 and 19 have been added, as on page 397. But number 19 about public confidence isn't in any event a matter for a Fitness to Practise Committee, so it may be that the additional No. 19 may not make a great deal of difference from a practical point of view. No. 18 we're not concerned with. Public confidence is obviously underpinning the whole of Fitness to Practise proceedings. Right, getting back to you, if I may, Dr Eperjesi, I am now at paragraph 29 of your report, it's the last bit of your report, you are dealing with issue (vi), and you say that if it is accepted that Professor Bush has discussed conditions or treatment of conditions with the patients without referring the patient to or involving another healthcare professional where the primary source of the condition is not the eye, then again that would be a breach of the statutes and the Code. Is that right?

A. Yes.

Q. And finally, you deal at paragraphs 30 and 31, if it's accepted that Professor Bush does involve other healthcare professionals-that they must seek a second opinion, and also at 31, if it's accepted that Professor Bush's claims in advertisements displayed at the practice then it's your opinion that he has breached the Code. You stand by your opinions in those two paragraphs, do you?

A. Yes. End p 42)

Then if I can just try and summarize this very briefly, would it be fair to put the after this way: that optometrists are expected to look for signs in the eyes that may indicate a health problem?

A. Yes, that's correct.

Q. But if there are blockages of arteries or if there is an indication of cardiovascular disease, something of that nature, then what should the optometrist do?

A. The optometrist should make a referral to a medical practitioner, and that would usually be the GP.

Q. And if the optometrist discusses the matter with the patient, to what extent should the optometrist either recommend a treatment or suggest that a treatment which the GP has prescribed is inappropriate?

A. The optometrist should not recommend a treatment; the treatment should be left for the medical practitioner to determine. Sorry, what was the second part to that?

Q. To what extent should the optometrist either himself or herself positively recommend treatment to the patient, or discuss with the patient the treatment which the patient is already receiving from a registered medical practitioner?

A. The optometrist should not recommend any treatment and should not discuss the medication that has already been recommended by a medical practitioner.

Q. Thank you. Is this because optometrists, as you say three times in your report, are not trained or qualified to treat cardiovascular disease problems?

A. That's correct. Actually, I have just thought of an example where an optometrist may comment on medication that has been issued by the practitioner, that's if that medication has caused some side effects which are affecting the eyes and the optometrist has become aware of, then the optometrist could contact the medical practitioner to say, the patient is on this medication, I think there may be an eye-related side effect, and obviously that would be then left to the medical practitioner to manage.

Q. Thank you. To what extent would it be appropriate for an optometrist – and this is in the course of practice, I'm not talking about academic research, this is an optometrist who is practising – to express views about the use of statins.

A. That would be inappropriate, to express views.

Q. Right. Can we just then finally turn to your supplemental reports? Page 414, you have written a supplemental report dated 30 May 2012, having read Professor Bush's book, is that right?

A. Yes.

Q. And you set out there the process of how books are published in the medical field, which I'm not going to read out, but I'll leave it to the Committee to read. End p 43) this report to themselves. Is there anything in his report at pages 414-415 you wish to change or alter, particularly in the light of having sat here and heard the evidence for the last two days?

A. No, there is not.

Q. Page 415A and B, again I am going to leave it to the Committee to read, but again, is there anything on those pages which you wish to alter, having regard to the evidence you have heard over the last two days?

A. No.

Q. Thank you very much indeed.

Ms Jones:

Thank you. I am going to give you the option, Professor Bush, as to whether you would like to take a lunch break now and begin your questioning after lunch, or whether you would like to commence now and we'll go to quarter past one.

Professor Bush:

Yes, I agree.

Ms Jones:

No, it's a question: which do you want?

Professor Bush:

I agree, we'll have a break now, I think.

Ms Jones:

Okay. Can I just remind you, Dr Eperjesi, that you are on oath, please don't discuss these matters which anyone else, thank you? We'll reconvene at 1.30. Thank you. [Hearing adjourned at 12.50[Hearing reconvened at 13.30]

Ms Jones:

Professor Bush, if you would like to commence your questioning of Dr Eperjesi.

Dr Frank Eperjesi Cross-Examined By Professor Bush

Q. Thank you, delighted to meet you, Professor Eperjesi.

A. It is Dr Eperjesi.

Q. Head of your department?

A. Yes, but I am not a Professor.

Q. Dr Eperjesi, in rugby if you were given the ball, you would carry it forward, that is the object, isn't it?
A. Yes. End p 44)

Can you imagine standing in front of a video screen attached to a new digital camera, the first in the world, the first to come into the UK with instant magnification that nobody has ever had before, can you imagine seeing changes, not being able to understand them, with a patient there asking you if there is a problem? You want time to think about it and finally you say there is no problem, then you realize what has happened-you have a new understanding of what you are seeing. Previous to this, you had always looked at arteriolar reflex as being a normality, that is what we are taught, isn't it?

A. Yes.

Q. You teach your students that the arteriolar reflex is normal?

A. We teach them that, if there is an arteriolar reflex that shows healthy retinal blood vessels.

Q. You would not expect to see a fundus with no arteriolar reflex?

A. In a diseased eye you might see that.

Q. I have here pictures of what is regarded as a normal eye, and they all show the arteriolar reflex – you would now disagree with that?

A. Mr Bush, you have lost me there I am afraid.

Q. I am saying do you regard the arteriolar reflex which you see in most people's eyes as normal?

A. Yes.

Q. Thank you. In that way, you are no different from any other optometrist or, to the best of my knowledge and belief, ophthalmologist?

A. I would agree with that.

Q. Thank you. If the arteriolar reflex were suddenly to take on a completely new relevance, a completely new significance which nobody had every thought of previously, and it fell to you to make that discovery, would you be a happy man?

A. Pause]

Ms Jones:

Professor, this is speculation.

Professor Bush:

You have made a discovery that the arteriolar reflex has more significance than you ever realized.

A. I have not made that discovery – are you saying if I had made that discovery?

Q. Yes, alright. If 200 patients were to show reductions of their arteriolar reflex as a result, they assure you, of taking vitamin C, what would you do with that knowledge?

A. I would class that knowledge as anecdotal evidence. There is plenty of good research that starts with anecdotal evidence. There are plenty of positive end p 45) useful findings which start as anecdotal evidence, but anecdotal evidence is the beginning of the research process. I would put it to you that the testimonials from your patients are anecdotal observational evidence that could be used to base further research on to see if there was anything that could be beneficial from that anecdotal finding.

Q. Does your use of the word "anecdotal" diminish its value then?

A. I would not put any emphasis in terms of medical care or research on anecdotal evidence other than to consider the possibility of further, more rigorous research.

Q. So when people started dying of Vioxx, you were one of those people who would say this is only anecdotal evidence? A. Can you inform me what Vioxx is, I am not familiar with that?

Q. An analgesic drug.

A. I have no knowledge of the Vioxx situation.

Q. If people started dying and their death or extreme illness were associated with a particular drug, you would simply dismiss it saying it is anecdotal?

A. I would not dismiss it, I would consider the possibility of more rigorous research.

Q. If you then found that, no matter how hard you tried, you could not get your suspicions into print in a learned journal, how would you feel?

A. I am very familiar with trying to get my findings into research journals, and it is a long and challenging process. Nevertheless, that is the process that is in place, so I know that

journals, in the main, do not publish anecdotal evidence, because it is not rigorous, the findings from anecdotal evidence can be biased by many things. Therefore, journals have a duty to publish accurate findings from rigorous research, and I would not put anecdotal evidence in that category.

Q. So you are a firm believer in the trustworthiness of the peer review journals?

A. I am.

Q. Yet, you have reviewed my book?

A. I have.

Q. And you have seen the graph on page 39?

A. I do not recall, I can look now if you wish.

Q. We are going to look at it but I am just asking you if you recall seeing a graph?

A. I do but I cannot recall any detail at this moment without looking in the book.

Q. You cannot recall the general purport of that graph?

A. Not at this moment End p 46)

Ms Jones:

There is no graph on page 39.

Professor Bush:

I am sorry?

Ms Jones:

There is no graph.

Mr Swinstead:

You may mean a graph on page 49.

Professor Bush:

My photographic memory may be deserting me!

Mr Swinstead:

There is a graph on page 49. With respect, Professor, if you want to refer to it, Dr Eperjesi should see it.

Professor Bush:

So you have seen this graph?

A. I have seen the graph.

Q. But you are now aware of its significance.

A. Am I?

Q. You are now aware of its significance.

A. I don't think that I am.

Q. Oh, would you kindly look at it for a minute or so.

A. Would it be fair to ask you to describe the graph, because you are more familiar with it than I am?

Q. What the graph shows is that up to 1958, there was no general bias among the editors of the learned journals as to whether or not

they published the term "scurvy" or "vitamin C deficiency". The terms were interchangeable and the graph shows that they were universally acceptable. After 1958 there is a gross divergence of the number of times that each term was allowed into the peer reviewed archive. This shows-and the editors at that time, in my submission, could not possibly have anticipated the introduction of computers-a general bias that was introduced in 1958 against the use of the term "scurvy" with the substitution of the term "vitamin C deficiency", as if the two were synonymous. Would you say that those two terms are synonymous?

