GENERAL MEDICAL COUNCIL

FITNESS TO PRACTISE PANEL (INTERIM ORDERS PANEL)

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

Thursday 14 October 2010

Chairman: Dr Peter Maguire

Panel Members: Miss Patricia Dunning
Mr Manny Devaux

Legal Assessor: Mr Andrew Wallis

CASE OF:

MYHILL, Sarah

MR GARETH BRANSTON, instructed by GMC Legal Team, appeared on behalf of the General Medical Council.

Dr Myhill was present and was not represented.

Transcript of the shorthand notes of T A Reed & Co Ltd
Tel No: 01992 465900

I N D E X

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THE CHAIRMAN: Good morning everyone, good morning Dr Myhill. This is an Interim Orders Panel being held in London on Thursday 14 October 2010 to consider a review of your case. My name is Peter Maguire. I am a medical doctor and I am the Chairman of the Panel today. I am assisted by two Panel colleagues, Miss Durning who is a medical member of the Panel, and Mr Devaux who is a lay member of the Panel. Our Legal Assessor is Mr Andrew Wallis. Mr Adam Elliott is the Panel Secretary. Mr Branston, who you have met with the Legal Assessor earlier, will present the case on behalf of the GMC. Naomi is our shorthand today who takes an accurate and contemporaneous note of the hearing.

Dr Myhill, you are present. Dr Myhill, it is my understanding that you have requested that this Interim Orders Panel hearing be held in public today. Can you confirm that for me?

DR MYHILL: Yes, I confirm that.

THE CHAIRMAN: The Panel are happy to accede to your request and I therefore ask the hearing be opened as a public hearing.

(Members of the public entered the public gallery)

THE CHAIRMAN: Good morning everybody. This is a hearing of the Interim Orders Panel being held on Thursday 14 October 2010. I have already introduced myself to Dr Myhill. As the hearing is now in public session, I will reintroduce myself. My name is Peter Maguire. I am a medical doctor and I am the Chairman of the Panel today. I am assisted by two Panel colleagues. My colleagues are Miss Durning who is a medical member and Mr Devaux who is a lay member of the Panel. To open the proceedings formally, Dr Myhill is present at the hearing today and is not legally represented. Mr Branston of counsel, instructed by the GMC Legal Team, represents the General Medical Council.

Dr Myhill, I will shortly ask you to confirm your full name and GMC number for the record. However, before I formally open the proceedings, could I just remind everyone, especially those in the public gallery, to ensure that your mobile phones are switched off? There are no plans for any fire drills or scheduled evacuations today. However, should fire alarms go off, they shall be dealt with by the GMC fire wardens. There is also an absolute prohibition on the use of any recording equipment, be it audio or visual, including cameras and of course mobile phones. Anybody who is found using this equipment will be asked to leave the building immediately.

This is a formal hearing of the GMC. Whilst the public, at Dr Myhill's request, are welcome, there should be no interruptions, such as applause or laughter or calling out. If we do have interruptions, sadly, we will have to ask for the room to be cleared. Finally, a written copy of any public determination of the Panel will be provided outside of the hearing room once it has been read out.

Dr Myhill, you have confirmed in private session that you wish this hearing to be held in public. I formally open these proceedings in public and I would ask you to confirm your full name and GMC registration number, please.

DR MYHILL: My name is Dr Sarah Barbara Myhill. My GMC number is 2734668.

THE CHAIRMAN: Thank you, Dr Myhill. Mr Branston, Dr Myhill, during the proceedings of this Interim Orders Panel today the Panel has determined that when we refer to documentation and to pages within the papers we would ask that the names of individuals should not be used. What should happen is that initials are used in lieu of names, please. This is to a degree to protect the identity of names within the papers. Using actual names does not assist the Panel in their deliberations. However, if you refer to the information on the page, that will be very helpful to the Panel. The Panel would also remind both parties here today that this is an Interim Orders Panel hearing and submissions should be limited to the question of whether or not an interim order is necessary.

Unless there are any more what I shall describe as preliminary matters, I would ask Mr Branston to open the case for the GMC. Can I check at this stage are there any preliminary matters? Mr Branston?

MR BRANSTON: Sir, yes. Can I clarify one thing on the question of anonymity? Does that apply to professional witnesses, as it were, in the papers as well as patients? There certainly may be a question of anonymity about certain partners in a practice to do with a patient, but I am thinking of the clinical scientist who makes a complaint about the doctor, and can I enquire as to whether you would wish me to anonymise his name also and any other such witness?

THE CHAIRMAN: There is no need to anonymise either expert witnesses or professionals. It is my concern that patient confidentiality is the issue as opposed to professional issues. Mr Wallis, do you agree on that point?

THE LEGAL ASSESSOR: Certainly, Mr Chairman.

THE CHAIRMAN: Thank you very much. Mr Branston, can you deal with the opening of any preliminary matters?

MR BRANSTON: Indeed. I believe that the Panel is in possession of a document dated 11 October 2010 from Dr Myhill entitled "Formal Submission - Statement".

THE CHAIRMAN: The papers are quite voluminous at this stage.

MR BRANSTON: They are.

THE CHAIRMAN: Can you refer to a page number, please? At this stage, Dr Myhill, can I ask you to confirm with the Panel the paperwork that we have in front of us so that we are all reading from the same documentation? We have a number of addenda up to and including Addendum (XVI). Our paperwork today ends at page 4253.

MR BRANSTON: So does my paperwork, and I hope the doctor has received all 16 addenda also.

THE CHAIRMAN: Dr Myhill, can you confirm that for us, please?

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DR MYHILL: I do not have any of that paperwork. Is that the stuff that was sent to me on 8 September in response to Rebecca Townsley's request that I attend the 7 October IOP?

THE CHAIRMAN: The bulk of the paperwork should have been seen by you. In front of me you will see that I have original documentation, and that relates to the hearing in April. The white documentation is newer documentation, much of it including submissions and correspondence you have had with the GMC. I am going to ask our Panel Assistant to provide you with an exact bundle of what we have in front of us so that we are all referring to the same documentation. (Same handed) Addendum (X) that we have includes everything up to 7 October 2010, or a week ago, to the adjournment. Addendum (XI) is recent correspondence between Mr Elliott and yourself. Addendum (XII) is an application under rule 28 from yourself and a response from Neil Marshall; you will have seen that. Addendum (XIII) is the supporting document. Addendum (IX) is letters and emails in your support. Addendum (XV) is a formal submission, and I believe that is what Mr Branston was referring to. Addendum (XI) is an email from Ms RP dated 13 October.

DR MYHILL: I have seen the expert report by Professor John Hunter. I have my own copies of this correspondence, but this is the first time I have seen this bundle, I have to say. Do you want me to go through it all to make sure that I have seen it all already?

THE CHAIRMAN: I expect that you have seen it all before. I suspect there is nothing new there. But it does help the Panel if we can refer to our pagination. That is why I want to make sure that you have exact copies of what we have.

MR BRANSTON: Sir, can I suggest that, as we will deal with some preliminary points, you may want to sit in camera to determine those. The doctor will no doubt have a chance to check whether she has seen all the material in the addenda during any break that will arise. I am only going to refer to one document, and I know that she is in possession of it because she wrote it.

THE CHAIRMAN: How I will deal with matters is that you are going to focus specifically on Addendum (XV), which is Dr Myhill's formal submission. She wrote this document so she certainly has seen it. Mr Branston?

MR BRANSTON: Sir, yes. The document is dated 11 October 2010. It is the doctor's document headed "Formal Submission - Statement of and by Dr Sarah Barbara Myhill", and it starts at your page 4241 within Addendum (XV). In that document Dr Myhill raises a number of issues, which she places under three headings. The first two headings are "Introductory housekeeping" at page 4242, and "A: This IOP has no locus standi" page 4243. The third heading is a submission not to review the conditions but to revoke the interim order, at page 4245. It is my submission that the first two headings are preliminary legal arguments which should be heard and considered first by this Panel pursuant to rule 27(4) of the General Medical Council (Fitness to Practise) Rules 2004. The third heading is the presentation, I suggest, of the doctor's substantive case on the decision whether to maintain, vary or revoke the interim order pursuant to rule 27(4)(d). I would invite the doctor to make her submissions under the first two headings to you. I will then respond to those and the Panel then can consider those submissions before proceeding to commence the hearing.

THE CHAIRMAN: Dr Myhill?

DR MYHILL: Before I open, can you just explain why patient confidentiality has to be protected at this hearing but at the last two hearings I had there was no such protection for that patient?

THE CHAIRMAN: I cannot speak or comment on behalf of the previous hearings, but we are where we are today. I would ask you for your submissions, please, in relation to the point made by Mr Branston.

DR MYHILL: I take this opportunity to make this written submission, which I propose to read into my transcript for the avoidance of any doubt.

I request that this Panel amends the transcript of the last hearing. It presently reads: "[You were] present at the hearing but [were] not represented." I ask you to change this to: "Dr Myhill was present and represented herself." This is because I am an articulate and compos mentis professional and consider myself to be capable of representing myself.

Neither section 41A(4) of the Medical Act 1983 nor the GMC Procedure Rules Order of Council mandate legal representation, hence stating "Dr Myhill was present but was not represented" is patently inaccurate, among many other matters of irregularity which I will address shortly.

If the Panel or Panel Secretary is not minded to make this reasonable amendment, in the alternative I would suggest the sentence in question to read that "Dr Myhill was present but was not legally represented."

I expect now the Panel to seek a response from the GMC counsel and advice from the Legal Assessor and then deliberate in camera, or will this Panel simply take a commonsense decision without such assistance?

THE CHAIRMAN: I will indeed turn to Mr Branston and the Legal Assessor for advice. However, a transcript is exactly that. It is a transcript and a contemporaneous note of proceedings. It is acknowledged by this Panel today that you were present and were not legally represented at the last hearing. Today you are also present and are not legally represented. Mr Branston, any observation?

MR BRANSTON: Sir, the doctor was not represented at the last hearing. Section 41A(4) of the Medical Act provides that no interim order shall be made by a Panel unless the practioner has been afforded an opportunity of appearing and being heard, and for these purposes a person may be represented before the Panel by counsel or a solicitor. Indeed, Rule 33 makes provision for counsel or a solicitor to represent the doctor. It is neither, I suggest, the intention nor the effect of the words "not represented" to make comment or observation on the composure of this doctor's mind, her mental faculties, her articulacy or her professionalism. It consists of an accurate description of the doctor's position at the last hearing. It is therefore an error to describe it as the doctor does as "patently inaccurate". It may be, sir, that for future transcripts the Panel would wish or suggest that it is recorded that the doctor was not legally

represented, but I suggest that this is a particular semantic cul-de-sac down which this Panel will not want to waste too much time.

THE CHAIRMAN: Thank you. Mr Wallis?

THE LEGAL ASSESSOR: Mr Chairman, I adopt what Mr Branston has said, but would add simply this. My advice is that Dr Myhill's point is incorrect. It is clear from the transcript of that hearing that she appeared on her own behalf. No one else represented her. She was the only person to address the Panel, apart from counsel for the GMC. She may have been assisted by others, but that is quite a different thing from representation. The same, of course, as you have already remarked, is true of today's hearing.

THE CHAIRMAN: Thank you. Dr Myhill, would you please continue?

DR MYHILL: I confirm that I make the following submission pursuant to section 41A(4) of the Act, relying on the following just assumptions:

(1) That this Panel is independent of the GMC.

(2) That adequate expertise and relevant experience lies within this Panel.

(3) That these Panel members are professionally competent and consequently able to shoulder the responsibility for their own independent decisions.

I am sure that all the members of this Panel would no doubt realise that this is not a run of the mill GMC case for rubberstamping a third party pre-drafted cut and paste determination, and to assume, for a payment of a daily tariff, ownership of a pre-determined outcome. It will not have escaped this Panel's attention that the Panel members would have to stand and fall by what they would determine by their own independent judgment, as the Legal Assessor no doubt will remind them.

I would like to put the following questions to each of the Panellists individually. Dr Durning, when were you appointed a GMC Panellist?

THE LEGAL ASSESSOR: Mr Chairman, I must intervene, if I may ---

THE CHAIRMAN: Please.

THE LEGAL ASSESSOR: --- to remind Dr Myhill that at this stage she is putting forward her submissions not questions.

THE CHAIRMAN: Please continue with submissions.

DR MYHILL: I cannot put questions to Panellists at this stage?

THE CHAIRMAN: Correct. But, if you want to read your questions out, the Panel certainly will take note of them.

DR MYHILL: I will read them out later.

THE CHAIRMAN: Thank you. Please continue.

DR MYHILL: This IOP has no locus standi. There are no procedural rules for a review hearing before an IOP, although it is legally mandatory to review an interim order within six months of a previous one. Part 5 (Rules 18 to 22) apply only to review hearings before Fitness to Practise Panel hearings (Rule 18), not before IOP pursuant to section 41A(2) of the Act. This is a grave error by omission in law.

Forgiving this lapse for the purpose of this hearing, the GMC Registrar breached Rule 20 by giving notice no later than 28 days before the hearing. The notice additionally breached Rules 20(1)(a) to (f) and 20(2)(a) to (b) and Rule 20(3), which would clearly breach my Article 6 (1) human rights. For avoidance of doubt, I take no point on these errors and omissions or negligence by the GMC before the Panel as it has no statutory remit to deal with the same, say, under Rule 22. It would also waste everybody's time and resources, more so of the GMC, especially considering it is a charity.

The Registrar also breached Rule 19(a) by failing to conduct any investigation or obtain a report thereof.

Assuming Rule 22 is binding upon this Panel for the purpose of this hearing, I make the following submission pursuant to Rule 22(d). The IOP would be hard-pressed not to allow oral evidence because Rule 22(c)(ii) and Rule 22(d) allow this. Again, I take no point before this Panel on the fundamental flaws and procedural absurdities of the GMC's actions against me, as this Panel remains powerless to do anything about it.

Although Rule 8(6) depends on the subjective opinion of a single anonymous case examiner, and Rules 4(3)(a) and (b), 4(4)(a), (b) and (c), Rule 8(2)(a) and 9(a) (about "closure"), Rule 5(2), Rule 6, Rule 7(2) (about "investigation"), and Rules 5(2), 7(6)(b) and 9(d) (about "referral to an FTP Panel") are all are repetitive, confusing and chaotic, common sense dictates that any interim decision must have a beginning point and an end point. The GMC has failed to define these.

Again, common sense would dictate that the Panel should appreciate that the most likely starting point has to be one of these two:

(a) The GMC starting their independent investigation into whatever issue they deem worth investigating; or

(b) my being referred to the GMC's Fitness to Practise Panel for a substantive public hearing.

Since the GMC receiving the partner's complaint on 18.2.09 and me receiving this complaint from the GMC on 8.12.09 and since my IOP hearing of 29.4.2010, to the best of my knowledge the GMC has not started let alone conducted any proper investigation into any complaint against me simply because they have nothing to investigate.

The Registrar has failed to apply Rules 4(4) and now 19(a) which have been prejudicial against me and wasteful for the GMC, a charity.

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Likewise, no GMC employee, staff or agent could lawfully refer me to an IOP without having referred me for a Fitness to Practise hearing under Rules 5(2) and 9(d), thus defining the anticipated end point to justify any interim actions the GMC seeks against my registration.

As a result of the above points, this Panel has no locus standi. If this Panel were minded to refuse my above submission, despite my explicit notice as to their personal liability, I would expect them to give plausible, objective and lawful reasons for such decision, as required by the rules.

B: Submission on the IOP "not reviewing the conditions" but revoking the order of 29.4.2010 forthwith ---

MR BRANSTON: Sir, may I ---

THE CHAIRMAN: Mr Branston?

MR BRANSTON: As I indicated at the outset, I believe that the submission starting with B is Dr Myhill's submission on the substantive issue and not a preliminary point. It may be that it is appropriate to leave that until later in the hearing.

THE CHAIRMAN: How I propose to deal with this is that Dr Myhill has raised a number of issues, she has mentioned a number of issues in law, and at this stage can I ask you, Mr Branston, to initially respond to those points? Then I shall turn to the Legal Assessor for his independent legal advice.