A. That is not really within my expertise.

Q. Kay. Dr Eperjesi, do you have any idea what percentage of people die of coronary thrombosis?

A. No.

Q. You have no idea?

A. No.

Q. Would it surprise you if I told you it's 60% End p 47) I am not sure, I have no idea what that figure is.

Q. If I said it is 60 per cent of people who die of coronary thrombosis, would you want to argue with it or say, that is fair enough, I accept that?

A. I would ask if that is in the general population, is it in a certain age group, is it in males or females?

Q. Overall.

A. Overall, because my knowledge base is zero in that area, I would not be able to comment whether your facts are correct or not.

Q. You have had plenty of comments to make about my book?

A. I have because I have had the opportunity to read your book.

Q. You said it has not been peer-reviewed, although the great majority of the articles in the book refer to peer-reviewed papers?

A. I would disagree. I have looked at the articles on which you base some of your comments and they are not peer-reviewed. From my reading of your book, as I state in my report, you refer to emails, lectures, other people's books and, in the main, those sources of information are not peer-reviewed.

Q. Dr Eperjesi, why do you think we are here today?

A. I am here to help the panel make the appropriate decision.

Q. But why do you think there is a meeting today of the Fitness to Practise hearing concerning me?

Ms Jones:

Excuse me, Professor. Dr Eperjesi is an expert witness, he has taken us through his evidence. This is your opportunity to question that evidence. Whatever Dr Eperjesi thinks about the process of fitness to practise work in general is not pertinent to what we are doing –

Professor Bush:

I am proving –

Ms Jones:

Please let me finish! It is not pertinent to why we are here, so please restrict your questions to the evidence and his expertise.

Professor Bush:

Thank you. I refer to Dr Eperjesi's learned summarizing of the literature which is being put to him, and he can only do that in context of his own prior knowledge. I am probing his depth of knowledge. Ms Jones:

You are asking Dr Eperjesi about the fitness to practise process, which is not something for which we have him here for his expertise.

Professor Bush:

No, let me put it another way. Is vitamin C toxic?

A. In certain quantities, vitamin C can cause nausea and diarrhoea – nausea and diarrhea End p 48 Is it toxic?

A. What do you mean by toxic?

Q. Poisonous?

A. Not to my knowledge.

Q. Thank you. So you would not be surprised if I said there is no LD50 figure for vitamin C. LD50 is the lowest dose at which 50 per cent of animals survive an overdose. Therefore, you would not be surprised if I said there is no LD50 figure –

A. No, I don't think that would surprise me.

Q. No, so you can't kill people with vitamin C. Would you expect the British Medical Journal, because you have already mentioned the peer review process, or the Journal of Medical Ethics to welcome papers from me on the subject of scurvy?

A. I cannot comment on what journals may or may not welcome. What I do know about the BMJ is that it is a very well-respected, highly-regarded journal in which I strive to get something published and fail.

Q. Dr Eperjesi, if the British Medical Journal were repeatedly to refuse point blank when challenged to publish a paper on scurvy, would that surprise you?

A. No. From experience of submitting manuscripts, around 80 per cent of manuscripts submitted to journals are rejected. It is a huge rejection rate.

Q. Yes, but we are talking about all papers submitted on the subject of scurvy, none is acceptable, that is not 80 per cent.

A. It sounds like 100 per cent but, again, I cannot comment on why or why not.

Q. If you had the experience as I have had of writing to editors of journals and saying would you accept a paper on the subject of scurvy and getting 100 per cent rejection, would that surprise you? A. Would it surprise me to hear that 100 per cent of –

Q. They say there is no use submitting a paper on scurvy because they are not going to read it, let alone publish it. A. Would that surprise me?

Q. You expect honesty on the part of the journals, you base your knowledge on learned journals?

A. Yes, but because it is a protracted process when you submit to a journal, journals will decide whether or not that manuscript is of value to their readership, and of value to the wider research world. There are

many things that editors consider in deciding whether or not even to consider an article for publication, never mind going ahead eventually to publish it.

Q. Do you accept that scurvy is a End p 49 Other than your use of the word "scurvy", I have not seen that word since my A level history or something like that. I have not seen that word for many years until I started to read through the case notes for this hearing. Therefore, it is not a word with which I am very familiar. I have some sense of what it means.

Q. If it is not a word with which you are familiar, it is not a disease with which you are very familiar?

A. My familiarity does go back I believe to my A level or even my O level studies, when I was aware that people who were travelling across the Atlantic on long boat journeys through nutritional deficiency ended up suffering with scurvy that was cured with citreous fruits.

Q. Do you know why they suffered from scurvy?

A. Because they had a nutritional deficiency I believe of vitamin C.

Q. Do you know why the nutritional deficiency is so important?

A. Generally or in that context?

Q. The origin of the nutritional deficiency. If it is deficient in their diet, why do people get scurvy?

A. You mean the biochemical reasons?

Q. No, I am thinking of genetic reasons?

A. I don't know.

Q. Do you have any idea what a genetic countermeasure is?

A. No.

Q. Do you know what a metabolic countermeasure is?

A. No.

Q. You are supposed to have read my book and be familiar with the Pauling/Rath theory?

A. No. I have read your book, I have made a report on your book, and I have made comments on what I believe is the lack of validity of some of the comments – of most of the comments – that you make in your book.

Q. Could it be that you have been denied – because your answers are in the negative so many times – knowledge, that you should be much more familiar with scurvy and its manifestations?

A. No, I don't feel that.

Q. But you eventually accepted, when I put it to you, that 60 per cent of people die of coronary thrombosis?

A. I do not think I did accept that.

Q. You didn't accept it? End p 50

No, I don't think I did. I said my knowledge base was so low that I could not offer any comment.

Q. So if I assure you that 60 per cent of people die of coronary thrombosis, you want to say I can't accept that? Or do you say, if

that is good enough for you, Dr Bush, I shall accept that? You would question my veracity?

Mr Swinstead:

With respect, if you are able to answer, you can do. If you do not feel that you are able to assist the Professor by answering, either through lack of specific knowledge or experience in your field, then you cannot answer. If within your knowledge and experience in your field you can answer that, then do so, but you can only answer if it is within your knowledge or experience to be able to give an answer. Mr Hamer, is that right?

Mr Hamer:

I entirely agree, sir.

Mr Swinstead:

With regard to any question, if you feel you can answer it within your knowledge and experience, then do so. If you feel you cannot, then make it clear that you do not have knowledge or experience in the particular area you are being asked about. It is a matter for you.

A. I cannot agree or disagree with you on your figure of 60 per cent.

Professor Bush:

Okay. You said out of your own mouth that transatlantic voyagers died of scurvy?

A. I did not say died of scurvy; I said they suffered with scurvy.

Q. If the voyage went on long enough, suffering from scurvy, you would expect them to die?

A. I think so, yes.

Q. In your opinion, then, the majority of those people on board ship, suffering nutritional deficiency manifested in scurvy, would be likely to die unless they reached a nutritional source of vitamin C before that happened?

A. I don't know whether it would be the majority, I am not sure how many it would be, and I am not sure of the longevity-

Q. You would expect survivors then, in saying that some people don't need vitamin C?

A. No, I did not say that some people do not need vitamin C.

Q. So if we do need vitamin C, they are all expected to die?

A. I don't know the diet of the individual people on board those ships. It is possible that the captain may have had a more nutritional diet than perhaps someone who was working down below, I don't know those facts. What I also know, from my vague recollection of my O level or A level studies, is that not everyone on those ships died, although lack of vitamin C was a problem.

End p 51 significant numbers made it there and back, didn't they? A. Significant numbers made it there and back.

Q. "Odd" people made it there and back. It may be that there were special circumstances, we don't know. We both accept then that a high proportion of people suffered from scurvy and could be expected to die if the voyage lasted long enough without them having access to vitamin C?

A. I am not sure whether it would be a high proportion.

Q. What would you call a low proportion?

A. I don't know, what would you call a high proportion?

Q. I would say a high proportion is over 80 per cent.

A. Again, I believe you are being speculative, because it depends on the length of the journey.

Q. To shorten this as much as possible, would you say a high proportion is over 80 per cent?

Ms Jones:

Professor Bush, could you pause a moment. Mr Hamer.

Mr Hamer:

I do not know whether Professor Bush has any paper or material to put before the witness. It seems to me that what he is putting to the witness is a proposition. If it is based upon a journal, it would be helpful to have it, also from my point of view and probably from the point of view of the witness.

Mr Swinstead:

Mr Hamer, can we perhaps put it this way. Is it within your knowledge or experience to ask this question? If you have an imaginary sailing ship in the 18th century and that ship is at sea for so long that all its crew developed a vitamin C deficiency simply because there was nothing they could eat which would allow them to maintain the level, is the possible ultimate corollary, if they never get anywhere where they can replenish their diet, that they could all die?

A. Yes, I would agree with that.

Q. With respect, Professor, I believe you are imposing that question but not perhaps like that. Doctor, do you accept that as a proposition?

A. I accept that.

Q. As an application of common sense to a problem, if I can put it that way?

A. Yes.

Mr Hamer:

If it helps, I have a medical dictionary here and scurvy is defined in it very briefly as "a disease due to deficiency of ascorbic acid marked by weakness, anaemia, spongy gums and mucocutaneous haemorrhages". That is how scurvy is defined in a medical dictionary. I am very happy to have that available for you. I do not believe it takes it a great deal further but we have End p 52 used the word "scurvy" so many times, it might be helpful to have the definition of what the word means.

Mr Swinstead:

Professor, does the point I have explored with the Doctor assist you to go on to ask your next question?

Professor Bush:

Thank you. Are you aware that when people die of other diseases like cardiovascular disease, which according to learned people - you have reviewed this book?

A. No, I haven't.

Q. Reviewed this book?

A. No.

Q. You have reviewed that book?

Ms Jones:

Excuse me, Professor, when you hold them up, can you say the title please for the recording of them?

Professor Bush:

This book is by Dr Thomas E Levy, cardiologist, who wrote the book Stop America's Number One Killer Now I thought you had reviewed that book. Would it surprise you to know that the cardiologist, Dr Levy, found 650 peer-reviewed papers germane to the subject of scurvy and cardiovascular disease?

A. I am aware of that fact through earlier discussions at this hearing.

Q. Thank you. Are you aware that Dr Matthias Rath wrote this book why animals don't Get Heart Attacks ... But People Do?

A. I have not reviewed that book and I was not aware of that book until you just showed it to me.

Q. Are you familiar with the paper Lipoprotein Alpha is a Surrogate for Vitamin C by Dr Rath and Dr Pauling?

A. No.

Q. It is a unified theory of heart disease proving that lipoprotein alpha is a surrogate for vitamin C?

A. am not familiar with that piece of work.

Q. I asked you earlier if you could explain the meaning of genetic countermeasure and you said no. I asked you earlier if you could explain the meaning of metabolic countermeasure and you said no. Both these countermeasures are fundamental to the preservation of life in scurvy and yet you have no knowledge of them?

A. I do not think I am here as an expert in scurvy End p 53 it cannot surprise you surely to know that scurvy is the prime cause of death of most people including everyone here, that we shall ultimately die of scurvy.

A. That does surprise me.

Q. But you have reviewed my book which details 50-odd diseases which are aetiologically based in scurvy. Did you not know that?

A. To be perfectly straight with you, I do not hold very much of what is in your book as being accurate simply because it relies on emails, lecture content and other information similar to that. The content of your book does not rely on what I would call good research that has been published in reputable journals that has been peer-reviewed.

Q. I am quoting something like a thousand peer-reviewed articles in this book.

A. In which book?

Q. In my book that I have written here. There are around 1,700 entries which quote around 1,000 peer-reviewed articles. Can you be happy to be so dismissive of all that body of evidence?

A. In my reading of your book, I followed up some of the references that you made and the references led me to emails, lectures, websites and other books.

Q. So the book is tainted by what you have read on the internet, we cannot accept anything that we read on the internet? So Pauling/Rath's theory if published on the internet is devalued because it is on the internet?

Mr Swinstead:

You have asked two or three questions but I think you need to go back to your first question, which is the suggestion to Dr Eperjesi that, because he has done research on the internet, that is the cause of him not accepting what is in your book. You may need to explore that with him so that he can answer that point, as I believe that was the original point you were making. Am I right that it is the first point, if he used the internet to explore the references in your book and he did not accept them, you were putting to him that we cannot accept anything on the internet and I think he should be able to answer that point.

Professor Bush:

Sorry, I could not quite grasp that.

Mr Swinstead:

Professor, you appear to be suggesting to the Doctor that, if he had researched the references in your book on the internet and did not accept them, "we" (all of us) cannot accept what is on the internet", and I do not know whether it was a comment or a question. The Doctor should be able to answer that and I shall put it to him if you do not so that he can answer the point. I understand that was the point you were making, was it not?

Professor Bush:

We must accept that most of our knowledge is coming to us through the internet. End p.54

Mr Swinstead:

With respect, you are putting a slightly different point. I believe you understand the point that the Professor was putting to you. Let us put it this way, in order to research the references did you go on the internet?

A. Yes.

Q. As I understand the Professor to be saying you, if you did not accept those, is it right that you should not accept anything on the internet, that sort of implication? Perhaps you should be able to answer that.

A. I see where we are now. One of your statements is underpinned by information which I believe is from the Epoch News or Epoch Times

Professor Bush: Epoch Times

A. - Epoch Times, which is an internet-based, as far as I can tell, newspaper.

Q. No, it is not.

A. As far as I could tell, it was an internet-based newspaper that was making some comment about your work and this topic. As far as I could tell, that is from where these comments originated, from this internet-based newspaper. Of course, well-prepared research articles are published on the internet but they are peer-reviewed and published in the online version of reputable journals like BMJ and many others. I looked at the website that your book had pointed me in the direction

of, which might be on the back somewhere, I cannot remember, and as far as I could tell, that website was the originator of some information that you were using to underpin comments and statements in your book. To my mind, information on the internet in that form is not a reliable source of information.

Q. Have you finished?

A. I have finished.

Q. The Epoch Times is a newspaper published in 17 countries in 37 languages. It also has an internet presence. It has honored me, making me one of their health correspondents for two years. I have explained to you that probably over 90 per cent of people die of some disease originating in scurvy, and you were surprised that I could say such a thing?

A. I was not surprised that you could say it; I was surprised at that fact.

Q. Yes. Would it surprise you to know that scurvy is so ubiquitous that, in many cases, it is a toss of a coin as to whether a person dies of cancer or of cardiovascular disease? It is a question of which one gets them first, because the cancer statistics are closely aligned to the scurvy statistics. Does that surprise you?

A. Yes, it would.

Q. If you have read my book, you will have learned that cancer in many of its forms is directly linked to scurvy?

A. I do recall that information from your book. End p 55 There is page after page of it, isn't there. When I put it to you that 60 per cent of people die of cardiovascular disease, you might fall into the trap of thinking it is just 60 per cent. Now I think you would change your mind, because you are compelled to include how many people with cancer also have cardiovascular disease, which might be slow to kill them compared with the cancer. So you accept that cardiovascular disease can be so ubiquitous that it affects almost everybody?

A. You want me to accept that cardiovascular disease is so ubiquitous it can kill everybody?

Q. The people whom it does not kill, those who die more quickly may be from something else like a car crash or a cancer.

A. I am afraid that this is beyond my knowledge base, beyond my expertise.

Q. Right. If you were a general medical practitioner-

A. - which I am not.

Q. If you were, you are an educated man, you have to think like a doctor very often, would it -

Ms Jones:

Professor!

Mr Swinstead:

Let him ask the question and we shall see where we go.

Professor Bush:

Would it concern you to know that, if the knowledge became generally accepted, that a little vitamin C could protect people from 50 diseases and increase life expectancy by 20 years or more, would that worry with regard to your income as a doctor?

Mr Swinstead:

With respect, Professor, that is quite difficult to answer. One, he is not a doctor; two, he cannot talk about a doctor's income because he is not a doctor. I think it is more properly a comment you could make, Professor.

Professor Bush:

I can put the question in another way.

Mr Swinstead:

If you can put it in a different way but it is difficult to put it in that context.

Professor Bush:

Let me put the question another way. He is an optometrist, would it fill you with delight, Dr Eperjesi, to know that, if you could get everybody to have vitamin C, they would not need your services?

Mr Swinstead:

As an optometrist, you had better make that clear.

Professor Bush:

As an optometrist.

A. They would not need my services in terms of providing contact lenses or glasses? End p 56 They would not need reading glasses, they would not have any eye diseases.

A. They would not have any myopia – would that fill me with delight if we were in that situation?

Q. Yes, would you be a happy man?

A. That is so unlikely, I don't know whether I can comment on that, because that is so unlikely for that to happen.

Q. It is a hypothetical question.

A. It is a very hypothetical question.

Q. If our living depended on our practice of optometry, we could in all honesty –

Mr Swinstead:

With respect, you are now commenting. That is a comment that you may want to make later and everybody will understand that, but he has already answered –

Professor Bush:

I think I have got the message across.

Mr Swinstead:

I am sure you have, Professor, and you can make the point.

Professor Bush:

You have taught, and you teach, that the arteriolar reflex is normal.

A. Yes.

Q. There is no argument about that. I have here a book which is older than all of us by Lindsay Johnson called The Pocket Atlas and Text-Book of the Fundus Oculi.

Mr Swinstead:

Just to make it clear, Professor, this gentleman would not be the former President of the United States?