MR BRANSTON: Sir, to respond to Dr Myhill's submissions, the doctor appears concerned that there may be room for "rubberstamping a third party pre-drafted cut and paste determination". It does of course go without saying, frankly, that this Panel will exercise its own independent and professional judgment in all of the decisions that it makes today, as the Panel has done for all of the decisions it has so far made in the doctor's case, whether or not there is a payment - and I note that the doctor removed the word "handsome" from her submissions.

The doctor's submission on locus standi, and by those I presume she means the jurisdiction of this Panel, is based on a misunderstanding or a misreading of the 2004 Rules. I wonder whether it would be appropriate that a copy of the Rules could be placed in front of the doctor because I will take the Panel to those Rules and I am not sure that the doctor has a copy in front of her today.

DR MYHILL: I have a copy here.

MR BRANSTON: I will ensure that we are all reading from the same copy of the Rules.

THE CHAIRMAN: Dr Myhill, can I check that you do have a copy?

DR MYHILL: Yes.

THE CHAIRMAN: Panel members, can I ask you to turn to tab 3, Statutory Instrument 2004 No. 2608, Health Care and Associated Professions Doctors? Mr Branston?

MR BRANSTON: Thank you, sir. The doctor submits that there are no procedural rules for a review hearing before an Interim Orders Panel. This is plainly wrong. If the doctor had read on in the rules, she would have reached Part 7, which commences at Rule 25 of the Rules and is headed "Interim Orders". Rule 25(1) provides that "This Part…", and by that it means Part 7:

> "…applies where an allegation has been referred to an Interim Orders Panel by the Registrar for consideration as to whether to make or review an interim order."

Thus Rules 25, 26 and 27 apply not only to the initial consideration of this Panel but also to review matters. That is evident in the reading of the first few words of Rule 26, for example: "Prior to the initial or any review hearing…" ---

DR MYHILL: Do you want me to comment on these as we go along or shall I save my comments till the end?

THE CHAIRMAN: If you could save your comments to the end, please.

DR MYHILL: No prob.

MR BRANSTON: The procedure at an Interim Orders hearing is provided therefore by Rule 27. Therefore, the doctor's observations that there is a "grave error by omission in law", or a lapse to be forgiven, or otherwise, is wrong.

The doctor spends her submissions on these preliminary points concentrating on Rules 18 to 22, which are contained in Part 5 of the 2004 Rules. Regrettably for the doctor's legal analysis, that part applies only to a review hearing at which a Fitness to Practise Panel is making a determination. That is self evident by a simple reading of Rule 18:

> "This Part shall apply to any hearing (a review hearing) at which an FTP Panel is to determine…"

etc., etc. This does not apply to this Panel.

Thus, contrary to the doctor's submission contained in paragraph 2, the Registrar did not breach Rule 20(1) or 20(2) or 20(3) on notice because that rule does not apply in this situation. The doctor graciously takes no point on these "errors and omissions or negligence by the GMC". Unfortunately, the errors are only those of Dr Myhill.

Similarly, her submissions in paragraph 3. The Registrar has not breached Rule 19 because it is utterly irrelevant to today's purposes. Similarly, in paragraph 4 of the doctor's submission, the doctor falls into obvious error when she assumes that Rule 22 is binding upon this Panel for the purpose of this hearing. It is not. She takes no point on this "fundamental flaw and procedural absurdity" because there is no point to take.

A The doctor goes on in paragraphs 5 and 6 to talk about "beginnings" and "end". It may not surprise the doctor to know that I am a little confused about the meaning and relevance of her observations about Rules 4, 5, 7 and 8, contained in paragraphs 5(a) to 5(d). However, if she wishes to know whether or where the interim decision has a beginning or end, then she can find these at the following places. Section 35C(8) of the Medical Act 1983 provides that if the Investigation Committee are of the opinion that an Interim Orders Panel should consider making an order for interim suspension or interim B conditional registration under section 41A to give a direction to the Registrar who shall refer the matter to an IOP and serve notification of the decision on the person subject to the allegation.

That is what has happened in this case and an interim order began on 29 April 2010. The end point to that interim decision is currently set at a point 18 months after the commencement of the order unless this Panel revokes the order or unless a successful C application is made pursuant to section 41A(6) of the Medical Act to the High Court. The doctor's observations at paragraph 6 about the start of investigations or her referral to an FTP Panel are therefore irrelevant.

Of course, it is right to say, contrary to what the doctor says in paragraph 7, that the GMC has started an investigation into the doctor and there is material, to which I will turn the Panel's attention in due course, that shows the fruits of that investigation.

D In paragraph 8 of her submissions, I am afraid I do not understand what the doctor alleges against the Registrar in terms of Rule 4(4), but that is hardly a matter for this Panel; and, as said previously, Rule 19(a) does not apply to this Panel.

In paragraph 9 of her submissions the doctor is again plainly wrong when she says the GMC could not lawfully refer her to an IOP without having referred her for a Fitness to Practise Panel hearing. Section 35C(8) of the Medical Act and Rule 6 of the 2004 Rules E make it clear that the doctor can be referred to this Panel at any stage. Her reference to Rule 5(2) is, I suggest, confused because that rule is in fact only concerned with matters contained in section 35C(2)(c) or (e) of the Medical Act 1983, which are matters wholly to do with criminal convictions, criminal cautions or determinations by another regulatory body. Rule 9(d) is concerned with the Investigation Committee and not this Panel.

In conclusion, the doctor's allegation that this Panel has no locus standi, or in other F words no jurisdiction, is in my submission misguided, based on a number of errors and in short nonsense.

The Medical Act provides for the creation of this Panel. The Act provides for the rules for this Panel and governing this Panel which themselves determine procedure. The Council is under a duty to investigate allegations that concern this doctor and the Registrar is under a duty to refer the doctor to this Panel where either he is of the G opinion that he should do so or where directed by the Investigation Committee. The Panel will have noted within paragraph 10 and elsewhere in the submissions apparent threats by the doctor about personal liability. It may be that the Panel will give those due consideration in due course, but again it goes without saying that the Panel will, as it always does, give reasons for its decisions on these preliminary matters. In my submission, sir, they can be dismissed fairly swiftly.

H THE CHAIRMAN: Thank you, Mr Branston. Dr Myhill?

DR MYHILL: The main comment I would make is that the GMC have formulated no allegations against me, and that was his opening sentence. There are no allegations against me. Indeed, the letter from Rebecca Townsley of 8 September asking me to attend this recent IOP simply invites me to make observations on my case, not asks me to respond to allegations because, as I say, the GMC have formulated no allegations against me.

THE CHAIRMAN: I turn to you, Mr Wallis, for your legal advice, please.

THE LEGAL ASSESSOR: Mr Chairman, again I adopt entirely what has been said by counsel for the GMC. I am not seeking to go through it in detail, I see no reason to do so, because Mr Branston has covered all the ground very thoroughly and there is nothing further I can add to it.

There is just one other matter, which is perhaps alluded to rather than directly addressed by Dr Myhill in point 4 of her submissions. It is based on a false premise because she relies upon Rule 22, which, as Mr Branston has pointed out, is not applicable to this Panel, but raises the question of the possibility of oral evidence. As that is, as it were, a procedural matter, if I may, Mr Chairman, perhaps I could deal with this now in case it raises its head later on. As I have already said, adopting Mr Branston's submission that Rule 22 is not applicable to this Committee, in any event Rule 27(2) provides that no person shall give oral evidence before an Interim Orders Panel unless that Panel considers that such evidence would be desirable to enable it to discharge its functions.

Mr Chairman, this makes it clear that oral evidence would be the exception rather than the rule, but if Dr Myhill wishes to seek to call oral evidence she will of course make that application to you and Mr Branston will argue it. That would be the basis of the advice which I would then be giving.

Apart from that, Mr Chairman, there is nothing further that I can usefully add, I feel.

THE CHAIRMAN: Thank you, Mr Wallis. The Panel shall shortly go into private session to consider the initial preliminary proceedings. Can I ask before we do that that you address the Panel on the issue of Rule 27(2), which is the use of oral evidence before an Interim Orders Panel so that the Panel can consider this at this particular stage in our deliberations in camera. Dr Myhill?

DR MYHILL: As you may well know, I would very much liked to have called witnesses today, expert witnesses and the doctors from the partners' practice who made allegations that had no foundation. I was told at my hearing last week that even if I subpoenaed witnesses to be here today this Panel here today would refuse to hear those witnesses. Therefore, my three expert witnesses are not here. I understand that my right to cross-examine the GMC expert witnesses and the GMC witnesses or my ability to subpoena them has effectively been nullified by the fact that I was told this Panel would refuse to call them. Therefore, I have no witnesses here today to substantiate my oral evidence.

THE CHAIRMAN: Thank you. Mr Branston?

MR BRANSTON: Sir, you have already been given guidance on the legalities of it by Mr Wallis. No person shall give oral evidence unless this Panel considers such evidence is desirable to enable it to discharge its functions. As indicated, it is exceptional to hear oral evidence in such hearings. It is entirely, of course, a matter for this Panel to consider, but the Panel would want to bear in mind that it is not engaged in finding facts and resolving issues of facts at this hearing. The doctor's wish to subpoena and to call, I think at least eight witnesses have been mentioned in the papers, the Panel would want to consider carefully whether it would be a useful exercise to embark upon that and whether it needs to embark upon calling any witnesses at all to discharge its function, which do not include finding facts.

DR MYHILL: It is clearly impossible for you to call on witnesses today because they are not here. That is a rather irrelevant argument.

THE CHAIRMAN: Mr Wallis?

THE LEGAL ASSESSOR: Mr Chairman, I wish only to add this. Dr Myhill will correct me if I am wrong, but my recollection from reading the correspondence which has passed between the GMC and her after the last hearing merely referred her to the provisions of Rule 27(2), to which both Mr Branston and I have referred, but certainly did not say that she *could not* call oral evidence. I will be corrected if I am wrong.

DR MYHILL: The witnesses that I would like to be here are reluctant witnesses. I have already invited them to attend. I asked them to attend my hearing last week of 7 October and they did not turn up. It was clear that my only chance of getting them here would be to subpoena them. I have been legally advised that to issue a subpoena one has to give 28 days' notice. Effectively, events have unravelled and indeed, I suggest, been construed by the GMC in such a way that it has been impossible for me to have the witnesses here today to evidence my statements.

THE LEGAL ASSESSOR: Mr Chairman, the person running a case on one side or another has to decide what evidence he or she wishes to call and when and take the appropriate steps in good time. The onus is on that person.

THE CHAIRMAN: Thank you, Mr Wallis. The Panel shall now go into private session to consider the preliminary issues.

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

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Dr Myhill, I shall now read you out the Panel's initial determination.

DETERMINATION

THE CHAIRMAN: Dr Myhill, the Panel has heard your submissions and the submissions paid by Mr Branston on behalf of the GMC.

In relation to your application to amend the transcript of the previous hearing the Panel notes your comments and of course accepts that you are not legally represented today and were not legally represented at your hearing on 7 October 2010. However, a transcript is a contemporaneous record and it would be inappropriate to amend it at this time. Within the meaning of the Medical Act 1983 as amended and the General Medical Council (Fitness to Practice) Rules 2004 you were, and are, unrepresented.

With regard to your submissions about the jurisdiction of this Panel and its ability to consider your case today, the Panel has carefully considered these, the submissions of GMC Counsel and the advice of the Legal Assessor. Your submissions are based on a misunderstanding and misinterpretation of the relevant Act and Rules and are an incorrect analysis of the law. Accordingly, the Panel has determined to reject your submissions in their entirety.

Your case has been appropriately referred to the Panel and the Panel is satisfied that it has the necessary jurisdiction to consider your case today. Should you have considered that the referral was wrong in law, it was and still is open to you to make the relevant application to a Court.

The Panel has noted the determination of the IOP from 7 October 2010. At that time the IOP determined that it was "neither necessary nor desirable for any oral witness evidence to be adduced" at that hearing. Accordingly, that Panel determined not to accede to your application that the IOP exercise its power to compel the attendance of any witness. The determination of the IOP from 7 October 2010 does not bind this Panel nor does it obviate your ability to apply to a Court for a witness summons. Accordingly, your observations to the Panel today that you have been prevented from arranging the attendance of any witnesses are incorrect.

The Panel is mindful of its duty and of the need to consider the case as presented to it. Therefore, the Panel will now hear from Counsel for the GMC. It will then, subsequently, afford you the opportunity to make submissions to it on the question of whether or not it is necessary for an interim order to remain imposed on your registration.

I now turn to Mr Branston for his submissions on behalf of the General Medical Council. Mr Branston?

MR BRANSTON: Thank you, sir. This is a review hearing of the Interim Orders Panel. The Panel first met on 29 April 2010 to first consider the doctor's registration. You will have read the transcript of that hearing at pages 3288 to 3329. This Panel on that occasion imposed an interim order of conditions for a period of 18 months. May I respectfully adopt the opening submissions made by my predecessor Mr Summers in that hearing for the detail of the material that had been gathered up until that point? Although I will refer to it briefly, I will not delve into it too deeply and I will delve more deeply into material that has been gathered since. You have already made reference, sir, to the fact that this Panel met to review the doctor's registration on 7 October, but that hearing was adjourned to today's date.

Sir, you know that Dr Myhill was referred to the General Medical Council on 18 June 2009 by a number of general practitioners in a partnership practice in the North of England. You will have seen their referral at pages 1 to 2 and their enclosures at pages 3 to 46 and the medical records enclosed at pages 47 to 205 in the bundle.

Dr Myhill is a 52-year old doctor in private practice in Powys in Wales. She has a particular interest in ecological medicine and in myalgic encephalomyelitis (ME)/chronic fatigue syndrome (CFS). You will have seen that there have been (and the doctor refers herself to) previous referrals to the GMC. I do not take this Panel's attention to the detail of those in any way bar a referral in 2005 which was enclosed with advice to the doctor that:

> "Whilst it is not always possible to avoid controversy she should ensure that everything possible is done to avoid unnecessarily alarmist statements and to avoid linking her views specifically with unproven, unlicensed medication which she or her representatives, associates or advertisers sell on the website or by other means."

The referral in June of 2009 came from a partnership practice raising concerns about Dr Myhill's suggested course of treatment for an adult patient with a rare neurodegenerative disorder. The patient's mother had contacted Dr Myhill towards the end of 2008 having found her website, www.drmyhill.co.uk. Dr Myhill had asked her to send a blood sample from the patient. After receipt of that, Dr Myhill had written to the patient's mother outlining various theories and treatments for chronic fatigue syndrome. The doctor also advised that amongst other treatments the patient could be prescribed and administered B12 and magnesium sulphate injections. One of the partners at the surgery discussed that issue with the patient's mother and advised that the drugs suggested by Dr Myhill could not be prescribed as they were off licence. He was also unsure why her son's disease was being linked to CFS and advised the patient's mother to speak further with the doctor. The patient's mother then requested a district nurse to train her to perform subcutaneous injections of B12 on her son, a request that was refused. The general practitioners at the surgery decided to refer the doctor to the GMC in light of the suggested treatment for that patient. You will note in their enclosures at pages 3 to 46 that they had received opinion from, for example, a

consultant neurologist that the subcutaneous injection of large doses of vitamin B12 was likely to be painful and that magnesium sulphate may make the patient vomit (that is at page 4), and the opinion of a consultant haematologist (page 7) who confirmed that she and her colleagues had never heard of such a use of B12 in large doses and would certainly be painful. You have within the bundle at pages 24 to 26 perhaps the first of Dr Myhill's responses to the issues raised.