Professor Bush:

Sorry? [Question repeated] We are not going to argue with this.

Mr Swinstead:

No, sorry, this is somebody who is a professional.

Professor Bush:

It is one of the first books to illustrate the subject of this conversation.

Mr Swinstead:

Can you give us the title of the book?

Professor Bush:

The title of the book is The Pocket Atlas and Text-Book of the Fundus Oculi by Dr Lindsay Johnson MD FRCS, illustrated by Arthur Head, a Fellow of the Zoological Society. This is the very first book to illustrate the features of the retina to which I refer, namely the arteriolar reflex. You would not be surprised to see the arteriolar reflex rep End p. 57 I cannot see from here.

Q. Come and have a look? [Book passed to expert witness] I am sure you won't argue with that, there is nobody who can. One hundred years ago, the fundus oculi was depicted as it is today with no change, no difference, and I am sure that Dr Eperjesi will not argue with that.

Ms Jones:

Hang on, are you asking him that question?

Professor Bush:

Would you say that is the same as the Mardeno Atlas today?

A. Are you asking me if this illustration here-

Q. Would you say that corresponds with the Mardeno Atlas depiction today?

A. I know the book to which you refer, the Mardeno Atlas, but I cannot right now picture in my mind all the images in the book. However, the book I am holding here now does look fairly typical of an illustration of a fundus, of the retina.

Q. It looks like a photograph today?

A. I would not say it looks like a photograph but it looks like an illustration that we could see in a more up to date-

Q. It is sufficiently lifelike for anybody to look at it, such as an expert like yourself, and see that is meant to be the human fundus oculi and I would not expect it to look much different today?

A. I would agree with that.

Q. Thank you. We have a situation, and Dr Eperjesi agrees, that arteriolar reflex that we see today is the same as it was 100 years ago.

Mr Swinstead:

You are making a comment again, Professor. Remember, at this

moment you are not giving evidence, so you have to confine yourself to questions.

Professor Bush:

I am putting the question to him that this is –

Mr Swinstead:

He is agreeing broadly with you.

Professor Bush:

He accepts that what we see today is the same as 100 years ago.

Mr Swinstead:

So what is your next question?

Professor Bush:

The next question is what if 60 per cent of people die of coronary artery disease and we now know that almost every eye that we look at as optometrists shows arteriolar reflex. Do you think there is a possibility, Dr Eperjesi, that we could connect the dots and say, aha, somebody has been missing this. Perhaps the ubiquitous nature of coronary artery disease. End p. 58 corresponds with the ubiquitous nature of the arteriolar reflex in every eye? Perhaps everybody has heart disease then, would that thought occur to you? A. No, it would not. For the sake of the panel, the arteriolar reflex is a reflection. When an optometrist looks into the eye through the pupil with an ophthalmoscope with a bright light, what most people would consider to be a good sign would be a reflection off the artery – you get a little bright line off the artery. Most optometrists would think that is a sign of health. You are suggesting, to my mind, that the arteriolar reflex – this shining of the artery when we do ophthalmoscopy – is a sign of ill health.

Q. Correct.

A. I would put it to you that children and young adults who cannot possibly have heart problems or cardiovascular problems-

Q. Sorry?

A. I would put it to you that children and healthy young adults who do not have cardiovascular disease also have an arteriolar reflex.

Q. I am pleased you said that. I have in my computer here the photograph of a nine-year old child, I won't bore you with it, which shows extreme arteriolar reflex until the mother had given the child a gram of vitamin C every day and promised to do so, so that I would fit him with contact lenses with less fear of having eye infections. It will surprise you to learn that, when she next attended for a second annual check, the child was back to square one, and the mother broke down in tears saying, "I am sorry, I have not been giving the child the vitamin C".

Ms Jones:

Professor, what is the question arising out of this for Dr Eperjesi?

Professor Bush:

Would it surprise you then, in view of what you have just said, to say such a thing cannot happen, because children cannot get

atherosclerosis? How do you then account for children of 15 dying from coronary thrombosis if children cannot get atherosclerosis – how do you account for that?

A. No doubt there are some children who can but, in the main, children do not have cardiovascular problems, don't have coronary heart disease in the main but what they do have is an arteriolar reflex, which the vast majority of optometric and ophthalmological profession would consider to be a sign of health, rather than of ill health.

Q. Then, Dr Eperjesi, I would invite you to ask yourself what would be your reaction if you suddenly learned the opposite to be the truth, how would you feel yourself having made this discovery?

A. I would be very surprised.

Q. Yes, you would be surprised indeed. What would you do with the knowledge being entrusted to you? You have suddenly made the discovery that good End p.59 health is absolutely ruined by this reflex that you are seeing in patient after patient after patient, the loss of this arteriolar reflex, and they are all saying, I took vitamin C – what would you do with that knowledge? Would you keep it to yourself?

A. I would do what I normally do in my research work. If I have a hunch that something might be worth investigating, I will set up a proper study to investigate my hunch or some anecdotal evidence, proper rigorous study, preferably across several centres either in the UK or across the world, where other people could do the same study. Then we would pool our data, analyze the data with common statistical analysis, review the results and then draw appropriate conclusions. What I would not do is try to publish my hunch, or try to publish my anecdotal evidence at that particular stage, because I would know that the chances of having that published would be zero. People do not publish hunches and they do not publish anecdotal evidence.

Q. So you would expect to be frustrated in your wish to disseminate this knowledge?

A. I often am frustrated in my research work.

Q. If you were a contact lens practitioner and you are over-running your time with every patient because of these features, these changes, how do you propose to start a formal study when you have to earn your living servicing these patients?

A. That is a fair point. How can a clinician who needs to earn a living further develop their hunch or their anecdotal evidence? The way I would approach that is that, if I were not working in a university environment, I would go to a university or academic environment and put my hunch to them.

Q. Which is exactly what I did?

A. It depends on your approach.

Q. We have Francis's thesis here for which he gained first class honors at Hull University, I did exactly that. What would you do if that failed?

A. What would I do if what failed?

Q. You have had the thesis published by a university, you have 200 testimonials but you find that no editor of any peer-reviewed journal

would entertain your papers; they are all refused time after time, paper after paper?

A. What I would do in order to be able to continue with my research career is find a different topic to work on that is what I would do.

Q. In other words, do some other work, give up on that?

A. Yes, that is what I would do.

Q. So you would accept defeat by the medical profession?

A. It is not defeat by the medical profession. Sometimes, and this was alluded to yesterday by Dr Davey, research topics are in favour, in fashion and End p. 60 sometimes they are not. When you work in the research world, you have to accept things like that.

Ms Jones:

I am conscious that Dr Eperjesi has been giving evidence for an hour. Do you wish to take a short break and we shall reconvene in 15 minutes. Dr Eperjesi, I am also asking you if you would like a break?

A. That is fine, thank you.

Professor Bush:

Yes. Dr Eperjesi, it can hardly fill you with delight to think you are frustrated in your wish to help people? Ms Jones:

Excuse me, Professor Bush, we have just stopped, I thought with everybody's agreement.

Professor Bush:

Okay.

Ms Jones:

We shall reconvene at 2.45 pm. Dr Eperjesi, I would remind you that you are still on oath. [Hearing adjourned at 14.30] [Hearing resumed at 14.45] Cross-examination of DR EPERJESI (contd.)

Professor Bush:

Can we resume?

Ms Jones:

Please continue, Professor Bush.

Professor Bush:

Does it surprise you, Dr Eperjesi, to discover that with this revelation of the ubiquitous nature of cardiovascular disease as evinced by the widespread appearance of retinal arteriolar reflex in almost every eye that we have arrived at a situation where the Act of Parliament governing optometrists and their requirement to refer all cases of disease has not only outlived its usefulness, but it has become a deterrent to good teaching and practice?

A. Does that surprise me? We fundamentally disagree on the information that arteriolar reflex provides. Your view is that it shows ill health, whereas my view, and that of many others, is that the arteriolar reflex is a sign of good health. So there is a fundamental disagreement there which I believe stops me or prevents me from answering that question.

Q. Perhaps I was a little ambitious in expecting you to agree with that, Dr Eperjesi. Could I perhaps modify the question a little by asking you if you can explain to the hearing committee what is Hollenhorst plaque? End p. 61

A Hollenhorst plaque, if I am correct, is a piece of cholesterol which may block an artery in the eye, and it is visible through ophthalmoscopy as a white or pale piece of debris within the artery.

Q. Thank you, Dr Eperjesi, for that masterly description of Hollenhorst plaque. I find it somewhat unreasonable then, with your good understanding of Hollenhorst plaque, for you to be (MISQUOTED – SHOULD BE UNABLE!) able to make the mental jump between Hollenhorst plaque and intraluminal plaque when you see it as the arteriolar reflex – what is your problem with that?

A. I do not think I have a problem. We have a disagreement. As I said, your view is that the arteriolar reflex is a sign of ill health. My view, and the view of others like me, in fact I would go as far as to say in the vast profession, would suggest that the arteriolar reflex is a sign of good health. Therefore, I am not quite sure how the arteriolar reflex relates to a Hollenhorst plaque, which is definitely a sign of ill health.

Q. Surely, Dr Eperjesi, you are confusing us. You have explained what a Hollenhorst plaque is and that it can cause blockage of an artery, and now you are saying that arteriolar reflex is a sign of good health, and you have not proved that arteriolar reflex is not intraluminal plaque?

Mr Swinstead:

Professor, could we step back a little because you have to remember that there are a number of members of the Committee who are not optometrists. I wonder if we could ask the Doctor to explain-

Professor Bush:

I am trying to keep my questions short.

Mr Swinstead:

I think you have explained the arteriolar reflex, you have explained the Hollenhorst plaque. Could you explain intraluminal plaque and possibly how they relate? Professor, with respect, it may be difficult for everybody to understand the point you are trying to make unless everybody understands exactly what we are talking about?

Professor Bush:

I am guilty of trying to keep my questions too short.

Mr Swinstead:

I am sorry but it would help if the Doctor can just explain this and then everybody, hopefully, will be able to understand.

A. Intraluminal plaque is not something with which I am familiar, though I could hazard a guess.

Q. Why don't you guess and the Professor will tell you whether you are right?

A. It is a deposit within the arteriolar vessel itself.

Professor Bush:

Dr Eperjesi, if you see the arteriolar reflex disappearing, how would you account for that?

A. It disappears with age through the process of atherosclerosis.

Q. So it gets better with age – it disappears as you get older? End p. 62

A Yes.

Q. The arteriolar reflex gets better as you get older?

A. I am not saying it gets better. I am saying it is well known that the arteriolar reflex disappears, or may disappear, with age.

Q. That is contrary to my expectation and knowledge. That is completely contrary to everything I know. Arteriosclerosis is a feature of hypertension, would you agree?

A. Yes.

Q. Arteriolar reflex is a more pronounced manifestation of hypertension surely?

A. Can you repeat that please?

Q. Arteriosclerosis-to give it its sold name because it is better understood-now known as atherosclerosis is a manifestation of arteriolar reflex at a higher level, a more pronounced arteriolar reflex that we expect to see as people get older. Is that not the case?

A. I am not sure I follow.

Q. Would you expect to see arteriolar reflex in children? You just said no in earlier questioning.

A. I would expect to see arteriolar reflex in children.

Q. You would?

A. I would.

Q. But you said earlier to my questioning that arteriolar reflex was less common in children?

Mr Swinstead:

No, he said the opposite because he gave the example, with respect, of children who would not have any cardiovascular problems but would show the reflex.

Professor Bush:

I said that is not true.

Ms Jones:

Yes, but Dr Eperjesi's evidence is what we are trying to recap, because there seems to be a misunderstanding in your recollection of what was said.

Professor Bush:

Dr Eperjesi said you do not get heart disease in children.

Mr Swinstead:

Exactly. With respect, and he can answer, I believe he said you do not get heart disease, you do get the reflex. Is that right, Dr Eperjesi?

A. Yes.

Q. That was his evidence. End p. 63

Professor Bush:

That you do not get arteriolar reflex?

Mr Swinstead:

You do get it. He was giving the example.

Professor Bush:

And I challenged you by saying children do not die of coronary thrombosis then?

A. In the main, no, they do not.

Q. But we know that they can?

A. They can and no doubt some do but it is a minority.

Q. Have we not reached the stage where you are prepared to accept that there may be more to arteriolar reflex than you have realized, and that its ubiquitous nature may reflect the ubiquitous nature of coronary artery disease in almost everybody? Are we now nearer to your accepting that?

A. No.

Q. We are not, okay. I would say that, if we could prove that the arteriolar reflex is due to intraluminal plaque and that intraluminal plaque is symptomatic of coronary artery disease, we have proved the value of the examination of the fundus by opticians to show systemic disease at a serious level, which the General Optical Council's Act of Parliament would regard as essential for us to refer our patients?

A. Was there a question in there, I am sorry?

Q. The question is do you agree that we are required to refer our patients who show signs of disease?

A. Yes.

Q. Yes, so we can agree that the ubiquitous nature of arteriolar reflex, if it does reflect coronary artery disease, would require us to refer almost everybody?

A. No. Optometrists will refer people who are showing signs of eye disease or signs of general health problems.

Q. You have to agree that, if it were true as I maintain that arteriolar reflex corresponds with coronary artery disease, that knowledge would require us to refer every patient?

Mr Swinstead:

Professor, let us start from the premise that the Doctor does not agree with you on the basic principle of arteriolar reflex and make that clear. The question is, Doctor, if it did, under the Act you would have to refer everybody to their general medical practitioner – I believe that is the question.

A. If it were proven and accepted that arteriolar reflex was a sign of disease, then, yes, people with an arteriolar reflex would have to be referred to a medical practitioner by their optometrist.

Q. Thank you. Now you are familiar with the work of Michelson, Morganroth, Nichols and MacVaugh? End p. 64

A. I am not.

Q. I would inform you that Michelson, Morganroth, Nichols and MacVaugh are the three cardiologists and ophthalmologists who, correctly, correlated the retinal arteriolar disease with coronary arterial disease. Their correlation in their paper of October 1979 in the Archives of Internal Medicine. I base my work on theirs. If that

work is true and accepted, and I have never seen it challenged, would you not be surprised to learn from that paper that the grade zero for coronary artery disease is taken as up to an including 49 per cent blockage of all major coronary arteries?

A. I cannot answer that question because I am not familiar with that piece of work.

Q. I am familiarizing you with it now and I am telling you that is chapter and verse – you cannot challenge it, it is there in the paper.

Ms Jones:

Professor, you would need to submit the paper for Dr Eperjesi to look at. If you are questioning him about a specific paper and drawing to his attention what you believe to be facts, he would need to be able to look at that paper to ascertain that, for example, on page 2 para 6 that was the case.

Professor Bush:

I can assure you, Madam Chairman, that I am quoting fact.

Ms Jones:

You may well be quoting fact but, for Dr Eperjesi to be able to agree or otherwise, he would need to see-

Professor Bush:

Let us make it hypothetical.

Mr Swinstead:

With respect, that is right, Professor, if you put it to him that, if it was generally accepted that those gentlemen are right in what they have said, then pose the question and see if he can answer it – he may not be able to do so.

Professor Bush:

If you found reading that paper that the grading of coronary artery disease started at a 49 per cent blockage of all major vessels, up to which point the official surgeon's grading is zero, would that surprise you? A. Yes, I believe it would surprise me.

Q. Now if I say to you that the widespread nature of retinal arteriolar reflex could correlate with coronary arterial disease, can it surprise you as much as previously when I tell you that the grade zero applies to blockage of all major arteries up to 49 per cent?

A. You are asking me to scale my level of surprise, is that right?

Q. You would not be happy would you, if I said to you that your coronary angiography finding was grade zero and you said to me, okay, doctor, is that as good as it sounds, what percentage blockage could I have and still be End p. 65 grade zero, and I said to you that you could have up to 49 per cent blockage – would you be a happy man?

A. If I am interpreting your information correctly, I do not believe that I would be a happy man.

Q. No, you wouldn't be a happy man at all, nobody would be because it is deception. To say that up to 49 per cent blockage of all major arteries is grade zero is sheer deception and not what the public expects, but that is modern cardiological practice.

Mr Swinstead:

Is that a comment or a question?

Professor Bush:

You agree that it is not very honest. Now I am saying to you-

Mr Swinstead:

Professor, I think you have put to him something and, Doctor, I do not know whether you are able to answer it? A. I don't think I am able to answer because it sounds as if it is in the realm of the cardiologist and I am not a cardiologist.

Professor Bush:

No, but we all take an interest in the way they measure things – we are measurers, we measure arterial disease – perhaps you don't. We measure, we are optometrists.

A. We do measure and that is where the second part of the word "optometrist" comes from, we measure and there is a measurement aspect to the artery/vein ratio.

Q. Would it surprise you to know that I measure the retinal arteriolar disease to a difference of 2-3 per cent per annum? A. That would surprise me.

Q. My objective is to demonstrate differences between 2-3 per cent, I want to see regression. If it were your eyes, you would be asking me have I regressed, has my arterial disease regressed. Would you be a happy man if I told you that your retinal arteriolar reflex was increasing?

A. We have a fundamental disagreement, don't we, in the sign-

Q. You say it is healthy.

A. Yes, it is healthy.

Q. So you would be a happy man if I said your arteriolar reflex is increasing?

A. It is not something that increases with age; it goes the other way. It tends to disappear.

Q. I do not believe that these have been entered into the record but they are pictures-everybody can have one-even from over there you can see there is a difference between these pictures. Could I have them entered into the record? End p. 66

Ms Jones:

We can, it is whether this is the right stage. If you are going to ask some questions of the Doctor, it would about this kind of evidence, whatever evidence it is. Wait, please do not pass it up yet. My understanding is that it would be appropriate, given that Mr Hamer accepts for it to be admitted, that those questions could be put to Dr Eperjesi and the Committee would have copies of that document.