Sir, there is a second complaint contained within the papers, and that came on 9 February 2010 when the GMC received a complaint from a Mr Stuart Jones, Senior Clinical Scientist at Queen's Hospital in Romford. You will have seen that at page 206. You will note that that complaint was not made anonymously to the GMC. The complaint raised concerns about Dr Myhill's advice and recommendations and said that Mr Jones had found the doctor's website very worrying and had concerns that patients were being seriously misled by the doctor's advice and in some cases he thought that her recommendations were a serious risk to patient safety. Mr Jones outlined a number of examples of the concerns that he had. You have these at pages 206 to 225, including what he described as evidence of poor practice and misinformation. He included screenshots from the website, which you have at those pages. They relate to a number of issues, including the active discouragement of routine mammograms in breast cancer screening, the active discouragement of the use of the oral contraceptive pill for all patients as "dangerous medicine" and actively discouraging the uptake of the MMR vaccination, continuing to promote the link between MMR and autism.

On 7 April 2010, the doctor was invited to appear before this Panel. You will now be aware that the doctor has a page devoted to her GMC hearing on her website. In preparation for her first IOP hearing, the doctor invited her supporters to write or telephone the GMC Investigation Officer with their input. This led to the investigation officer, Mr Bridge, receiving a large number of emails and phone calls. You have in the large bundles various documents provided by both the doctor and her supporters, including petitions and messages of support, in particular at pages 260 to 955, first of all.

According to a petition that is included in the bundle, and which this Panel will have noted, entitled "Witch Hunt of Sarah Myhill", according to the petition it is clear that Dr Myhill is regarded by very many people as a very caring and very supportive and dedicated doctor. You will have seen that petition had at least 3,000 signatories by 24 April of this year and, on my last examination of the petition on 6 October, was up to over 4,000 signatories. There are also in the bundles a very large number of testimonials supporting the doctor. Indeed, from pages 969 to 3285 that is all material sent in in support of the doctor. This Panel will have given that due regard.

You will, though, have noted also within the bundle one or two other emails of concern. First of all, on 15 April 2010, an email from an RM. This is at page 966. The email of 15 April from RM indicates that RM went to see Dr Myhill in late 1996 and was greatly harmed by her treatment that at the time consisted of EPD injections for allergies along with an over severe elimination diet that was even more severe than her present Paleolithic ("Paolithic", it says there) diet. She used to at one time do the "Lamb and Pear" diet, which was even more extreme.

A You will also have seen emails of 19 April from GS at 965, in which GS, who states that they have fibromyalgia as well as a debilitating fatigue-related illness of unknown aetiology, was disturbed by the doctor's website which GS stated "is filled with unsubstantiated medical information".

You will also have seen at page 964 an email of 20 April from AF, a person suffering from ME. You will no doubt have given that consideration.

B

The Panel, prior to the last hearing, had a report from a Professor Pierre-Marc Bouloux at pages 957 to 963. This was in response to instructions from the GMC and an enquiry from the GMC concerning the original complaint made by the general practitioners at the practice in the North of England. You will see that Professor Bouloux, Consultant Endocrinologist, states an opinion as follows at page 960:

C

> "There is no clinical nor biochemical basis on which Dr Myhill could reasonably connect the aetiopathology of…"

- the particular disease with which this patient was suffering -

> "…with CFS, and the tenuous connection that Dr Myhill has made between…"

D - the disease he names -

> "…and the origins of CFS. This loose connection, based on a (hypothetical) shared mitochondrial dysfunction between the two disorders presumably led to Dr Myhill to then recommend a course of treatment based on Dr Myhill's practice in the management of CFS."

E He goes on:

> "This course of action was inappropriate".

Professor Bouloux was asked at 961:

> "Does Dr Myhill's overall standard of care fall below that expected of a
F reasonably competent general practitioner?"

The Professor's conclusion was:

> "Yes. I believe that Dr Myhill's overall standard of care does fall below that expected of a reasonably competent medical practitioner. I see no evidence that Dr Myhill has seen the patient nor collated and scrutinised all the previous
G medical records/dossier prior to formulating the proposed course of treatment for this patient. Moreover, she was extrapolating from her experience with her own (idiosyncratic) management of patients with CFS to make recommendations for a patient with…"

- and he names the disorder. He says:

H

> "…a disorder with an entirely different and distinct aetiology.

The Professor was asked:

> "If so, in what way, and to what extent did such care fall seriously below that standard?"

The Professor states:

> "It is incumbent on a practitioner to perform a full evaluation of a patient prior to making a diagnosis and instituting a course of treatment. There is no evidence that Dr Myhill observed these principles of good clinical practice here. Thus there are ethical issues as well as those good clinical practice which appear to have been violated here."

Over the page:

> "I conclude that Dr Myhill has seriously violated the principles of good clinical practice by not adhering to duties of care and due diligence expected of a practitioner."

No doubt, sir, the Professor will have had regard to paragraph 3 of *Good Medical Practice* to which I will refer this Panel a little later.

This Panel first met on 25 April 2010 and imposed, as I have indicated, an order of conditions for a period of 18 months. You have those conditions set out at pages 3326 and 3327. I will read those, sir, because it will be one of the functions of this Panel to consider and confirm if necessary that the doctor has complied with those conditions. There are five conditions. At page 3326:

> "1. You must not prescribe any prescription-only medication, as detailed in the British National Formulary;
>
> 2. Within 14 days of today's hearing you must ensure that in relation to your website, or any website relating to your medical practice or business, all pages, downloadable content, including documents, forum or discussion board content, or other references or online media relating to the following subjects must be removed:
>
> a. The medical management of cases relating to cardiology, or cardiovascular disease including: chest pain due to ischaemic heart disease; acute coronary syndrome; heart failure; or pulmonary embolus;
>
> b. The treatment of asthma;
>
> c. The treatment testing, identification, diagnosis or management of breast cancer;
>
> d. The use of hormonal contraceptive medication;

e. The pharmacological management of primary or secondary prevention of vascular disease;

f. Any immunisation or vaccination;

3. You must obtain the approval of the GMC before accepting any post for which registration with the GMC is required;

4. You must inform the GMC if you apply for medical employment outside the UK;

5. You must inform the following parties that your registration is subject to the conditions, listed at 1 to 4 above:

a. Any organisation or person employing or contracting with you to undertake medical work; and

b. Any prospective employer or contracting body (at the time of application)."

Sir, since the April hearing there have been many more letters, emails and testimonials provided. You will have seen these and will have given them due regard at pages 3365 to 3718, 3779 to 4030 (that is Addendum (IV)), 4065 to 4171 (that is Addendum (VIII)), and I think material that I received this morning at Addendum (XIV), pages 4211 to 4237. Again, the Panel will have noted those.

The Panel will be interested to note the doctor's immediate reaction to this Panel's hearing in April at page 3734. On 2 May 2010, a few days after the hearing, an email was received from a KM, raising concerns about the doctor's response to that recent hearing as expressed in her information release. That is set out in that email, and I quote from Dr Myhill:

"Thank you all for your fantastic support and interest. This has raised the profile of my case so that it is becoming un-ignorable! Do read the account of the hearing. I chuckled all the way home on the train. The whole carry on was so outrageous and so out of proportion that it is clear to all it is an outrage. The General Medical Council behaved as badly at the hearing as they have for the past 9 years. Their actions were disproportionate and inconsistent, for example their recent behaviour over patients' killer Dr Jane Barton. My view is that we must not lose sight of the big issue which is that the GMC have been taking patients' private and confidential medical notes illegally. I shall be down in London on Tuesday with a top solicitor to discuss strategy. I have some great ideas to kick the hornet's nest again…. The day was won by all who attended the Hearing and Demo. The GMC were seriously rattled by that. They did their best to freeze you out but well done for sticking to guns and giving the Press some great moments. As one said, there is a documentary to come out of this! See my Speech on YouTube, courtesy of One Click. Much love to you all and a million thanks again.
Information Release, Dr Sarah Myhill"

A At page 3733 opposite you have an email dated 25 April from a DP who complained that there was misinformation about asthma on the doctor's website, but it is clear that that has now been removed in response to the interim order of conditions.

At page 3721 you have an email dated 30 April from a CB who quotes a link on Dr Myhill's website in response to the restrictions placed on her by the IOP previously. The relevant section is as follows:

B

> "Whatever I do the website continues in its current form
>
> I have always made information freely available without copyright. A moment of brilliance from a Face Book contributer [sic] means my entire ungagged website has been made available to everyone. You can see it at…"

C - and then the link -

> "Ungagged.Website."

Sir, you and the Panel will wish to consider whether that matter and that link on the doctor's website is in accordance with the conditions imposed upon her on 29 April.

D On 12 May you have at page 3736 an email again from DP, who remained concerned about the doctor's website and the contents thereof. You will see that DP states:

> "This doctor has created a new website where I think she may be attempting to get around her conditions of registration. This is the link to one page where she informs her patients they can order the drugs she cannot now prescribe on the internet. Underneath the name of the website of this drug supplier in the South
E Pacific. She asks patients to e-mail her if they have any problems, which in my opinion is code for asking patients to ring her for a verbal prescription so that they can order.
>
> I would be grateful if you could check whether it is satisfactory for a British doctor registered with you, who has conditions to her registration, to advise patients to order online drugs."

F

Again, sir, you will wish to consider whether that is in accordance with the conditions imposed.

On 13 May you have at page 3735 an email from a Dr Hickman, raising concerns that the doctor appears to have given advice to one of his patients by letter.

G At page 3719 to 3720, you have a letter from an RS dated 18 May. RS describes themselves as "an author with an interest in alternative medicine". RS too expresses concern that the doctor may be or appears to be circumventing the conditions on her registration by recommending alternative treatments which are not in the BNF through the appearance of an allegedly unrelated mirror website. You will see that RS sets out a letter from Dr Myhill to her patients at page 3720 dated 11 May 2010.

H

Sir, as well as that material, the GMC has instructed several experts to prepare further expert reports on the issues raised in this matter. These relate to the website complaints. The first of these is the report of a Dr R Harker. You have this at pages 3335 to 3364. It is right to say that Dr Harker considers the various aspects of Dr Myhill's website and makes conclusions that are and appear favourable to Dr Myhill. May I summarise from pages 3361 to 3362 where, at the penultimate paragraph at 3361, Dr Harker states:

> "For all the reasons given above, in producing her website and giving information and opinion I consider that overall Dr Myhill's actions are appropriate and of a reasonably competent standard.
>
> In my opinion it is difficult to clarify the role Dr Myhill has. She is not acting as a GP in producing her website. In my opinion it is fair to say that on the evidence available Dr Myhill is acting as a reasonably competent doctor providing free advice and opinion."

Opposite at page 3362, the final paragraph:

> "I consider that if acting as a GP Dr Myhill would have a different role in that I consider that her role would be different if giving advice and treatment to her own patients in face to face consultations with her contractual obligations as a GP and her duty to her own patients under [Good Medical Practice]. On the evidence I have I cannot comment on Dr Myhill in this role and it may be that the GMC wish to look at Dr Myhill's performance as a GP."

Following receipt of that, sir, there was a further email of concern dated 24 May. This is at page 3738. This was from a person who, although not a patient of Dr Myhill's, describes himself as "a reasonably well-informed thyroid patient". This person again raises questions over the doctor's apparent recommendation of an offshore pharmacy.

On 4 August, sir, the GMC received an email from Su Green of the Shropshire County Primary Care Trust (page 3742). Ms Green explained that the PCT had received invoices for treatment from the doctor for a patient for whom she had been prescribing during May and June of 2010, obviously after the conditions were imposed. You will see that she says:

> "It has come to the PCT's attention that Ms Myhill has had conditions imposed against her as from 29th April 2010 in which she must not prescribe any prescription only medication as detailed in the BNF. Shropshire County PCT has received invoices for treatment from Ms Myhill for a patient to whom she has been prescribing during May 2010 and June 2010 which breaks these conditions.
>
> The PCT contacted Ms Myhill on 12th July 2010 informing her of the PCT's intention to report this breach to the GMC."

The GMC awaited further information about that apparent breach of the conditions and material has now been received from the Shropshire County NHS Primary Care Trust, received on 4 October and found at pages 4054 to 4064 in your bundle. You will see in particular a letter from Dr Myhill at page 4055, dated 12 July of this year… I am sorry,

a letter to Dr Myhill, in which Su Green expresses her concern about not having been notified of the conditions on the doctor's registration. The doctor responds at page 4057, three days later, indicating that the matter was an oversight. The doctor says:

> "If I have failed to inform you of the deliverance of the General Medical Council's Interim Order restriction then I can assure you that this is simply an oversight. I believe there are two patients who you fund to see me. They are infrequent attendees. The nature of the billing in my practice is such that when patients consult me I often forget whether they are self-funding or funded by a PCT."

On 21 August, at page 3743, you have an email from a Dr Morgan, who raises concerns that a patient has received therapeutic recommendations from Dr Myhill despite the fact that the patient has not been seen by Dr Myhill. Dr Morgan also raises concerns or comments that there is still some advice on cardiovascular disease and contraception on the website which may be contrary to the doctor's conditions. Again, you will wish to consider that material and whether there is an impact upon conditions.

A further expert report was received from Professor John Hunter. You have this at pages 3746 to 3751, which is Addendum (I). Professor Hunter is Professor of Medicine at the University of Cranfield and an Honorary Consultant Physician at the Addenbrookes Hospital in Cambridge. His report concerns nutritional information given on Dr Myhill's website. You will see that Professor Hunter sets out his report at those pages and concludes that the doctor has fallen below the standard expected of a competent doctor in that she has failed to comply with points 3(b), 3(c), 61 and 62 of *Good Medical Practice*. The Professor deals with nutrition and he sets out under "Background" at page 3748 three lines down:

> "Dr Myhill supplies nutritional supplements including vitamins, fatty acids and minerals to her patients and also apparently to persons whom she has not seen professionally but who are able to order these supplements through her website. This page on her website is entitled *'Nutritional Supplements - what everybody should be taking all the time, even if nothing is wrong'*.

He goes on to note that:

> "Dr Myhill has prepared her own combination of minerals (*Myhill's Magic Minerals*)… She claims that *'it contains minerals in the correct proportion for human requirements'* and *'these amounts are those considered desirable from modern nutritional research*.'

Professor Hunter responds to Mr Jones's complaint in the next paragraph.

> "Mr Jones' complaint arises in part from Dr Myhill's recommendations for daily mineral supplementation in perfectly healthy subjects with daily doses of five minerals which are greater than those recommended by national guidelines."

Professor Hunter notes that:

"To date however there have been no reports of any person coming to harm as a result of taking Dr Myhill's supplements."

In his "Opinion":

"This complaint reflects a matter which has long been a cause of dissent in the medical profession."

Then he gives a history of that dissent.

I turn over the page to page 3749 where, about two-thirds of the way down, Professor Hunter notes that:

"The National Institute for Clinical Excellence (NICE) recommends that nutritional support is only necessary in patients who

- Have a BMI of less than 18.5
- Have lost more than 10% of weight in 3-6 months without trying or
- BMI less than 20% with more than 5% weight loss in 3 to 6 months.

The FSA claims that all the minerals recommended for supplementation by Dr Myhill should be present in adequate amounts in a well-balanced diet."

He then goes on to consider the recommendations of excessive dosage in five minerals that it is claimed Dr Myhill recommends. First of all, boron, then cobalt. It is perhaps more relevant if we turn first to cobalt because he says that, in contrast to boron, excess cobalt is definitely harmful. In his concluding line in paragraph 2 on page 3750, he says:

"There can be no scientific justification for Dr Myhill's recommendation for 5mgs daily in healthy people."

In relation to iodine, he concludes in the final four lines of that paragraph:

"Davies and Stewart (*Nutritional Medicine*) recommend a daily supplement of 10-150 micrograms of iodine. In the face of these recommendations, Dr Myhill's suggestion of 15.05mgs of iodine daily on top of dietary intake seems grossly excessive. It is over 100 times greater than the estimated daily requirement for health."

In relation to manganese at point 4 in his concluding four lines:

"The FSA recommends a maximum dose of 4 mgs of manganese supplements which is reduced to 0.5 mgs daily in the elderly. Davies and Stewart do not include manganese in their recommended supplements for adults and elderly people. Thus Dr Myhill's recommendation of manganese 10.3 mg daily is greatly in excess of recommended allowances and could possibly lead to toxicity."