Mr Hamer:

I am not quite certain whether what Professor Bush has is at the bottom of page 128.

Professor Bush:

It is in black and white instead of in colour.

Mr Hamer:

Is that what he has – that is what I believe he has. We have not looked at that but I am perfectly happy, if there is a better copy of the bottom of page 128, for us to have a better copy if it is relevant.

Ms Jones:

Is this evidence that you are submitting, or is it questions you want to ask Dr Eperjesi about now – which one? You want to ask the Doctor questions now?

Professor Bush:

Yes.

Ms Jones:

In that case can you please submit them and we shall call it R-

Mr Hamer:

It may be helpful if Dr Eperjesi could turn to volume 1 page 128.

A. I am there.

Q. You have that, and what I believe the Professor has is a better copy of the bottom of what is on Professor Bush's writing paper.

Ms Jones:

Professor, if you could now supply us all with copies of the card, that would be helpful. [Copies distributed]

Mr Hamer:

I would quite like one.

Mr Swinstead:

Could Mr Hamer see one first before we go any further?

Ms Jones:

Are you happy, Mr Hamer, that we see a better copy?

Mr Hamer:

Yes, I do not want to stop Professor Bush putting in material, so if it is a better copy of a document that is already in the bundle, my general feeling is that it should go in. How far the witness can deal with it is another issue.

Mr Swinstead:

Could I see one very quickly? End p. 67.

Ms Jones:

For now, if this is permitted in, the panel can share but could I ask that you bring some more copies tomorrow so that the panel members have one each if we need to refer to it over the next few days?

Mr Swinstead:

Mr Henley, if you are happy, and if the witness can have one. [Copies distributed]

Ms Jones:

That would be R-

Mr Henley:

Are you going to make that separate rather than what is already in the bundle?

Mr Swinstead:

It should be separate because it is a colour version so, therefore, it is a separate exhibit.

Mr Henley:

In that case, it will be R3.

Mr Swinstead:

On the back is the Professor's name, qualifications and various things.

Professor Bush:

Dr Eperjesi, I put it to you that the picture showing the smaller blood vessels there is a picture showing more intraluminal plaque restricting the blood flow through the vessels, would you find that acceptable?

A. You would need to explain to me how this image was taken.

Q. The same eyes, nine years apart.

A. It is a fundus camera, is that right?

Q. Yes, a digital 5SWS-it is an optical 9W5S, a 45 degree camera with enlargement of the disk.

A. Just remind me what you are asking me please?

Q. What?

A. Can you remind me what you are asking me about this image?

Q. Yes. Do you find it difficult to accept that the picture showing the smaller blood vessels is demonstrating more intraluminal plaque? In the next picture where the blood vessels are wider, the intraluminal plaque is reduced, dissolved, which can only happen if it is cholesterol. Everybody is taught that the blockages in the arteries are cholesterol. You have expertly described Hollenhorst plaque and you would not argue with me if I said Hollenhorst plaque is formed mainly of lipoprotein alpha.

Mr Swinstead:

I think we have a lot of questions here, Professor. I do not know if you are able to answer all of them, Doctor?

A. I would agree with you – I am looking at this and I am looking at the image on my left which looks to be the abnormal image, and the image on the right looks to be the image of the healthier eye. End p. 68.

Professor Bush:

Which one is that, you are talking about the wider arteries and the thinner arteries?

A. To my mind, the image on my left has the narrower arteries, and the image on my right has the wider arteries.

Q. Which one is healthier?

A. The healthier one is the one on my right.

Q. The wider arteries?

A. Yes.

Q. Thank you.

A. I can say that the image on the left does have narrower arteries but I am not sure why that one artery there is yellow – I don't know. It does not look like Hollenhorst plaque, that is one thing I can say.

Q. Thank you. The images are taken nine years apart and all that has happened in the meantime is that the patient assures me that she has taken more vitamin C every day. With a gradual reduction of 3 or 4 per cent per annum, we have arrived at that sort of change over a period of nine years. It is obvious, you will agree, that if the change had gone the other way, it would have been pathognomonic of an early death?

A. It would be a sign of disease if it had gone the other way.

Q. Yes, you would not want it?

A. You would not want it.

Q. Thank you. Why do you find it difficult when I suggest to you that the arteriolar reflex is intraluminal plaque – why do you find that difficult to accept?

A. Because other than you, I have never heard anyone else say that. I have never read that anywhere else other than perhaps in your book.

Q. If what I am saying is true though, do you think it could mean that the Opticians Act is out of date, obsolete and must be brought up to date if it is to serve the people properly, because it is becoming a deterrent to good practice? We are not being taught to recognise disease in all its forms are we? I am saying that cholesterol, this intraluminal plaque, is blocking the blood vessels and that it must be recognised as corresponding with heart disease. You are saying there is no correspondence there. Surely, you must be coming round to my view, having looked at those pictures, in thinking perhaps this is right, perhaps we are seeing cholesterol in all the arteries, Hollenhorst plaque is just another example you have described yourself. How can you see Hollenhorst plaque in here and not expect a similar thing elsewhere in the vessels? End P.69.

Mr Swinstead:

Professor, let him answer.

Ms Jones:

Professor, you have asked nine questions since the Doctor last responded. I have been counting them and trying to attract your attention –

Professor Bush:

I am trying to make it easy for him.

Ms Jones:

You are not making it easy for the Committee, because we are not hearing the answers to each of those nine questions and, by the time we get to the end, we have forgotten what the original question was.

Mr Swinstead:

Professor, if you remember, I said try to ask one question at a time and you rather went on and I think we are all lost now.

Professor Bush:

I am trying to find common ground here between us.

Mr Swinstead:

With respect, can you start at the beginning, which is get from the Doctor what he considers, if he is able to say, is causing the narrowing of the arteries in the left eye, because there is still a fundamental difference between you. If you want to close the gap, you need to take it stage by stage. The first stage, you have talked about the Hollenhorst plaque and so on, I am not sure that the Doctor is coming with you as you put the various elements of your questions. Can we go right back to the beginning and, with respect, the first question you need to ask the Doctor is what does he say is the cause, if he is able to say, of the narrowing of the arteries in the left eye, and take it on from there.

Professor Bush:

I wish I could go right back to the beginning but Dr Eperjesi has already said that he has no knowledge of a genetic countermeasure or a metabolic countermeasure.

Mr Swinstead:

Professor, can I ask, on your behalf, and let us see if we can go along your track. Can we start with what I believe was the Professor's first question, although he put it in the form of a comment, which is are you able to say or agree with him as to what the cause of the narrowing of the arteries in the left eye is?

A. Based on these images, no, I cannot say what the cause is definitively.

Q. With respect, I believe the Professor is saying that they are intraluminal plaque, that is what you are saying, so are you able to agree with him on that, or are you able to make a comment on that?

A. I am unable to agree with him simply because I do not know what intraluminal plaque looks like.

Professor Bush:

Can I ask you, what is your understanding of Hollenhorst plaque?

A. I did mention that earlier on.

Q. What is it? End p. 70

A. It is a cholesterol deposit.

Q. Any particular kind?

A. I don't know what kind, I know it is a cholesterol deposit.

Q. Is it high density cholesterol?

A. There are two types of cholesterol – high density and low density – and right now, I cannot remember which one is the good one and which is the bad one. One is considered to be of use, and one is considered to be harmful.

Q. Would it surprise you to know that there are three kinds of cholesterol?

A. Yes, that does surprise me.

Q. The two kinds of cholesterol you mentioned that you know are both innocent – neither of them is associated with heart disease, does that surprise you?

A. It does.

Q. That is all you know about cholesterol, that in some vague way cholesterol is associated with heart disease but you do not have a clue how, because you have named high density and low density cholesterol and you think they are both innocent?

A. I am not a cardiovascular expert.

Q. Sorry?

A. I am not a cardiovascular expert.

Q. No, but you look at cholesterol every day of your life when you look in the eye. You told me about Hollenhorst plaque.

A. Not every patient has Hollenhorst plaque.

Q. So you are looking at cholesterol when you see that?

A. When I see Hollenhorst plaque, I know what it looks like and I know that it consists of cholesterol, and I know that person needs to have some medical intervention.

Q. So what you are saying then is that almost everybody needs to have this medical intervention?

A. I am not saying that.

Q. What percentage of eyes would you expect to see that do not show Hollenhorst plaque?

A. That doesn't show Hollenhorst plaque?

Q. Yes.

A. The vast majority, over 99 per cent of the patients whom I have seen, would not, in my clinical experience, have a Hollenhorst plaque
End P. 7172

Q. I find that very interesting, Dr Eperjesi, it is the complete opposite of what I have found and the opposite of what you are holding in your hand, which is fairly representative of what I see. I do not think that you understand Hollenhorst plaque as well as you might. Hollenhorst plaque is composed of a different kind of cholesterol, not low density and not high density cholesterol, but lipoprotein alpha – you have heard of that?