Finally, zinc. He concludes in that paragraph on zinc:

"Zinc is toxic in excess and it has been calculated that the tolerable daily upper intake for healthy persons is 40mgs a day. Davies and Stewart quote 2-24mgs of zinc as a daily supplement and this too is considerably less than the 47.8mgs recommended by Dr Myhill."

Professor Hunter goes on:

"It is well established that occasional increased doses of trace elements such as iodine and zinc may need to be administered under medical supervision in patients where there is demonstrated or suspected deficiency. Dr Myhill apparently makes her 'Myhill's Magic Minerals' available to individuals through her website who are not her patients and of whose medical conditions and dietary intake she has no knowledge.

It must be stressed that no research has yet been performed to confirm that in healthy individuals nutritional supplements of the sort recommended by Dr Myhill promote health and nor, given the length of time required for such complex studies in diverse human populations, are they ever likely to be. Progress has been made simply by the detection and correction of deficiency states, and Dr Myhill has no way of routinely checking the nutritional status of customers who buy supplements through her websites."

The Professor concludes:

"In my opinion Dr Myhill has fallen below the standards expected of a competent doctor in that she has failed to comply with points 3(b) and (c), 61 and 62 of the GMC guidelines of good medical practice. In particular, she:

1. Prescribes mineral supplements to persons who are not her patients and of whom she had no medical knowledge.
2. Recommends daily supplements of boron and cobalt for which no scientific medical basis is available.
3. Recommends excessive does of cobalt, iodine, manganese and zinc which could potentially be harmful.

These doses not only exceed the recommended daily intake suggested by national authorities such as the FSA but are also in excess of those recommended by her fellow members of the British Society for Nutritional Medicine in their book *'Nutritional Medicine".*

I believe that these errors should be pointed out to her and should be corrected in her future work. However, as we have no evidence of any persons actually coming to harm as a result of taking these mineral mixtures, I do not believe she has fallen **seriously** below the standards expected of a doctor of her grade and discipline as regards nutrition."

The third expert report that you have is found at pages 3770 to 3778. That is the report of a Dr Ann Hubbard, dated 27 September. That report deals with the doctor's website entries concerning breast cancer diagnosis. Dr Hubbard sets out the issues that she has

A been asked to address regarding the information on the doctor's website. I read from a small part of her report at 3773 first of all. The issues she addresses are:

> "Whether the information documented on Dr Myhill's website is accurate, appropriate and in line with any national guidelines."

Dr Hubbard goes through the statements on the website individually. First of all:

B

> "1) 'Standard screening tests currently available for breast cancer are not very satisfactory because they lack sensitivity and specifically because the test involves radiation. We know that radiation can cause cancer and exposure should be kept as low as possible'."

I go straight to the conclusion at the end of part 1 on page 3374. Dr Hubbard states:

C

> "The statement above exaggerates the risk of mammography and would cause unnecessary anxiety."

Statement 2:

> "We now have top cancer specialists telling us that overall routine screening
D with mammograms barely changes the rate of diagnosis or care of breast cancer."

Dr Hubbard's conclusion, two paragraphs down, is:

> "This biased statement might put off women from attending their routine screening mammography, and hence lead to the premature death of 8.8-
E 5.7/thousand accessing this website."

Statement 3:

> "Much better is thermal imaging. For cancers to grow they need a blood supply and when they are growing they need more blood than surrounding tissues. This can be picked up by thermal imaging. It is extremely sensitive."

F

Dr Hubbard's conclusion at the end of part 3:

> "Dr Myhill's statement there is therefore false and misleading."

In relation to statement 4:

G

> "The technique is now well established in Germany."

Dr Hubbard claims no knowledge of services offered in private clinics in Germany.

Statement 5:

> "If (thermography) is available in this country from Integrated Health
H Screening."

Dr Hubbard states:

> "The website of the clinic referred to leads to the website of Dr Nichola Hemby GP. This website claims that Mammo Vision digital thermal imaging is non-invasive, radiation free method of breast screening. No evidence is offered in defence of this false claim."

Statement 6,:

> "If there is a lump do not let someone stick a needle into it."
>
> "The advice given is false and likely to cause needless anxiety."

Statement 7 on the doctor's website:

> "If regardless of the result, excision biopsy is required, do not make a situational (*sic)* potentially worse by sticking a needle in."

The conclusion of Dr Hubbard:

> "Again this advice is misleading and liable to cause unnecessary anxiety.

Statement 8:

> "What is interested is a recent report that suggests 22% of all breast cancers regress spontaneously. This emphasises the point that the body is well able to cure itself of cancer given the right circumstances."

Towards the bottom of part 8 Dr Hubbard concludes that:

> "Dr Myhill may not have the detailed knowledge to enable her to understand the shortcomings of this theory, but this is a dangerous statement to make in this uncritical fashion, and might well lead a woman with breast cancer to delay presentation to her doctor in the hope that this will spontaneously regress."

In the "Issues to address" at page 3777, Dr Hubbard notes:

> "Has in providing the misleading and inaccurate information noted above Dr Myhill fallen below the standard to be expected from a reasonably competent medical practitioner?"

The conclusion of Dr Hubbard is:

> "The information documented on Dr Myhill's website in inaccurate, presented in a biased, misleading form, and contrary to National Guidelines. It encourages the use of an alternative screening method (Infrared Thermography) which has no value in screening for breast cancer, and for which women following the advice given must travel to a private clinic in Bristol and pay £160.00. It discourages the use of routine mammographic screening as advised by NICE and

A

the NHS Cancer Screening Programmes, and puts the lives of those women who refuse mammography at unnecessary risk.

It encourages delay in the presentation to medical care of women who have breast lumps which may be cancerous and causes unnecessary distress by bringing into doubt standard diagnostic triple assessment - clinical examination, imaging and needle sampling.

B

In promoting her own biased selection of controversial statements in this way, and providing misleading advice of this type Dr Myhill's conduct falls seriously below the standard to be expected of any reasonably competent medical practitioner."

C

Sir, the final report that has been gathered so far is that of Dr S Savla, a registered general practitioner. You will find this in Addendum (VII) at page 4044 to 4052. Dr Savla deals with the doctor's entries on her website concerning contraception advice. Dr Savla sets out the opinion at page 4046:

"Issues to address

D

Contraception

Dr Myhill starts off in her report that 'contraception is an entirely unnatural state of affairs!' A General Practitioner who is providing contraceptive advice should not make such a statement as I believe it is inappropriate. One of the principal duties of a General Practitioner, which is reflected in the Good Medical Practice booklet from the GMC, section 21.e, is to support patients in caring for themselves to improve and maintain their health. I believe that 'contraception is

E

an unnatural state of affairs' can be misleading to the public and may put off women who require contraception and who should be provided with methods of contraception that are most acceptable to them.

Oral contraception

F

Dr Myhill further adds, 'Using the Pill as a contraceptive is a dangerous medicine'. I believe that this information is inaccurate and inappropriate and does not fall in place with national guidelines or frameworks."

Dr Savla goes on in the paragraph below:

"She writes that there are 'immunosuppressive effects of the Pill which can make any infection more virulent'. I do not believe this is factual and it is not reflected

G

in any national guidelines.

It is my opinion that these aforementioned statements fall below the standard of a reasonably competent medical practitioner and seriously so.

Further, Dr Myhill writes that 'taking the Pill increases one's risk of cancer, breast, cervix, uterine and ovary) especially when the Pill is started in young

H

women. The longer the Pill is taken, the greater the risk'.

> I draw attention to a number of national guidelines and documents which will make it clear that such a statement is inaccurate as well as misleading as well as her remarks that 'using the Pill as a contraceptive is a dangerous medicine'."

At page 4047, two paragraphs up, Dr Savla states:

> "I therefore consider that the information as stated in her website that 'taking the Pill increases one's risk of cancer…' inaccurate and inappropriate. It does fall below the standard to be expected from a reasonably competent medical practitioner. It is misleading to an extent that it falls seriously below the standard with regard to uterine and ovarian cancer risk association. In my opinion, Dr Myhill has published information which is contrary to competent medical practice, and I draw your attention to section 60, 61 and 62 of Good Medical Practice.
>
> The literature does confirm a breast and cervical cancer risk association with COC use, and therefore this component of the statement is not incorrect and appears to be verifiable. I believe that Dr Myhill could have been clearer in her remarks with respect to cancer association of the cervix and breast and hormonal contraception."

On page 4048, Dr Savla at the third paragraph down states:

> "Next section, in the third paragraph of her Internet site statements, she writes 'the Pill has many other life-threatening side effects such as increased risk of thrombosis and heart disease, depression and suicide as well as lesser symptoms. I know I do not want my daughters ever to take the Pill'. I believe that Dr Myhill should have been clearer regarding her statement."

Two paragraphs down:

> "Dr Myhill writes that the Pill has 'many other life-threatening side effects such as increased risk of thrombosis'."

Dr Savla concludes on that:

> "I believe that this does not fall below the standard expected of a reasonably competent medical practitioner, but Dr Myhill should have been clearer in her statements."

In the paragraph below:

> "Furthermore, this statement remarks upon depression and suicide as a side effect of the Pill."

Dr Savla draws attention to the Faculty of Family Planning and Reproductive Healthcare document, and concludes towards the bottom of that paragraph at the top of the next page that:

> "Dr Myhill should have been clearer and provided more accurate information regarding the Pill and depression rather than issue a broad statement which implies a definitive risk association. I can see no evidence for a direct association between the Pill and suicide, and this is contrary to national guidelines and expert opinion. I conclude that in writing this statement Dr Myhill falls seriously below the standard expected of a reasonably competent medical practitioner."

In relation to "Injectable contraception":

> "Dr Myhill further states that she has 'similar reservations against their having a long-term, i.e. injected contraceptive, E.g. Depo-Provera."

Four paragraphs down Dr Savla states:

> "Dr Myhill is misleading in that she infers that the injectable progesterones are associated with an increased risk of venothromboembolism… This appears to be non-factual and does fall below the standard expected of a reasonably competent medical practitioner advising on contraception."

Over the page at page 4050, Dr Savla observes:

> "Again, Dr Myhill has not provided full disclosure of information which can be misleading to the public. It is my opinion that she has not kept up to date with knowledge and skills and appears to be expressing some of her own beliefs to patients. This appears to be contrary to section 60-62 of the *Good Medical Practice 2006* Guideline…
>
> I therefore believe that Dr Myhill has fallen seriously below the standard expected of a reasonably competent medical practitioner regarding the information on her website concerning 'injected contraceptive'."

She makes observations about the cervical cancer incidence and concludes that the doctor's statement that:

> "…in young women with an immature cervix sperm may be directly carcinogenic to the cervix…"

Dr Savla concludes:

> "This is misleading and also falls seriously below the standard expected of a reasonably competent medical practitioner."

In regards to "Safe contraception", the penultimate paragraph on that page:

> "Dr Myhill further writes that 'when women tell me that the condom did not work because it burst, I am afraid that I do not believe them. They are far too tough."

Dr Savla's conclusion:

> "I believe that this critique falls seriously below the standard expected of a reasonably competent medical practitioner and the Faculty of Family Planning Guidance on instructions on the use of male condoms indeed does highlight the fact that there can be problems with the use of male condoms."

Finally, Dr Savla's conclusion:

> "It is my opinion that Dr Myhill's statements on contraception fall seriously below the standard expected of a reasonably competent medical practitioner. This is highlighted in specific sections..."

She goes on:

> "She has not indicated in her website any benefits of oral or depot contraception which does not enable women to make informed decisions regarding their preferred method of family planning. I believe that her statements regarding 'the immunosuppressive effects of the Pill' are misleading, and her statements regarding cancer risk are not factual with regard to ovarian and uterine cancer."

Finally:

> "I believe Dr Myhill has not made sure that all of the information regarding contraception is factual and verifiable and this is contrary to … *Good Medical Practice*."

Sir, very little further material before I conclude. At page 4173 you have an email from a GK dated 8 October, someone who is trying to find someone he should write to regarding his adverse reactions to treatment under Dr Myhill. Clearly, there is very little detail about that at present.

Sir, that, I hope, concludes my taking you through the material that has been gathered since the last substantive hearing.

As far as the timescale is concerned, it is clear that we are at a fairly early stage in the investigation, but it is not true to state that the GMC has not started investigating. Those expert reports to which I have turned your attention show the fruits of that investigation so far.

The doctor will make her submissions in due course to you. You have those in her written document on this matter. It may be that if she deals with matters of procedure and law within her submissions that you might invite me to respond to those at the conclusion. I make one or two observations at this stage.

The doctor will submit that her current interim order of conditions is wrong in law because it has the effect of suspension. It is right to say that the case of *Udom v GMC* was a case of concern or where the High Court found that a Panel could not impose a particular condition that had the effect of suspension. That condition was a condition that a doctor only take up clinical attachments. The High Court found that that was an inappropriate condition because it had the effect of suspension and was combined with

other conditions and therefore amounted essentially to two orders being made by the Panel.

The doctor has not, certainly in the written document, provided any evidence to suggest that the conditions imposed by this Panel in April 2010 has had the actual effect of suspension. Indeed, one notes from the doctor's own website following the hearing in April that she or they were pretty much back on normal function after that hearing. If the doctor is going to rely on what she says in paragraph 12, she will have to explain why that has had the effect of suspension. I suggest the conditions have not.

Sir, in all the circumstances of this case, it is submitted by the GMC that there may be an impairment of this doctor's fitness to practise which poses a real risk to members of the public, or may adversely affect the public interest, or indeed may affect the interests of this doctor. After balancing the interests of this doctor and the interests of the public, it is submitted by the Council that an interim order is necessary to guard against that risk.

You, if you agree with that submission, will make the appropriate and proportionate order. It is submitted by the Council that that order must be at least an order of conditions. You will want to consider whether the doctor has breached both the letter and indeed the spirit of her current conditions, and you will want to consider, if you do impose conditions on the doctor, whether the doctor is capable and willing to abide by such conditions, that they are workable and enforceable and whether she will respect this Panel's jurisdiction and judgment.

You will be directed to the guidance contained in the GMC's guidance issued to this Panel on imposing interim orders. In particular, I draw your attention to paragraphs 18 and 19 of that guidance which deal with the test. There is a suggestion in the doctor's submissions that the GMC on the last substantive occasion, the Legal Assessor and the Panel itself, in some way failed to apply the correct test. That is a bald assertion made by the doctor in paragraph 18 to 19 of her submissions. I see no material to support that assertion.

If one looks at pages 3299 and 3324 of the transcripts, in my submission there was nothing wrong in the test as outlined either by my predecessor counsel or by the Legal Assessor on that day, and the Panel considered the appropriate test which is set out at paragraph 18.

In paragraph 19, one of the matters that you will need to consider at (c) is whether it is in the doctor's interests to hold unrestricted registration. It sets out an example that the doctor may clearly lack insight and needs to be protected from him or herself.

In paragraph 24 you will also want to consider as one of the factors in your decision-making whether the practitioner has complied with any undertakings given to the GMC or conditions previously imposed under the procedures.

Sir, what may be the impairment, or what may constitute the impairment that may exist in this case? There are questions about the doctor's performance and the impact that it may have on patient safety. You will want to consider the patient (Patient X) who is the subject of the referral and the conclusion of Professor Bouloux that the standard of care

of this doctor fell below that to be expected. There is no evidence in particular that the doctor had seen or considered the patient's medical records.

Secondly, you will want to consider the website recommendations, the various recommendations. Again, matters that by their nature involve recommendations without seeing patients. You will want to consider whether the advice given might be considered contrary to the advice that I set out that was given to the doctor in 2005 about avoiding unnecessarily alarmist statements. You will consider particularly the three reports of Professor Hunter, Dr Hubbard and Dr Savla in relation to nutrition, breast cancer and contraception.

Amongst the wealth of supportive testimonials, you have the matters of concern, the emails of concern, that I have set out from RM, GS and AF. You will want to consider whether there have been breaches by this doctor of the conditions imposed. The apparent link to the "ungagged website", whether she is recommending alternative ways of obtaining that which she cannot prescribe and whether the recommendation of the offshore pharmacy amounts to such a breach. The fact that she appears not to have informed the Shropshire County PCT in relation to two patients, is she therefore contracting with the PCT in relation to those patients? Then the suggestion by Dr Morgan that there may still have been some advice on cardiovascular disease on her website.

You will of course want to consider the doctor's insight, her reaction. That will or may not come at the point that you decide whether an order is necessary, but would certainly, I suggest, come at the point where you decide whether an order of conditions is enforceable and workable. You will consider her reaction to the Panel 's judgment after the last hearing, and you will have noted the observations she makes in her written submissions: the panellists' cartel of fraudulently extracting more daily wages from the GMC and misfeasance in public office; her urging you to refrain from repeating mistakes at your own peril; and her endeavouring to hold the three panellists personally liable for compensating her loss, damages and injury, as well as various other people.

Sir, I make it clear of course that the doctor has not been referred to this Panel because she has that attitude to this Panel. This is not primarily about how the doctor has reacted to the imposition of an interim order. But that is a relevant factor if you decide that an interim order is necessary. You will have to decide the appropriate order and whether an order is workable. Therefore, you will consider those matters.

Sir, in all the circumstances, the GMC suggest that there may be impairment and that an interim order of at least conditions is appropriate, proportionate and necessary.

Those are my submissions.

THE CHAIRMAN: Thank you, Mr Branston. The members of the Panel may have questions for you. Mr Devaux is a lay member of the Panel.

MR DEVAUX: Mr Branson, is it your view that if the Panel decides to impose conditions that the conditions should be the same as on the last occasion?

MR BRANSTON: Sir, the conditions of course are a matter for you. You will need to determine whether the doctor has complied with the conditions as set. If you have concerns about that, you will decide whether you need to strengthen the conditions or add to the conditions or to reword the conditions, if necessary, to make sure that the doctor does comply and is able to comply and that you can enforce those conditions. I do not have any specific observations about the individual conditions.

MR DEVAUX: Can you answer clarify something for me? Correct me if I am wrong, but I am not so sure whether any information has been put in front of the Panel today to suggest that any patients that we know of have come to harm. Am I wrong in saying that?

MR BRANSTON: There is, as I say, a very short, lacking in detail, email of 8 October from GK indicating a wish to write to someone regarding his adverse reactions to treatment under the doctor. I cannot say the extent of that apparent harm. I cannot give you any information about that. But that may constitute harm to an actual patient. There is the email of 15 April 2010 from RM, who claims also to have been harmed by the doctor's treatment in late 1996, but again I have very little to put before you about that.

MR DEVAUX: Thank you.

THE CHAIRMAN: Mr Branston, there are no further questions from you from Panel members. Next it will be the turn of Dr Myhill to address the Panel with her suggestions. I suggest that the Panel adjourn for lunch at this stage. The time is currently 12.30. I propose that we reconvene at 1.15 and the Panel shall then hear from you, Dr Myhill.

DR MYHILL: How much time do I have to speak available? Mr Branston has covered an enormous amount of ground. If I am it to go through all the references that underpin the references on my website, that will take an inordinate length of time. Are there any particular issues you wish me to address as a priority or would you like me to go through my full submission as I have prepared it?

THE CHAIRMAN: I would like you to focus specifically on the issue of an interim order. This is an Interim Orders Panel. It is not a fact-finding tribunal. It is not a Fitness to Practise Panel.

DR MYHILL: I see that entirely, but Mr Branston has presented a great deal of evidence and I have evidence that will contradict what he has said. Many of the facts that he has stated are actually not facts, and I have to be heard.

THE CHAIRMAN: It is obvious that there is a dispute of information between the information that you will give the Panel and the information that has been given by Mr Branston to this Panel. However, we will not adjudicate on facts. We will balance information and at the end of your submissions we shall then go into private session and shall determine the outcome of today's Panel.

It would be normal, in fairness to the doctor, particularly when they are not legally represented, that approximately twice the amount of time which is given to the GMC presenter will be allocated. That would be the norm. That is what I would expect.

DR MYHILL That is very helpful. Thank you.

THE CHAIRMAN: We will adjourn for lunch. I will say 1.20 for reconvention.

(Luncheon adjournment)

THE CHAIRMAN: Dr Myhill, Mr Elliott has passed me a note to say that Mr Branston wishes to make a further closing comment before you start your submissions. I am quite happy to accede to that. Mr Branston?

MR BRANSTON: Sir, my apologies for not having included this before lunch. I did say that I was going to refer you to *Good Medical Practice*. I am not going to read from it, but can I just refer the Panel to a number of paragraphs that have been mentioned in the course of my submissions and invite you to consider those when you are considering the question of impairment? They are paragraphs 3, 33, 60, 61 and 62. Thank you, sir.

THE CHAIRMAN: Thank you, Mr Branston. Dr Myhill, I turn to you for your submissions to the Panel.

DR MYHILL: I calculate that Mr Branston spoke for an hour and a quarter so that permits me two-and-a-half hours roughly to speak?

THE CHAIRMAN: There is no hard and fast rule on this, but I think in fairness to the parties - I am looking at a clock as we speak and it is currently 1.28 - let us see how we get on in the next couple of hours.

DR MYHILL: Okay.

THE CHAIRMAN: Does that sound okay for starters?

DR MYHILL: That is absolutely fine. What I was going to say is, if at any point you want to stop or interrupt me or pick me up on anything, then please do.

Registrar Rebecca Townsley summoned me to IOP on 8 September. She asked that I address the IOP on what action they should take in relation to my registration, and that letter also invited me to make observations on my case in writing to be circulated to the IOP before they consider my case. This I have done in an extensively referenced defence document together with the patient experience document and the medical reference documents that you all have in your bundles. This was all submitted electronically. All these have been made available to this Panel for perusal prior to this hearing.

She asked me to submit observations on my case in writing that are relevant to the four issues in her letter. Firstly, have I complied with GMC sanctions? Secondly, the website complaint. Thirdly, the partners' complaint. Fourthly, additional complaints about my website and other concerns from third parties, many of which are anonymous.

A

Compliance with GMC sanctions

These sanctions essentially were to remove pages from my website with which the GMC had concerns. This I have done. I wrote to the GMC stating that I had done so and requesting that the website be checked by a GMC officer to agree compliance. This was agreed in a letter which I will read out to you from Mr Paul Bridge.

B

GMC sanctions meant that I was unable to prescribe any medication within British National Formulary. I received an email from Mr Paul Bridge below which stated that any medications outside British National Formulary I was permitted to prescribe. This I have continued to do and have prescribed to my patients preparations not listed in the BFN. These include micronutrient supplements, essential fatty acids, natural thyroid extracts, magnesium chloride, methylcobalamin, enzyme potentiated desensitisation and other homeopathic herbal over the counter preparations.

C

THE CHAIRMAN: Dr Myhill, I have just heard a comment from the shorthand writer that she is unable to keep pace with your diction to the Panel. Can I ask that you perhaps slow down a little for the benefit of the shorthand writer?

DR MYHILL: I am also mindful that I have not so much time in order to present all my information.

D

With respect to recommending a website, this was in response to my patients who asked me how they could get the prescription medication that I had previously prescribed to them. They needed this prescription medication and had often been refused this prescription medication by their general practitioner. The website that I recommended that they go to for prescription medication comes highly recommended. All the products in there are guaranteed as being identical to those either in the American Pharmacopoeia or the British Formulary only. As I am sure you are aware, there are many websites where one can get prescription medication, some of them not reliable at all. There is only one that I particularly recommended, as I say, for these reasons.

E

So far, the GMC have not shown me any evidence that I have breached any sanctions on my practice. The letter from Su Green that Mr Branston referred to earlier included invoices for two preparations that were both outwith British National Formulary. This is the letter from Mr Paul Bridge:

F

> "Dear Dr Myhill,
>
> Thank you for your email. I have looked at your website and am satisfied that in my opinion you have removed the relevant sections of your website as requested by the IOP.
>
> In respect of your prescribing, the conditions specify that you must not prescribe any prescription only medication as detailed in the British National Formulary. No mention is made of prescription only medication that is not detailed in the BNF and therefore my opinion is that you may continue to prescribe such medication as long as it does not contravene any other guidance.

G

H

> Should any issues in relation to these matters arise at your IOP review hearing, I am happy for this email to be produced before the Panel. I would, however, also advise you to seek clarification of the conditions at your review hearing."

The website information

I note the GMC have commissioned an expert witness report from Dr Richard Harker who has concluded:

> "…in producing her website and giving information and opinion, I consider that overall Dr Myhill's actions are appropriate and of a reasonably competent standard.
>
> In my opinion it is difficult to clarify the role Dr Myhill has. She is not acting as a GP in producing her website. In my opinion it is fair to say that on the evidence available Dr Myhill is acting as a reasonably competent doctor providing free advice and opinion."

The only concerns that Dr Harker iterates with respect to information on my website has to do with mammography and the Pill. He requests that I reference the following comments:

(a) 22% of tumours regress;

(b) that needle biopsy is a potentially dangerous intervention;

(c) that significant doses of radiation are received during the course of mammography; and

(d) using the Pill is dangerous medicine.

Of course, many of these are the issues that the other expert witness reports pick on. My comments now are also relevant to those specific issues.

(a) 22% of breast tumours regress

Cancers, even advanced cancers, can sometimes undergo what is called spontaneous regression, i.e. they can simply disappear without trace. A recent study carried out by a team of researchers led by epidemiologist H Gilbert Welch MD of Dartmouth Medical School suggests that spontaneous regression may be considerably more common than previously thought. The study published recently in the journal Archives of Internal Medicine followed a group of almost 110,000 Norwegian women who underwent periodic mammographic screening for breast cancer over a five-year period between 1992 and 1997 and compared these women with a second matched group of women who did not undergo regular routine breast cancer screening during the same period. Surprisingly, the women who underwent regular screening had 22% more invasive breast cancers than those who did not.

The publication of the study was considered sufficiently important to merit an accompanying editorial in the Archives of Internal Medicine. The authors of the

editorial point out that it will be impossible to verify whether or not the 22% difference in breast cancer diagnoses between screened and unscreened women is indeed due to spontaneous regression of breast cancers unless a full scale clinical trial is performed. That said, it would probably never be possible to conduct such a clinical trial since it would be considered unethical to leave one group of women untreated. "Despite the appeal of early detection of breast cancer", wrote the editorialists, "uncertainty about the value of mammography continues."

This study is not the first to raise troubling questions about the natural history of certain breast cancers and the risks versus the benefits of screening mammography. For example, an earlier study carried out in Canada in 2002 also found an identical 22% difference in cancer diagnoses between women who went unscreened and those given regular mammograms. That was Miller 2004. Another study, this one published in the prestigious BMJ journal in 2004, reported similar rates of over diagnosis, concluding:

> "Without screening, one-third of all invasive breast cancers in the age group 50 to 69 years would not have been detected in the patient's life time. This level of over diagnosis is larger than previously thought."

I can reference those papers, should you need them.

The second point that Dr Harker asked me to discuss is that needle biopsy is potentially dangerous. My concern with needle biopsies was fired by two patients who came to see me, both of whom had recurrence of their breast cancer on the exact site of skin where the original needle biopsy was performed. I then researched this, of course, and found the following report which seemed to confirm my fears. A June 2004 report from the John Wayne Cancer Institute in California has rekindled a longstanding debate over whether or not needle biopsies are safe. The paper set out to examine whether this technique, widely used to obtain specimens in cases of suspected cancer, might itself allow malignant cells to spread from an isolated tumour to nearby lymph nodes. The authors reluctantly conclude that a needle biopsy my indeed increase the spread of the disease by 50% compared to patients who receive the more traditional excisional biopsies or lumpectomies.

This is a rigorous study and it comes with an excellent pedigree. The lead author, Nora M Hansen MD, was Chief Surgical Resident at the University of Chicago from 1994 to 1995 before coming to the John Wayne Cancer Institute in Santa Monico, California in 1997. She is currently Assistant Director of the Joyce Eisenberg Keefer Breast Center, St John's Hospital and Health.

(c) <u>Radiation doses with mammography</u>

I became concerned about the radiation doses received during a mammogram when I was unable to elicit a clear response from an NHS mammography screening unit who were unable to tell me the actual dose of radiation given during the course of a routine mammogram. I again researched this area and found the following advice. This is from Professor Samuel Epstein, Professor of Environmental and Occupational Medicine at the University of Illinois. Routine mammography delivers an unrecognised high dose of radiation, warn Dr Epstein and Dr Bertell. If a woman follows the current guidelines for pre-menopausal screening over a ten-year period she would receive a total dosage of

about 5 rads. This approximates to the level of exposure to radiation of a Japanese woman one mile from the epicentre of atom bombs dropped on Hiroshima or Nagasaki. Screening mammography should be phased out in favour of annual clinical breast examination by a trained nurse and monthly breast self examination, also following training by a trained nurse. This is an effective, safe and low-cost alternative to diagnostic mammography, the two experts advise. Such action is all the more critical and overdue in view of the still poorly-recognised evidence that mammography does not lead to decreased cancer mortality, they say.

This led me to research other possible screening techniques that could be done over and above monthly breast self examination, and subsequently I attended two lectures given by Dr Nicola Hembry to find out more about the benefits of thermography. I came to the view that thermography in skilled hands is a preferred screening test for breast cancer. This is a quote from that presentation:

> "An innovative and non-toxic kind of diagnostic test is thermography, which detects abnormal patterns of heat emanating from areas of high metabolic activity. Although thermography has had its ups and downs, the result of a four-year multi-centre clinical trial led by the University of Southern California was unambiguous. Infrared imaging offers a safe, non-invasive procedure that will be as valuable in determining whether a lesion is benign or malignant. The sensitivity of the test in the study was an astonishing 99%."

I now come on to about the Pill. Using the Pill, in my view, is dangerous medicine. I have been an advocate of the views of, Dr Ellen Grant MB ChB DObstRCOG since I read her book, "The Bitter Pill", when first published in 1985. I have attended a great many of her lectures and read her second book "Sexual Chemistry" published in 1994. Indeed, I assisted Ellen in the reparation of the graphs which showed a substantial rise in breast cancer. To do this, I obtained the original data from government sources in order to prepare these graphs for her. Dr Grant is one of the most prolific contributors to the published medical literature on the problems of exogenous oestrogens and progesterones, including the Pill and HRT.

There is a clear, logical basis why exogenous sex hormones should increase the incidence of cancer in all hormone sensitive tissue. There is excellent and compelling data showing highly significant increased risk of breast and cervical cancer.

The data for ovarian and uterine cancer is not so clear. Grant maintains that this is for two reasons, both of which centre around the selection of control groups. Firstly, the effect of even a very short course of hormones may have profound, long-term effects. Of course, the best example of this is stilbestrol given to pregnant women. With a great many young women (estimated to be over 90%) taking the Pill at some stage in their lives, it is now impossible to set up a control group of never users.

The second issue here is that side effects on the Pill are very common. The mechanism of these side effects, we now know, is due to poor nutritional status and poor immune function. These women then stop taking the Pill. But these same women are then used as the control group. The point here is that they are pre-selected for poor immunity and poor nutritional status, so that their likelihood of getting cancer is increased before any study starts to look at outcomes. The more robust women who do tolerate the Pill are at

A the start of the study less likely they are to get cancer because they must have good nutritional status and good immune function.

This issue of control group selection clouds the results of virtually all recent studies looking at the problems of the Pill and HRT. Thus, the very early studies, such as the Royal College of General Practitioners 1968 to 1969 study of 47,174 women, the Oxford FPA 1968 to 1969 study of 17,032 woman, and the Walnut Creek 1968 to 1972
B study of 16,638 women, provide the most reliable data showing increases in cancer of the cervix, breast, endometrium, skin, lung, urinary tract and thyroid, with equivocal results for ovarian cancer. Grady, Rubin and Petitti, Annals of Internal Medicine, conclude:

> "Whilst there is no evidence that HRT has any prolonged overall benefit, more women are being exposed to prescribed hormones and it is an irrefutable fact
C that more of them will develop cancer because of this exposure."