Ms Jones:

The question is?

Mr Swinstead:

Have you heard of lipoprotein alpha?

A. No.

Professor Bush:

You have not heard of lipoprotein alpha?

A. I have heard of lipoprotein but not lipoprotein alpha.

Q. Lipoprotein alpha is fundamental to the Pauling/Rath theory of heart disease, all cardiovascular disease. How can you have an understanding of one without knowing about the other?

A. I have already said I do not know the Pauling theory.

Q. You are teaching your students about coronary artery disease – sorry, about arterial disease – and how to recognize it in the eye, is that right?

A. We teach our students how to detect signs associated with general ill health.

Q. What do you teach them, how to look at the eyes to recognize arterial disease when they see it – how do you describe it to them?

A. We teach them to look at the calibre of the arteries and of the veins. We teach them to look for haemorrhages in the retina.

Q. I am talking about vessels not haemorrhages, I am not talking about exudates. I am talking about the vessels.

A. We teach them to look at the calibre of the vessels and we teach them to look for focal narrowing of the vessels. We teach them to look for blockages in the vessels, that is what we teach.

Q. Tortuosity?

A. Tortuosity, yes, we teach that as well.

Q. Can you imagine what causes tortuosity?

A. Tortuosity is common in people who have high blood pressure.

Q. Can you explain to us what causes it in the fundus?

A. No.

Q. Why is that, you have spent your life studying this and you teach people about it?

A. I have not spent my life studying tortuosity. End P.72. Would it surprise you to know that tortuosity is caused directly by compression of the arterial microvasculature when it becomes blocked? In other words, when the artery fills with blood and the blood cannot get out at the far end, two things can happen. The vessel can widen or it can lengthen. Tortuosity has its origins in the lengthening process. Did you not know that?

A. That seems like a plausible explanation to me of tortuosity.

Q. Okay. I am unhappy that you appear to have no knowledge of Hollenhorst plaque.

A. Let me correct you, I do have knowledge of Hollenhorst plaque.

Q. But you do not even know what it is made of?

A. I know it is made of cholesterol. My job as an optometrist-

Q. You didn't even know it is lipoprotein.

A. My job as an optometrist is to detect abnormal signs and refer to a medical practitioner for treatment.

Q. Can you explain what causes the Hollenhorst plaque?

A. Hollenhorst plaque comes from high levels of cholesterol in the blood.

Q. So if you have low cholesterol, you cannot have Hollenhorst plaque?

A. I feel like I am in an exam here, I really do. This is not really my area of special knowledge.

Q. But you examine patients and you take notes as to their medication and if a doctor says they have high cholesterol or low cholesterol, you record that don't you?

A. Yes.

Q. Is it of no interest to you to note that people with low cholesterol often have high levels of arteriolar reflex?

A. People with low levels of cholesterol have high-

Q. They have high levels of arteriolar reflex, pronounced arteriolar reflex. Have you not made that observation?

A. To my mind, low levels of cholesterol are a good thing to have, and that would then be a sign of good health, and it would then be reasonable to expect a decent arteriolar reflex. Again, we have this fundamental disagreement about the value of the arteriolar reflex.

Q. Have you not noticed that the patient's statement which shows he has a low cholesterol level is not always accompanied by lower degrees of arteriolar reflex – have you not made that connection?

A. Have I made the connection that low levels of cholesterol are not always associated with End P.73.

Q. - pronounced arteriolar reflex.

A. I have not made that connection.

Q. Do you never notice that?

A. I don't think I have.

Q. So you would expect always to see that people with reported high cholesterol levels would have high arteriolar reflex?

A. High cholesterol leading to high-you are really losing me, I think I am confused.

Q. Is it not interesting to you as an optometrist, looking at these people and comparing them, is that not of great interest to you?

A. Which people?

Q. The patients.

A. Comparing my patients to what?

Q. When they tell you that they have high cholesterol, wouldn't you expect, according to your theory, to see pronounced arteriolar reflex?

A. When they have high cholesterol?

Q. Yes.

A. No, I don't think I would expect that.

Q. You have just said that arteriolar reflex corresponds with the plasma cholesterol.

Mr Swinstead:

He didn't say that, he didn't say that, Professor. I think you may have misheard him.

Professor Bush:

Okay, I am sorry. You said that arteriolar reflex is a healthy sign?

A. Yes, I have said that several times now.

Q. So you would expect that to be accompanied by a high plasma cholesterol?

A. No, because high plasma cholesterol is a sign of ill health.

Q. In fact, you do not see any connection between plasma cholesterol and arteriolar reflex?

A. Arteriolar reflex is more to do with the calibre of the artery, so a narrow artery is less likely to have an arteriolar reflex than a wide artery.

Q. If you were informed that postmortem your patients with high cholesterol levels who died in crashes or whatever had low heart disease, would you be interested to go to your notes and make comparisons with what you had recorded about them?

A. I would find it surprising if people who have been killed in car crashes who had high cholesterol were then found to have low levels. I believe you said of End P.74 coronary heart disease. That would surprise me but it would not make me go to my notes.

Q. As I said, you don't know anything about genetic and metabolic countermeasures, about Pauling/Rath theory of heart disease, you cannot explain what causes Hollenhorst plaque. Would it interest you to know that Hollenhorst plaque is nature's way of reinforcing a weak point in the retinal microvasculature?

A. That is not a theory that I have heard before.

Q. It is the basis of the Pauling/Rath theory that the deposition of intraluminal plaque is a countermeasure against the weakening of the arterial wall?

A. That is not a theory I have heard before and, to my mind, that is not a plausible theory and it is not an accepted theory.

Q. So you would contest the statement that plasma lipoprotein alpha is inversely proportional to plasma vitamin C levels?

A. I don't think I have the expertise or knowledge to make a comment on that question.

Q. Surely, it must be a matter of great interest to your students.

Mr Hamer:

May I just interrupt because we are getting into areas which may be of interest to his students. I have been very patient, this witness has been giving evidence for a long time. My broad approach is that I do not want to stop the Professor putting his case but there comes a time when I would respectfully draw the Committee's attention back to the Notice of Allegation. One begins to wonder to what extent this line of questioning is relevant to the allegation in the Notice of Inquiry. It has been a very long time now and, while I do not want to stop proper questioning and I appreciate there is an area of what one might call ophthalmic medical knowledge which is appropriate to put before the Committee, but it is background material. One has to go back ultimately to these allegations and I am not certain how far this line of questioning, which has been going on for a long time, is pertinent to the allegations?

Ms Jones:

Professor Bush, would you care to take five minutes in view of that observation made by Mr Hamer to think about your questions for the last session of the day? Perhaps we could all take five minutes.

Mr Hamer:

I am also anxious, it seems to me to be appropriate to try to finish Dr Eperjesi's evidence today – I was rather hoping it would finish before but I would hope that his evidence will be concluded today. It is already half-past three and, if we stop at four o'clock, I would hope that Professor Bush would bear that in mind as well and that he does not have a great deal more to put to the witness. I only have one question in re-examination. End p. 75

Ms Jones:

I am slightly circumspect about saying that things might end today. The Professor must have the time he needs to take.

Mr Hamer:

I accept that entirely, I do not want to curtail it but I only have one question in re-examination, although the Panel may have questions, I appreciate that.

Ms Jones:

We shall take five minutes. Mr Henley, would you please clear the room. By all means leave papers here if you find that helpful and, Dr Eperjesi, you are still under oath. Hearing adjourned at 15.30] [Hearing resumed at 15.38]

Ms Jones:

We appear to be without Mr Tippet Cooper who I am sure will join us in a moment. May I suggest that we recommence. I do not know, Professor, whether you wish to continue with questions particularly relating back to the evidence that DrEperjesi has submitted in writing and said today.

Professor Bush:

Dr Eperjesi, you view the presence of arteriolar reflex as a sign of good health?

A. Yes.

Q. Which is the exact opposite of my finding.

Mr Swinstead:

I think you have established that, Professor.

Professor Bush:

I can't think of any more questions I want to ask him. I think you have adequately explained or described the position of the teaching staff of optometry students. In your opinion, optometry students are all trained to believe that the widespread appearance of arteriolar reflex means universal good health among all their patients?

A. It does not mean universal good health. It is an indicator of possible good health but there are, of course, many other diseases which do not have any effect on the retinal vasculature.

Q. The fact that 60 per cent of people die of coronary thrombosis, and the high proportion of the remainder who apparently die of other causes may be also harbouring heart disease does not rest heavily on your shoulders when you see that they also show arteriolar reflex. They are healthy because they show arteriolar reflex?