My views and opinions on my website simply reflect those views of Dr Ellen Grant, and are very much supported by my own clinical experience.

In addition, the issue of travel vaccinations, as discussed on my website, was raised by Dr Harker. The GMC, in an anonymous and possibly unqualified opinion, specifically
D flagged up the issue of travel advice to patients with chronic fatigue syndrome and the issue of vaccination. I have asked the GMC for authorship of this opinion but this has been refused. I note Dr Harker clearly rebutted the GMC's view with the following comment:

> "Whilst I do not profess to be an expert in ME/CFS, in my opinion Dr Myhill's advice is not significantly at variance with advice from other sources. Whilst her
E advice not to travel may appear to be draconian, in fact in my experience with patients with severe ME/CFS rarely wish to travel long distances. Avoidance of infection is important and the role of vaccination unclear.
>
> In my opinion, the advice given on her website is not inappropriate. It should be remembered that Dr Myhill is giving advice and opinion. The patients have a choice to seek advice from their GP and indeed many GPs run specialist travel
F clinics."

Professor Findlay is a consultant neurologist who runs the National Hospital for CFS/ME at Harold Wood. In a letter to one of my ME patients, he advises her on travel vaccination with the following words:

> "There is always a slight risk of relapse in chronic fatigue syndrome/ME
G following vaccination or immunisation, particularly when they are multiple. I would avoid going to Third World countries where the risk of infection is high."

We now come on to the partners' complaint concerning B12. This complaint has been the subject of detailed letters to the GMC which are contained within the defence document that you all have a copy of. I discuss these issues at length in the next section, so I will just skim over them now. This boils down to (1) the partners' practice told
H untruths and refused to correct them when they were pointed out. This complaint is

A founded on fabricated evidence. The reference for that is in my defence document section 3.2.1.

The GMC further misconstrued these allegations as evidence by the letter by GMC Legal to Professor Bouloux. The reference for that is in my defence document 3.1.14. It is littered with factual inaccuracies. One of those factual inaccuracies includes describing me as a "male consultant anaesthetic"!

B

The expert witness report was incompetent and unprofessional and came to erroneous conclusions. Again, that is detailed - and if I have time I will go through this - in the defence document section 3.1.15. Professor Bouloux's expert witness report does not follow GMC guidance on expert witness reports.

At 4 we now come to the new information. The GMC submitted to me a bundle of
C documents, including various emails and letters which criticise my opinions given in my website. I have to say that I find it little short of astonishing that the GMC can place so much weight on these communications, many of which are anonymous, but apparently ignore the wealth of communications from my patients or people who have benefited from advice contained within my website. By wealth, I mean the many, high quality, personalised, intelligent, incisive and often heartrending accounts.

D I will deal with the communications in the order they appear in the bundle of information sent to me.

A letter from Ms RS, who requests anonymity. In this she encloses the letter I wrote to my patients detailing the effects of GMC sanctions on my prescribing rights. GMC sanctions have had a disastrous effect on many of my patients by depriving them of essential information and medication and causing great consternation and many anxious
E phone calls to my office. The patient experience document contains the evidence base for the serious and adverse effect that GMC sanctions have had on my patients. In the letter I tell patients the rights that I do have and what actions they may take to mitigate GMC sanctions.

Many patients already purchase medications online. Some online suppliers are reputable, some are not. I direct my patients to a reputable site where they can purchase
F medications they find essential to their good health.

At (b), email from Ms CB who also requests anonymity. The style of this posting very much resembles that of a CB who also bloggs on the Bad Science website. She points out that ungagged copies of my website have been made and are available on the internet. I can hardly be held responsible for others copying my website. Indeed, I welcome the free distribution of information freely given.

G

At (c) a letter from Dr Mererid Owen concerning a mutual patient. There is no complaint in that letter. He simply invites an opinion as to whether further action is to be taken. However, attached to his letter are copies of the private and confidential letter that I wrote to the patient's GP, apparently without the patient's knowledge or permission to so disclose, and also without fully anonymising that letter. In this respect that GP is in breach of GMC guidance *Good Medical Practice*.

H

At (d), an email from a [DP] who disagrees with my treatment of asthma. This is in contrast to the opinion of GMC expert witness Dr Richard Harker. Also, the medical references documents contain medical papers supporting the views on this area as expressed in my website.

MR BRANSTON: Sir, I am sorry to interrupt but could I remind Dr Myhill that you made a direction at the outset that individuals who are not professionals should be referred to by initials. I think there may have been a slip there.

THE CHAIRMAN: May I ask that you comply with that, please, Dr Myhill?

DR MYHILL: I apologise for that. That was an oversight. But this was an email from somebody who did not object to my using her name, apparently.

THE CHAIRMAN: For the purposes of these proceedings today, if you do not mind, perhaps you could use initials.

DR MYHILL: yes, sure. An email from a KM, who states that I am and I repeat her words verbatim - "not understanding that the information she provides on her website is erroneous and that she could hurt some of her patients." This clearly is in contrast to expert witness Dr Harker, who opines that my website is of a good standard.

Email from a Dr JH. Again, no complaint, merely an observation on my prescription of thyroid hormones. This is an issue investigated at length in the past by the GMC, who opined I had no case to answer.

Another email from a D who requests that my website is checked by someone "with more knowledge than herself". She is right. GMC expert witness, Dr Harker, did so, and is satisfied that the information and opinions expressed are of a good standard.

We then have an anonymous email with multiple complaints about information on my website and a further anonymous email that states:

> "Dr Sarah Myhill is not fit to practise in my opinion recommending B12 and/or magnesium injections to patients. Is that a wise thing to do to patients who have a fear of needles? I also fear her website could lead to brainwashing and should be taken down completely. If anyone wants to get a diagnosis or symptom, they should go to the NHS website and consult a competent doctor."

It is little short of astonishing that the GMC should even consider these communications. My view is that they are all vexatious, but there is no evidence that the GMC have applied their own procedures for vexatious complaints.

I now wish to make some general comments with respect to the expert witness reports by Dr Harker, Dr Hunter, Dr Hubbard and Dr Savla.

The GMC has now commissioned five expert witness reports pertaining to my website. The first report by Dr Clark made up part of the GMC's investigation into my website during the years 2005 to 2007, and that was dropped with no case to answer in October 2007.

The Harker report was dated 28 May 2010. This report the GMC did not release to me until Rebecca Townsley in her letter of 8 September 2010 summoned me to an IOP hearing on 7 October. This report was very much in my favour and Dr Harker's conclusion I have already read to you, and I will not reiterate that, but he concluded that "Dr Myhill is acting as a reasonably competent doctor providing free advice and opinion".

Despite having two favourable reports in their possession, the GMC went on to commission a further three reports. These three further expert reports were all commissioned and dated in September, yet they were not made available to me until three working days, two working days and ten hours respectively prior to my second IOP hearing last Thursday. Although the GMC released these latter three expert witness reports as soon as they were completed, they retained Dr Harker's expert witness report for fifteen weeks before releasing it to me.

Furthermore, the Harker report was not released to me as a result of a Data Protection Act search on 16 June 2010. There is a further letter of apology dated 9 September 2010 from Elizabeth Hiley of the Information Access Team for documents created or received subsequent to 17 April 2010. Again, the GMC is in breach of the Data Protection Act.

Once more, this demonstrates the lack of impartiality of the GMC for two obvious reasons. Firstly, it appears acceptable to the GMC to withhold expert witness reports that are favourable to my defence, but as soon as one appears that is not, it is served on me without delay. Secondly, expert witness reports that are unfavourable are commissioned and delivered at short notice in an attempt to railroad me into a necessarily incomplete consideration of these reports. I am being denied my full right to make full and meaningful observations on reports submitted to the IOP.

Before I consider these expert witness reports individually, there are some important general points that are common to all. In the interests of not repeating myself, I shall go through these general points first before turning my attention to the specific points.

1. <u>In what capacity am I acting by making available my medical opinions freely online?</u>

Dr Harker very correctly brought up this issue in his expert witness report. It is clear that when giving my opinions on my website I am not acting as a general practitioner. As a GP I am acting as a patient's advocate and it is incumbent on me to act in the best interests of that particular patient. This may well involve me giving advice that is not wholly consistent with my opinions if I considered, in discussion with that patient, that their best interests were otherwise better served. So, for example, in my treatment of a patient with arthritis my general advice is against taking painkillers because this accelerates the rate at which joints are damaged. However, if that patient needs pain relief in the short term to be able to deal with a particular life event, then painkillers may well become a necessary expedient.

As the GMC knows, I do consider the prescription of female sex hormones to be dangerous medicine. Actually, this is for many of the same reasons that pregnancy is

dangerous. High levels of endogenous sex hormones increase the risk of diabetes, hypertension, thrombosis and, if already initiated, will drive up the growth of a sex hormone dependent malignant tumour.

I have seen two patients diagnosed with breast cancer during pregnancy who have had to undergo a termination of pregnancy and mastectomy as life-saving interventions. However, as a short-term expedient in a woman experiencing heavy periods, risking anaemia and awaiting surgery, the prescription of progesterones may be totally appropriate. Indeed, as already mentioned, Dr Richard Harker comments:

> "…in producing her website and giving information and opinion, I consider that overall Dr Myhill's actions are appropriate and are of a reasonable competent standard."

Dr Harker also comments:

> "I would stress I have no evidence that Dr Myhill is denying her own patients treatment. She is expressing an opinion on a website which people choose to look at and the views represented."

In fact, I would ask this Panel: does this Panel consider I am acting as a GP in producing my website or as an independent expert? (Pause) No comment!

2 Informing my general opinions and making them available freely on my website I am acting in the same capacity as the author of a book.

There are many such books on the market written by doctors who give advice which is often outwith national guidelines. Examples of such books include "The Bitter Pill" and "Sexual Chemistry" by Dr Ellen Grant, "The Truth about Vaccines" by Dr Richard Halvorsen, "Migraine" by Dr John Mansfield, "Chemical Victims" by Dr Richard Mackarness, "Stop Bellyaching" by Dr Peter Mansfield, and many others.

However, I do not see these doctors subject to General Medical Council scrutiny for giving advice that lies outwith NICE guidelines. This is another example of one of the many inconsistencies in the application of GMC policies that have arisen from the GMC investigation into my website.

The opinions iterated in my website have sound, logical reasons behind them, which are supported by respectable references from the scientific literature. I shall present this evidence… or I have presented that evidence.

It is the GMC's policy, as iterated in a letter dated 7 August 2006, by GMC Assistant Registrar Neil Jinks, that it is not the place of the GMC to take a position on the correctness or otherwise of generally recommended or possible cutting-edge treatment. Again, does the Panel support this statement or has the General Medical Council policy changed since Mr Jinks opined on this issue? (Pause) No comment!

THE LEGAL ASSESSOR: Mr Chairman, forgive me for interrupting, Dr Myhill, I noticed on both of those questions, which I imagine the Committee took to be rhetorical questions, when there was no response (I would expect there not to have been) she said

"No comment", which indicates to me that she was in fact expecting a comment rather than posing them as rhetorical questions. If that is correct, Dr Myhill should be aware that any tribunal, whether it is a court of law or a panel such as this, is not here to be questioned. It is here to receive and to consider information from both the GMC and Dr Myhill herself. Therefore, it would not be right to assume that because the Panel did not respond that they were in any way disagreeing or agreeing with what she stated.

DR MYHILL: Okay.

THE CHAIRMAN: Thank you, Mr Wallis.

DR MYHILL: It is no crime to pass opinions that are outwith national guidelines, as demonstrated by the following correspondence from NICE, a letter from K Ellis dated 28 May 2010.

> "It is important to emphasise that the National Institute for Health and Clinical Excellence (NICE) Clinical Guidelines are just that, guidelines for healthcare professionals. The guideline emphasises a collaborative relationship between clinician and patient and recognises that there is no one form of treatment to suit every patient, but that what is needed is a personalised, holistic approach. Once NICE guidance is published, health professionals and the organisations who employ them are expected to take it fully into account when deciding what treatments to give people. However, NICE guidance does not replace the knowledge and skills of individual health professionals who treat patients. It is still up to them to make decisions about a particular patient in consultation with a patient and/or their guardian or carer where appropriate. Health professionals retain their independence to apply their clinical judgement in deciding which guidelines to use for the diagnosis and treatment of their patients."

This opinion is also in my defence document, section 4.25.

Furthermore, the *Bolam* principle is as follows - and this comes from English case law. *Bolam v Friern Hospital Management Committee* [1957] WLR 583 is an English tort law case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals such as doctors. It is called "The *Bolam* test". Where the defendant has represented himself or herself as having more than average skills and ability, this test expects standards which must be in accordance with a responsible body of opinion, even if others differ in opinion. In other words, the *Bolam* test states that if a doctor reaches the standard of a responsible body of medical opinion, he is not negligent.

I also quote from Professor Wendy Savage, who makes the point of clinical autonomy. Professor Wendy Savage, erstwhile elected member of the GMC Council from 1989 to 2005, wrote a book concerning her experiences with GMC principles regarding the above point. In that book, "A Savage Enquiry", she stated that:

> "One of the most important principles of the practice of medicine is that of clinical autonomy, which allows a fully trained doctor the responsibility for deciding which mode of treatment is best for his or her patients. In practice, clinical autonomy means that consultants and GPs are of equal status, are

> responsible for their own clinical decisions and should not be criticised by their colleagues, as long as those decisions are within the 'broad limits of acceptable medical practice'. The GMC's handbook also states that the deprecation of a doctor of the professional skill, knowledge, qualifications or services of another doctor could amount to serious professional misconduct."

This was followed up in April 1987 by the following comment made by Sir Donald Irvine in the Blue Book on the issue of disparaging of professional colleagues:

> "It is improper for a doctor to disparage, whether directly or by implication, the professional skill, knowledge, qualifications or services of any other doctor, irrespective of whether this may result in his own professional advantage, and such disparagement may raise a question of serious professional misconduct."

The Blue Book 1990 includes an identically worded section.

It is my view that the GMC is acting outwith its capacity of jurisdiction. The complaints against me are based on disagreements with me on the correctness or otherwise of generally recommended or possible cutting-edge treatment. Judgment on this is not within the remit of the GMC as evidenced above. Given that the GMC is acting outwith its capacity, the opinions of Drs Hunter, Hubbard and Savla should be set aside in their entireties.

As I say, this is the fifth occasion that my website has undergone GMC scrutiny. At the first occasion, all concerns with respect to the website were dismissed in a letter of 9 October 2007 by Simon Haywood, Assistant Registrar of the GMC, in which he commented:

> "Dr Myhill's website is littered with warnings about its safe use. Council notes the many warnings which are given by Dr Myhill on her website, many of which were pointed out in Dr Clark's report."

Indeed, I reproduce below what I ask all patients to read before going on to my web pages.

> "New symptoms which are not resolving and/or are getting progressively worse such as:
>
> - pain,
> - fatigue,
> - malaise (feeling ill),
> - unexplained weight loss,
> - loss of appetite,
> - failure to grow (in a child),
> - generalised weakness,

- new lumps anywhere in the body,
- complete or partial loss of a sense (sight, hearing, taste, smell, sensation),
- complete or partial loss of use of muscles (hands, feet, limbs, trunk, face, eye movements),
- difficulty breathing,
- recurrent fevers or sweating,
- pain in the tummy,
- bloating,
- a change in your normal bowel habit not accounted for by a change in diet,
- a change in the way you normally pass urine,
- abnormal discharges from any orifice (e.g. vaginal bleeding between periods, vaginal bleeding after the menopause, blood in the urine or stool),
- coughed up blood,
- changing voice or hoarseness,
- palpitations and so on.

It is your job to use this site responsibly.

REMEMBER that tests ask a specific question and give a specific answer. Just because the tests are negative does not mean all is well. Progressive symptoms should be aggressively investigated by tests which are obviously beyond the scope of this website, such as X-rays, ECGs, ultrasound, endoscopy, biopsies, exploratory surgery and so on."

In view of all these above issues, the questions put by the GMC Legal Team to their expert witnesses are irrelevant.

Furthermore, the conclusions contained in the three unfavourable expert witness reports represent illogical, conceptual leaps. What is common to these conceptual leaps is that on the basis that my medical opinion is at odds with their medical opinion ergo my behaviour falls seriously below that of a competent medical practitioner.

Today's GMC prosecutor, Mr Gareth Branston, has leapt on these conclusions without a careful and considered view of the evidence base which so clearly fails to underpin these ridiculous conceptual leaps. Indeed, and in the interests of fairness and proportionality, I must state that these expert witnesses are drawn to these conceptual leaps by the nature of the briefing document supplied to them by the GMC Legal Team. It is clear from the tone within these briefing documents that the GMC is not conducting an impartial investigation of my website opinions, but rather wishes these expert

witnesses to interpret my opinions in such a way as to come to a desired expert conclusion.

The only expert witness report commissioned for this latest investigation which has stood up against these GMC directives and which has provided a proper and balanced opinion is that of Dr Richard Harker. The other three expert witness reports are in direct contrast to his well-constructed, fully referenced and logically argued document.

Because there are Data Protection Act searches that are essential to my defence still outstanding, I only have the letter of instruction from the GMC Legal Team to Dr Richard Harker. When the other three GMC letters of instructions are made available to me and I have had time to give them mature consideration, I may be able to further evidence this assertion.

The following are extracts from the GMC's Legal Team's letter of instruction to Dr Richard Harker.

> "Upon considering the information upon Dr Myhill's website and her comments at enclosure 13, please provide comment upon the following:
>
> - Whether the information documented on Dr Myhill's website is accurate, appropriate and in line with any national guidelines. If it is not, please provide comments as to what is inaccurate and/or inappropriate and why you consider the same.
>
> - If you consider that any or all of the information is inaccurate and/or inappropriate, please state whether, in providing this information, Dr Myhill has fallen below the standard to be expected for a reasonably competent GP.
>
> - If Dr Myhill's actions were below the standard expected of a reasonably competent GP on all or any of the above questions, please comment upon whether these actions fell seriously below the standard of a reasonably competent GP.
>
> - Any other issues which in your opinion are relevant to this case and which I have not raised in the above questions."

These questions have been framed by the GMC Legal Team in such a way as to achieve the desired conclusion, which any expert witness who did not have a strong independent mind but who wished to provide the GMC with their desired outcome would concur with. They are in effect leading questions. By specifically mentioning national guidelines as a test for accuracy and appropriateness, they are misleading both in their direction to Dr Harker and also in fact.

The points here are as follows. In passing opinions on my website I am not acting as a general practitioner. Questions which address this issue should be set aside. In any case, it is not a crime to pass opinions outwith national guidelines. At the risk of repeating myself, I would refer the Panel to the comments concerning the

inappropriateness of GMC involvement in such issues as made by Assistant Registrar Neil Jinks and as previously mentioned above.

Dr Harker in his expert witness report asked me to reference some of my opinions, and this I have already done in my more detailed analysis of his report.

However, a mature consideration of the above points clearly shows that the Drs Hubbard, Hunter and Savla reports are based on the erroneous assumption that I am acting as a GP and that all information provided has to conform with national guidelines, and their reports should be set aside.

I now turn to a more detailed analysis of these individual expert witness reports.

We will look at Dr Ann Hubbard's report. It appears to be standard policy for the GMC Investigation Team to do absolutely nothing until the last minute. This is yet another expert witness commissioned at the last minute by the GMC in order to try to bolster the already inadequate evidence they had in their prosecution of me. Clearly, Dr Ann Hubbard is a pupil of the Professor Bouloux school. Her expert witness report is on unheaded paper, the pages are not numbered, the paragraphs are not numbered, and it appears the report was faxed. There is no declaration of interest in her report, but, for the Panel's interest, Dr Ann Hubbard is employed at a private clinic at the private hospital of Spire Hull and East Riding, which offers mammograms. I telephoned the clinic and the cost of consulting with Dr Hubbard is between £150 and £200, in addition to £140 for a mammogram and £210 for ultrasound. She has not declared this in a declaration of interest, but clearly she has a financial interest in promoting mammography. Perhaps her report can hardly be described as independent.

She has been instructed to provide an expert witness report addressing the issue of whether the information documented on my website is accurate and appropriate and in line with national guidelines. We have covered this already.

What Dr Hubbard goes on to iterate are her opinions and some of those she references. All the opinions that I express in my website with respect to mammography, breast screening, needle biopsy and radiation doses, I can and have referenced.

What we are looking at here is a continuation of the debate over the benefit of mammograms that has now been raging for some decades. There are many opinions at either end of the spectrum, all of which can be well supported by references. Indeed, one of the references she cites is only just published and not available to me when I opined.

The opinions I express on my website are just that, based on the scientific literature, and I have provided all the necessary references, combined with my own clinical experience. I have seen many women who have suffered as a result of mammograms. In particular, the procedure is painful and some women have been left with chronic pain as a result. Furthermore, I have seen women with secondary skin recurrences at the site of needle biopsy, and I have seen one patient for whom mammogram completely missed the tumour. In this instance, the patient was so reassured that she took no further medical action, even when the lump continued to grow. This patient - and I remember her well, Penny, presented to me with an advanced tumour. Indeed, her partner called me at

home on a Sunday for help. This happened to be my birthday and I was supposed to be preparing Sunday lunch for my husband and two toddlers. Instead, I spent two hours cleaning up Penny, who was lying in a pool of haematemesis and diarrhoea. She died later that day. She conducted her own legal case against the mammography service with the help of expert witness Professor Karol Sikora.

This is the difference between clinicians and researchers. It is for the clinician to be familiar with all the available literature to learn from their own clinical experiences and to interpret that to patients in a way that will guide them safety through the very many options available. In expressing my opinions, I have to use a language which is patient friendly. If Dr Hubbard is critical of that, then I apologise. What I can say is that I have never been contacted by any patient who has suggested that my opinions have caused anxiety or distress. Indeed, I have been contacted by patients who are grateful to be given a chance to see both sides of the argument.

Where Dr Hubbard acts in a completely unprofessional way is in her conclusion. For example, she criticises me for recommending thermography because a private clinic in Bristol, with whom I have no financial links, will charge patients £160. However, I would point out to you that by contrast, Dr Hubbard, by promoting mammography, stands to gain financially herself because she is a consultant at a private screening clinic. Furthermore, Dr Hubbard fails to look at my website in its entirety. As Simon Haywood of the GMC commented previously, "Dr Myhill's website is littered with warnings about its safe use."

Dr Hubbard's inference from my opinions is that there will be delay in the presentation to the medical care of women with breast lumps and cause unnecessary distress by bringing into doubt what she sees as the standard diagnostic triple assessment. This is pure conjecture and inference on her behalf, which should not be sustained in such a court of law.

As a result of her biased view, her own biased selection of references, and, I suspect, her own financial interest in mammography, Dr Ann Hubbard concludes that my conduct falls seriously below the standard to be expected of any reasonably competent medical practitioner.

This expert witness report should be set aside for the above reasons.

We now come to the expert witness report of Dr John Hunter. Professor Hunter has been commissioned by the GMC to write a third GMC expert witness report on the opinions contained within my website. Professor Hunter appends pages from the website which detail the content of Myhill Magic Minerals (the MMMs). This is a physiological mix of minerals that I routinely use. I designed this mix myself because I could not find a commercially available preparation which contained all essential minerals in physiological doses and in a readily absorbed form. My patients find this a cheaper and easier way of obtaining the vitamin and minerals required for the protocols I advise.

Professor Hunter appends the comments of MMMs, which are as follows. What I would like you to do is have a look at that list of what is contained in that 1 g of

minerals because it is relevant to what I am going to say next. I am not sure where that is in your reports. (Pause) It is on page 3753 of the bundle of documents that you have.

THE CHAIRMAN: Which is within Addendum (I).

DR MYHILL The dose of minerals I prescribe my patients is 1 g per 2 stone of bodyweight, up to a maximum of 5 g daily. The doses here are that for a 10 stone person.

Professor Hunter goes on to make comments about the minerals and the doses which are at odds with the facts. Let me go through his comments.

Cobalt

Professor Hunter states that a daily dose of 5 mg of cobalt is dangerous. I would agree. But, in contrast to Professor Hunter's assertion, there is very little cobalt in my mineral mix. However, there is vitamin B12 and a full dose of MMMs would contain 5,000 international units, which is 125 mcg of B12. This is not the same thing as 5 mg of cobalt, although cobalt is of course present in B12. The percentage of cobalt in vitamin B12 is 0.0435%. The amount of cobalt in B12 is 5.4 mcg, not the 5 mg that Hunter states. Dr Hunter is inaccurate and incorrect by a factor of a thousand.

Iodine

Again, Professor Hunter has calculated his figures incorrectly. In the MMMs there is 0.3 mg of iodine per gram, so a 10 stone person taking the maximum recommended dose would be taking 1.5 mg a day. Hunter's calculation of 14 mg a day is wrong. Having said that, iodine is an extremely safe mineral and can be bought over the counter in doses of up to 12.5 mg a day. An example of such preparation is Ioderal.

Manganese

Again, Professor Hunter has made a simple arithmetical miscalculation. The MMM supplement contains 0.2 mg of manganese per gram. For a 10 stone person, this would give a dose of 1 mg per day. This is ten times less than Hunter's calculation of 10 mg a day.

With respect to zinc, the dose of zinc is 6 mg per gram. A 10 stone person would receive 30 mg of zinc per day, not the 47.8 mg that Professor Hunter quotes.

It appears that Professor Hunter has taken his figures directly from the anonymous complainant, Mr SJ, instead of checking the facts for himself. Indeed, all he had to do to check the facts was to turn to the appendix that he himself attaches to his expert witness report.

It is also the case that any potential toxicity from one mineral is greatly mitigated by physiological doses of others. It is very much safer to prescribe minerals in combination than in isolation. This is another reason why my patients prefer to take vitamins and minerals in this combination form. For example, it is well documented that high levels of iron will block zinc absorption. Indeed, this is the reason why routine

iron supplementation during pregnancy has been abandoned. This important biochemical issue Professor Hunter does not address.

I would also refer the Panel to the expert witness report that the GMC has already commissioned from Dr Richard Harker dated 22 May, who points out that in all the doses I recommend all these minerals he was easily able to purchase over the counter at his local Holland & Barrett health food shop.

Finally, should the Panel need any further reassurance, I regularly lecture to the British Society for Ecological Medicine, a society of doctors with a special interest in nutrition, who know full well the comments of MMMs and have never flagged up any concerns.

The specific issues raised in the expert witness report of Dr Savla, I have already covered in my general comments.

This IOP today should never have happened. Today should have been a Fitness to Practise hearing. The reason it is not is because the GMC has failed to investigate my case adequately. It has awarded itself ten months to investigate the partners' complaint before my last IOP in April 2010. Now, a further six months down the line, at the last minute it has served up three expert witness reports with respect to opinions expressed on my website, one delivered with just four working days' notice, one with just two working days' notice, and one with ten hours' notice. In view of the fact that the GMC have had six months notice before this hearing, this is completely unfair and it is also against all the laws of natural justice that I should be allowed such a short time to respond.

Since my April IOP hearing the GMC has made no further investigation into the partners' complaint. In particular, it has not even requested witness statements from the complaining doctors. Neither has it bothered to investigate the very many untruths it has been told, as pointed out to myself on numerous occasions. I know this because of Data Protection Act searches served on the GMC. All the GMC has done is to commission an expert witness report into my website, which, as I have shown you, is entirely favourable.

Since 29 April 2010, I have assembled a mass of information that I have already presented to this IOP. It includes my defence document, which is extensively referenced, and has a full evidence base. It also contains patient experiences and patient counter examples. Many are from patients whose needs have not been served by NICE guidelines and who have relied heavily on the information within my website to put them back on the road to good health.

I also submit many references which underpin opinions expressed on my website which I have not iterated in the last hour.

By contrast with the allegations of the GMC, everything that I say will have an evidence base that can be fully referenced, and I shall illustrate that evidence base as I go along.

Professor Green, in his memo of 1 October 2010, states:

> "It is entirely reasonable for Dr Myhill to point out what she believes the factual inaccuracies are to the Panel, and no doubt they will take this into consideration, as they did in their last determination."

Rebecca Townsley, in her letter to me, states that I am invited to address the IOP on the action they should take in relation to my registration. This presentation is in various sections. In this section too, I shall go through in detail why my last IOP in April 2010 was seriously flawed procedurally and evidentially and with respect to the sanctions applied. On the issues contained within this section alone, the IOP conclusions of that day should be set aside. We also have the cross-examination of witnesses, which I say would demonstrate that witnesses told untruths. The handling of my case by the GMC Legal Department was incompetent. The GMC expert witness report by Professor Bouloux was unprofessional. Any reasonable person would see that such a serious problem in any one department, let alone all three, would be cause immediately to drop any further GMC investigation.

I have requested the following doctors attend my hearing to give evidence, namely three doctors from the partners' practice, Dr W, Dr Y and Dr P, and expert witness Professor Bouloux, and my own expert witness Dr David Freed. But, as you have heard from earlier discussions, this is not possible. Indeed, Dr Freed attended last week's hearing, but I have received no response from any of the other witnesses.

<u>A brief history of GMC investigations into my case</u>

Since 2001 I have faced the prospect of six GMC Fitness to Practise hearings. No complaint has ever come from a patient, all emanating instead from doctors or from the GMC itself. During those investigations, my website has been extensively examined by the GMC and not found wanting then. All allegations were dropped with no case to answer and no sanctions were placed on my practice. Indeed, GMC counsel, Mr Tom Kark, stated: "No one can seriously doubt Dr Myhill's good intentions."

I simply wish to practise medicine unencumbered by spurious GMC investigations. With this in mind, I commissioned an independent QC, Mr John Macdonald, with the remit of reviewing my case history, which is appended in the defence document, for discussion with the GMC. This resulted in a meeting with Head of Investigations, Jackie Smith, on 12 August 2009. At that meeting, Ms Smith refused to allow Mr Macdonald to attend, she refused to answer my questions, she refused to sign minutes of that meeting and has refused all communication with me since.

<u>The complaints</u>

On 8 April 2010, I received a letter from Rebecca Townsley, Assistant Registrar of the General Medical Council, stating that two complaints about my medical practice had been received by the GMC. The GMC considered that these complaints suggested that my fitness to practise may be impaired and so instigated an IOP. The documentation is attached.

The bringing of these complaints against me are seriously flawed, either because they had no basis in fact or because the GMC, in bringing these complaints, broke with their own procedures.

I will go through the procedural points first. As a result of the Data Protection Act searches made by me, it became clear that nearly all the letters that I had written to the GMC were missing from the official GMC data record on me. In total there were 45 letters missing. I complained about this and on the morning of the hearing received a letter from Julian Graves of the GMC, dated 26 April 2010, delivering all those letters to my office. Mr Graves lists 38 as not having previously been disclosed, five as having been disclosed and two as not being found. It is a procedural requirement of GMC hearings that the relevant past GMC record of the defendant has to be considered in the determinations of the Panel overseeing the hearing. These letters are by their nature clearly relevant to the hearing evidence. Clearly, in all probability this did not happen at my hearing, given that so much evidence relevant to the case in hand was missing from the official GMC record. As well as a procedure point, this is also an evidential point because the Panel, and indeed GMC investigation officers, could not avail themselves of the full facts and history of the case against me. The fact that crucial evidence appears to be missing from that presented to the Panel members has the effect that that IOP decision should be set aside, and unless evidence can be brought forward by the GMC that these letters were indeed available to GMC investigation officers and Panel members, it is therefore required that each member of that Panel produce a signed affidavit to the effect that they had sight of all these said letters.

There are many letters on the GMC files which I hold myself concerning this issue. The key letter admitting the error by the GMC was the said letter from Julian Graves, and this is located at section 4.3. Should it be necessary, copies of all 45 letters can be produced for the purpose of ascertaining their relevance.