A. That is my current thinking.

Q. Yes, I think we understand that now. We are diametrically opposed and I would say that the teaching has to change, because if I am right and Dr Eperjesi is wrong, we are inflicting ill health on the whole of the British population. I think I can rest it there. End p. 76

Ms Jones:

Thank you very much, Professor Bush. Mr Hamer? Re-examined by MR HAMER

Q. Very briefly, may I ask some questions to you, DrEperjesi, arising out of R3? I appreciate that not all the panel have R3 but, looking at this, you said the image on the left shows the narrowing arteries and is less healthy than the image on the right which shows wider arteries and is, therefore, more healthy?

A. Yes.

Q. As I understand your evidence, you are not able to say as an optometrist what was the cause of the left eye problem?

A. That is correct.

Q. Are you able also to say or not say as an optometrist what has produced the better version on the right?

A. The version on the right is definitely better but I am unable to say what caused that, what treatment has been given. That is not apparent to me from this card.

Q. Exactly, and underneath the photographs it has on the left the words "before nutrition" and on the right it says "after nutrition"?

A. Yes, I can see that.

Q. The question I am asking you is are you able to confirm or say whether those words are linked into that photograph, in other words the one on the right is better because it is after nutrition?

A. That is the way the card has been set out, to show a 'before' and 'after' image – before nutrition and after nutrition – and the suggestion is that the nutrition has caused the blood vessels to be wider and, therefore, the whole situation is healthier.

Q. I am asking you as an optometrist whether in fact in your professional opinion you can say that is a correct situation. A. I am not sure I follow.

Q. If you are not able to know what treatment was given to make it better on the right, are you able to confirm whether it would be because of nutrition?

A. I am taking the card at face value, I am taking into account Professor Bush's comment that the image on the right has been produced after some vitamin C.

Q. But, in your professional opinion, from what you know of this situation, would that surprise you?

A. Yes, it would surprise me to see that vitamin C therapy had that level of an effect on the blood vessels. End P. 77

Q. Thank you very much. Just to get this quite clear, these are photographs of the retina, is that right?

A. The pale areas on both of the photographs, the pale disk is the optic nerve head, that is what connects the eye to the brain, and the blood vessels are those overlying the optic nerve head.

Q. I see, thank you very much.

Questioned by the Committee

Ms Jones:

DrEperjesi, this is the opportunity for the Committee to ask you some questions now, and I would like to start by asking our optometry colleagues and then the lay members afterwards. MrReily?

MrReily:

I have two questions. DrEperjesi, the Opticians Act allows us, when we find ocular pathology, to decide whether to refer a pathology or not. If it is a minor pathology, we have the choice of not referring it, though we have to record why we are not referring it.

A. Yes.

Q. In your understanding and knowledge, does that also stand true for when we find ocular signs of systemic pathology?

A. When an optometrist finds a sign of systemic pathology, they would record their finding in the notes and make a referral to the GP. We would treat minor conditions like conjunctivitis but something that is suggestive of a general health issue would be noted, a referral letter would be written and passed to the GP and the patient advised to go to the GP. It would be recorded in the notes.

Q. Similarly, if there are ocular side-effects of systemic medications, would an optometrist have a choice about whether to refer that or not?

A. They would have a choice but the reasonably competent optometrist, having detected a side-effect of some general health medication, would again note that and make a referral to the GP.

Q. The most common one probably would be dry eye?

A. As a side-effect of medication?

Q. Yes.

A. That is a side-effect that can occur.

Q. That could be treated in-house?

A. That side-effect could be treated in-house but the reasonably competent optometrist, to my mind, would still inform the GP of the side-effect of that medication.

Q. That is all I wanted to ask you. Thank you. End p. 78.

Mr Lomas:

You talked about arteriolar reflex, what is that and how does it relate to the width of the blood column in the artery?

A. The arteriolar reflex is a reflection of light from the blood vessel. The more obvious the reflection, the greater the calibre of the blood vessel which, to my mind, is a good thing. I am not quite sure how it relates to the blood column though.

Q. If you were looking in an eye, would you regard narrowing of the blood column as a more serious sign of pathology than changes in the reflection off the vessels?

A. Yes, definitely.

Q. Would you say that the pictures we have of before and after nutrition are to do with the blood column width, or changes in reflection from the –

A. The image on the left-hand side, as I view it, has a narrower blood column than the image on the right-hand side, as I view it.

Q. Thank you.

Ms Jones:

It is the lay turn now, Ms Hallendorff?

Ms Hallendorff:

I have one question which you can possibly answer. Is it possible that a different exposure of photograph, or a different and more modern camera, bearing in mind that these photographs were taken nine years apart, could have an effect on the photographs as presented on this card?

A. No.

Dr Azubike:

Dr Eperjesi, there are two areas which I need to explore with you please. I notice you have co-authored four books?

A. I have edited one book and co-authored three books.

Q. Right. I believe it is on page 411-

Professor Bush:

May I come in at this point as to the relevance of the question that you are asking?

Ms Jones:

No, at the end of the Committee questions, you may return. Please make a note of the question you wish to follow up on. DrAzubike?

Dr Azubike:

One of the books is to do with nutrition of the eye?

A. Yes.

Q. I just want to explore that with you, because you say something about nutrition of the eye, and Professor Bush pursued quite a lot of areas with respect to nutrition of the eye?

A Yes End P. 79

Q. You must have quite a lot of knowledge about nutrition for you to be the author of a book?

A. Yes. My area of research interest is the effect of diet and nutritional supplements on age-related macular degeneration. It should say that this book was edited by Eperjesi and Beatty. We had contributions from other experts whom we brought together in the book. We wrote some of the chapters but many were written by other experts that we then edited and put together in the book.

Q. That is fine, thank you, that explains quite a lot. The second point I wish to explore with you is with respect to the book written by Professor Bush. Can you go through what your main criticisms of the book are?

A. My main criticism of the book is that when Professor Bush makes comments and backs them up with a reference, when you go back to that original reference it is often a piece of information that has not been peer-reviewed. For example, something that someone says in a lecture is not peer-reviewed. You can stand up in a lecture, pretty much say whatever you want, but it is not peer-reviewed. To take that information from that lecture and use it to underpin a statement that you are making in a book I believe is a poor way of doing things.

Q. What I am not sure of is what you would have expected in terms of references in the book?

A. The usual procedure that I would follow, and that all the colleagues I know would follow, is that when we make a statement

that is not something that is of our own finding, we would back that statement up with a reference to information that comes from a peer-reviewed article, from a reputable journal.

Q. Thank you.

Ms Jones:

I have one question on your report which is on paragraph 14 page 407. You wrote this report last September in which you say: "CardioRetinometry is not a term I am familiar with"?

A. That is correct.

Q. Is this terminology that is growing in the field within which you operate?

A. No.

Q. So other than seeing the advertisement for the doctrinal study, you are not seeing it elsewhere?

A. I have only seen it in that advert that I mention in my report on this book and in the contents of this book. I have not seen that term anywhere else.

Q. With emerging medicine and discoveries, I take it that, at some point, somebody must coin a phrase for what they are discovering. Is it usual to have an "R" and a little circle after it? Is it normal that new medical discoveries or terminology is registered in that way in your experience? End p. 80

A. In my experience, no, it is not normal for it to be registered, although I have heard of pharmaceutical discoveries where names have been registered. However, it is not, in my experience, in the eye world the norm.

Q. Thank you very much. Before I come back to you, Mr Hamer, I would like to take the follow-up question from Professor Bush to one of the Committee questions.

Mr Hamer:

I have nothing arising out of the Panel's questions.

Ms Jones:

Professor Bush, you have a follow-up question?

Professor Bush:

Yes, for MsHallendorff. Like her, our thoughts when we discovered so many changes in the appearance of the fundus photographs, were immediately that our camera must be aging. There must either be a problem with the chip or a problem with the flash.

Mr Swinstead:

With respect, this is evidence that you can give later. This is an opportunity to ask questions. It is not your opportunity now to give evidence. It is your opportunity to ask questions. One of the matters

that you can certainly deal with when you give evidence is the issue of equipment.

Professor Bush:

I take it, DrEperjesi, that the Panel might have thought these pictures could be subject to age changes within the camera?

A. I did not think that.

Q. It did not occur to you?

A. No. I took it at face value.

Ms Jones:

Are there any other questions you wish to follow up on in relation to-

Professor Bush:

I just wish to address the-

Mr Swinstead:

You can deal with that in your evidence.

Professor Bush:

I have finished with DrEperjesi, thank you.

Mr Swinstead:

I was not quite sure whether Mr Bush was referring you to a question from Dr Azubike.

Ms Jones:

In that case, Mr Hamer and Professor Bush, if you have no further questions, may I thank Dr Eperjesi for his evidence, you may stand down. [The witness stood down]

Mr Hamer:

Madam, that completes my case, I close my case formally. End P. 81

Ms Jones:

I invite the parties to return here tomorrow, we shall commence at 10 am, and I want to thank everybody for today and enjoy the sunshine this afternoon. [Hearing adjourned at 16.00 End P. 82].

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Conflicts of interest

Author declares that there is no conflict of interest.