<u>The GMC did not follow their own advice on vexatious complaints</u>

The website complaint is vexatious, as defined by GMC Rules. Criteria 8 of "Vexatious Allegations Guidance on the Application of Rule 4(3)(c) of the GMC (Fitness to Practise) Rules 2004, states that:

> "Broadly, a complaint can be vexatious within rule 4(3)(c) in either its intrinsic nature or in the manner in which it is brought and/or pursued: that is, if there are reasonable grounds to believe that one or more of three criteria apply:
>
> A. The complaint's primary purpose and/or effect is to disturb, disrupt and pressurise the doctor, the GMC and/or another organisation and/or individual.
>
> B. The primary purpose and/or effect of the manner in which the complaint is brought is to disturb, disrupt and/or pressurise the doctor, the GMC and/or another organisation and/or individual.
>
> C. The complaint is otherwise manifestly unreasonable."

The anonymous website complainant was motivated by his own personal belief systems rather than any evidence based scientific concerns. The complainant is a regular and frequent blogger on the web forum Badscience. He consistently take a negative view of any medical practices which operate outwith national guidelines and considers all such practice dangerous. There are examples of abuse on that web blog which are personally

directed at me in a manner which I consider to amount to harassment. Indeed, in addition, very many repeat and trivial allegations have been brought in a short period of time by this one complainant. Indeed, he is flippant about the whole affair, stating - these are posts on the Badscience website - this one is from Thursday, 15 April 2010:

> "Ok, so I finally bit the bullet and complained (anonymously for reasons that will become clear) to the GMC about uber-quack Dr Sarah Myhill and to my surprise they have decided to launch a Fitness to Practise investigation. Her response has been quite interesting so I thought I would share it with the Bad Science community. It will be interesting to see how the GMC proceed, as I believe she has been in the same situation on numerous occasions in the past with similar public campaigns resulting in the GMC dropping charges for undisclosed reasons.
>
> She has a public Interim Order Panel hearing on 29 April at which she could have her licence to practise suspended for 18 months.
>
> Those who live in glass houses should masturbate in the basement."

Jonas then went on to say subsequently:

> "I actually find this quite funny as my initial contact with the GMC was just a speculative email to the general enquiries email asking whether it would be worth submitting another complaint given the failure of the previous six efforts. This was written in some haste during coffee break and hence contained a few typos. Amusingly, after submitting my full complaint, the GMC decided to use this email to front the complaint to Myhill 'sigh'.
>
> Those who live in glass houses should masturbate in the basement."

On the day of my hearing, he posted this remark. Thursday, April 29th:

> "Did I read that correctly? She included my Dara quote in an official submission to an interim order panel. Brilliant, absolutely brilliant.
>
> I expect Rita Pal/xmrv and co will now be attacking every person they see at the GMC who's wearing shades and drinking a can of coke.
>
> Those who live in glass houses should masturbate in the basement."

A further quote by Jonas:

> "The latest from Myhill's mystical world of mind boggling misinterpretation and make-believe madness."

And again his signature:

> "Those who live in glass houses should masturbate in the basement."

Detailed arguments as to why this complaint is vexatious are detailed in the appendix notice in my defence document. It is concluded that all three thresholds noted in criterion 8 above were met by this complaint.

If any professional has any concerns about the opinions of another, the usual code of conduct is that of direct contact. I am easily contacted by email, but Jonas never did this. He is acting unprofessionally. Given that this complaint was vexatious, as defined by the GMC's own guidelines, it should be set aside in accordance with GMC procedures for the purpose of determination by the IOP.

The GMC has been unable to provide evidence that its case officer even considered the vexatious nature of both complaints. It is a requirement that such consideration must be made by the GMC before bringing forward any hearings. Due to this procedural lapse, the decision by the IOP should be set aside until such time as a detailed account of what the GMC has done in order to determine the vexatious nature or otherwise of these two complaints has been made.

Independence of the Panel

At the 29 April 2010 IOP hearing, there were two members of that Panel who may have had prior knowledge of my case. Dr Lewis Morrison was a member of the Panel in this case. Dr Morrison works for Lothian NHS and is involved in the provision of stroke services in Scotland. In January 2006, Dr Charles Swainson, a Medical Director of Lothian NHS, also involved in the provision of stroke services in Scotland, complained about me to the GMC. In addition, Ms Angela Macpherson, also a Panel member, has spent many years as a senior figure on the Scottish Executive Health Department and may well be known by or to either of Drs Morrison or Swainson. Obviously, this raises the possibility that Dr Morrison or Ms Angela Macpherson, or indeed both, had prior knowledge of my previous cases and were therefore in some way prejudiced.

This point has been raised by the GMC and Neil Marshall, Assistant Director, responded, stating that he had contacted Dr Morrison who had confirmed he had no knowledge of my previous cases, and also that Dr Morrison had not informed the GMC of any potential conflicts of interest prior to the hearing.

The independence of that Panel has not been demonstrated in a transparent and accountable manner. For the avoidance of doubt and for the record it is required that Dr Morrison, Ms Angela Macpherson and Dr Swainson produce signed affidavits to the effect that discussions concerning my previous GMC cases had not taken place between them or indeed via third parties, either prior to or after that hearing. Until and unless these affidavits are forthcoming, the IOP's decision should be set aside on the basis that it has not been openly demonstrated that the Panel was independent.

Discussion of the IOP sentence before the hearing of evidence

Discussions on the restrictions to my practice to be placed upon me took place prior to me giving my statement. Indeed, my representative at that hearing, Mr John Macdonald QC, was told before the hearing was even opened that sanctions would be placed on my practice. This gives the clear impression that the IOP had decided upon the outcome of the case before all evidence had been submitted to the Panel. Whilst the Panel did have

limited written evidence concerning the B12 complaint, there was neither such written evidence nor even an expert witness report about the website complaint.

Even if it is accepted that the Panel could come to a fair decision regarding the B12 complaint without my statement, which in itself seems to run against natural justice (me not having had a chance to put my case first), there can be no acceptance that such a decision regarding the website complaint is justified, given the complete lack of documentary evidence available to the IOP on this complaint.

Given the lack of proper procedures regarding the order of tabling of evidence, the IOP decision should be set aside until and unless it can be demonstrated that the discussions regarding restrictions before my giving of evidence were only preliminary in nature and were indeed capable of being reversed after the submission by me. Once again, signed affidavits from the Panel members confirming this are required.

Lack of fair notice accorded by the GMC to me.

Initially I was given one full working day's notice of my April IOP hearing. This notice was received in a letter dated 8 April 2010 requiring me to attend a hearing on 12 April 2010. GMC (Fitness to Practise) Rules 2004 state at Rule 11:

> "In practice doctors will normally receive at least seven days' notice of a hearing, but in exceptional urgency the period of notice may be shorter."

THE CHAIRMAN: Dr Myhill, at this stage you are drifting into information. I can assure you that we have all read these papers in detail and we know the sequence of events and dates. That is not particularly helpful. I would like you to focus more on the issue of today's interim order, please.

DR MYHILL: I had problems with the partners' complaints for the reasons iterated in your opening sentences, but I will try and make this as anonymous as I possibly can. Mr Gary Summers, counsel for the GMC, presented his case in such a way as to reveal the identities of both the partners' practice and Patient X to a determined observer. This knowledge is now public. The most relevant paragraph in Mr Summers' presentation is reproduced below, but there are other examples within his presentation where basic errors in protection of the partners and Patient X's identities were made. I am not going to read that paragraph out for the reasons iterated in your opening remarks.

The effect of the IOP decision is that the GMC has broken its duty of care to patients and complainants in preserving their public anonymity. Mr Gary Summers' presentation is in the public domain. There is little that can now be done to undo this breach of trust by the GMC in terms of the position of the partners and Patient X. But this cavalier approach by the GMC to its general duties of care do cast doubt on how seriously the GMC takes its other more specific duties, such as the conducting of a thorough and fair investigation.

It is concluded that when the weight of evidence of other points contained herein is considered, this lack of exercising by the GMC of its duty of care in this instance should be taken into account.

I would also point out that I have the right to be judged by my peers and this is enshrined in the Fitness to Practise Rules 2004, Part 3, section 5. In selecting a specialist performance adviser in relation to a particular case, the Registrar shall select somebody who is suitably qualified. Professor Bouloux, by his own admission, has no experience in the diagnosis and treatment of either chronic fatigue syndrome or mitachondrial disorders. Indeed, he states that he refers this group of patients to specialists rather than treat them himself.

Within the GMC case notes on me, there is a piece of advice dated 16 February 2010 from an expert GP witness, which states that he did not have sufficient knowledge of CFS to be in a position to answer questions posed, and that in view of Dr Myhill's background he feels the GMC should instruct an expert not just with mainstream knowledge of CFS but an expert with a special knowledge or interest in CFS. By instructing Professor Bouloux, who is neither expert in nor has a special interest in CFS, the GMC has ignored its own expert advice.

Patient X's notes were taken without permission or knowledge. A number of issues have arisen concerning this point. The GMC has not disputed that it took Patient X's medical notes without permission. Indeed, the GMC has argued that this practice is in no way improper. Neil Marshall comments that:

> "The Medical Act gives us powers to obtain and use information as is necessary to ensure the public interest is protected."

Mr Marshall continues in his letter of 16 June with the comment:

> "The GMC can require a doctor or any other person to supply information or disclose documents which appear relevant to the carrying out of our fitness to practise function."

However, the Medical Act 1983, section 35A(4) and (5), states that:

> "(4) Nothing in this section shall require or permit any disclosure of information which is prohibited by or under any other enactment.
>
> (5) But where information is held in a form in which the prohibition operates because the information is capable of identifying an individual, the person referred to in subsection (1) above may, in exercising his functions under that subsection, require that the information be put into a form which is not capable of identifying that individual."

GMC policy - and this is in a letter from Patricia Collins, GMC Officer, to me - was as follows:

> "We do not have written procedures regarding access to patients' records where a patient refuses access to them. If however we need to see a patient's medical record to consider a complaint, we will ask the patient for access to their records. Where a patient refuses access to the records, we consider whether it is in the public interest to have sight of them. If we do not consider this is the case, then the matter ends there. If however we consider that there is a public interest

> argument for having sight of the records, then it is open to us to obtain access under section 35A of the Medical Act. If we decide to take this action, we inform the patient before serving an s.35A notice to allow them to contact us further or to seek legal remedy to prevent access. We do not hold information regarding patients' rights in this regard."

Notwithstanding for the time being whether the GMC is correct in its assertion, the manner in which this access of information was carried out did not even comply with internal GMC disclosure requirements.

In a letter from Dr Y of the partners to Mr Bridge, the following point was made:

> "I enclose the completed disclosure consent form. You will see I have not completed section 6 and 7. The patient is not capable of understanding the matter and his mother has not expressed dissatisfaction with Dr Myhill.
>
> As requested, I enclose anonymised copies of the medical records and of all other documentation."

Dr Y filled in the GMC disclosure consent form improperly. He failed to complete paragraphs 6 or 7. He failed to get approval of the patient's mother. She had no idea that the GP was complaining. She had no idea that her son's private and confidential medical records were being sent to the GMC. Furthermore, there is no letter of consent from the patient's mother. Furthermore, the notes were not anonymised, so the patient and/or his mother's name (sometimes full, sometimes first name) were written on 36 occasions in the first 20 pages of the numbered bundle of notes sent to me and made available to the IOP. This is no minor clerical error.

Even if the GMC argument regarding the justification for the removal of Patient X's notes without permission is correct, the internal GMC procedures for doing this were not properly followed.

In taking Patient X's notes without knowledge or permission, the GMC is in breach of their own internal procedures and in breach of the Data Protection Act. It is my view that the GMC have acted illegally.

Putting aside for the time being the correctness or otherwise of GMC action in this context, the fact that the GMC used Patient X's notes in its prosecution raises a further issue of the unfairness of the trial.

I asked permission, quite properly and correctly, to use my own private medical notes on Patient X for my defence case. This permission was denied on the grounds that the patient's mother did not want her son's identity potentially to be compromised. At this time the patient's mother did not realise that the GMC had already taken her son's notes without any permission, knowledge or without even having followed their own internal procedures properly. This meant that there was no symmetry in the evidence available to the GMC and that available to me at that hearing. This compromised my defence because I could not repudiate claims made concerning Patient X's medical notes, as this would have meant me going against the wishes of my patient and his mother. This is manifestly unfair and contrary to natural justice.

There are other points that I would like to make, but I am going to have to skip over them and I hope that you have read them in the defence document, but this is an important one.

The prescription only medication restriction placed on me by the IOP is illogical and disproportionate. Whilst disagreeing with the procedures followed and evidence base used in arriving at its conclusions, the IOP requirement for me to take down certain web pages is at least logical and proportionate to the complaint made, even though it has been shown that this restraint should be set aside. However, the restriction that I should not prescribe prescription only medication as detailed in British National Formulary is wholly illogical and totally disproportionate. The concerns (even if taken to be true) raised by the complaints do not involve me inappropriately prescribing medicines from the BNF. The web pages complained about and the B12 complaint do not implicate me at all in the wrongful prescribing of prescription only medications. This sanction is inconsistent. For example, in the Jane Barton decision of 29 January 2010, this doctor was implicated in the murder of 92 of her patients with morphine drugs. She lost her right to prescribe morphine type drugs only. Otherwise, she was able to function normally as a doctor.

The illogical and disproportionate nature of the restriction on me from prescribing prescription only medication is such that this restriction should be lifted.

The letter of instruction from the GMC legal officer to Professor Bouloux is littered with factual inaccuracies. The said letter of instruction contains so many errors as to make it inadmissible. The full detail of the errors is laid out in a letter referenced in the evidence section below which I have not got time to go through today. However, by way of example as to how poor the construction of this document was, the following comment was made to Professor Bouloux:

> "In this letter I set out some instructions for you to provide your opinion on whether the doctor's action and treatment fell short of what could be expected of a reasonably competent consultant *anaesthetic*, and if so in what ways and to what extent. Also, if the facts alleged against Dr Myhill are proved *his* fitness to practise is impaired to a degree that would justify action on *his* registration."

<u>Professor Bouloux's expert witness report does not follow GMC guidance on expert witness reports</u>

Professor Bouloux has broken virtually every one of the guidelines contained within the GMC document "Guidance on acting as an Expert Witness". His breaching of the guidance is laid out in detail in the letter from me to Scott Geddes, Head of Investigations GMC, as noted in section 4.32. I have asked the GMC to investigate Professor Bouloux's action in this respect. In addition, it reflects poorly on the GMC that they accepted this expert witness report given its lack of compliance with the GMC's own guidance document.

I now come to the evidential defence points. The B12 complaint from the partners' practice is based on an untruth. In his letter of complaint to the GMC of 18 June 2009, Dr Y of the partners' practice states that:

> "On 24 March 2009 I had a further telephone conversation with the mother. I reiterated that we had not agreed to administer or train her to administer the injections."

However, in Patient X's medical note there is a letter dated 4 March 2009 from Dr P of the partners' practice to the district nurse, stating:

> "Dear Colleague,
>
> Please can [Patient X's] mum be taught how to administer the B12 injections.
>
> Yours sincerely,
>
> Dr P"

It is clear then that the partners' B12 complaint is based on an untruth about the actual facts of the complaint. I can assure you there are many other untruths. Dr Y, in his letter of complaint, has lied to the GMC.

Making an untrue complaint is also vexatious, as detailed in the GMC rules noted at section 3.1.2 above, and so the GMC has again broken its own rule on vexatious complaints by even accepting to investigate this complaint, meaning that this point is a procedural, defence as well as an evidential point.

This complaint should be set aside because at its core there is an untruth which has been absolutely proven. This untruth is not a matter of opinion. It is a bald fact.

There are further untruths which I would like to explore in a cross-examination of these doctors but that opportunity has been refused me.

I have complained to the GMC that the above doctors had been dishonest, but there have been disagreements between us with respect to the definition of dishonesty. Again, I would like to explore this in a cross-examination of GMC officer Mr Stephen Farnworth who has yet to respond to my letters.

The GMC has not obtained either adequate corroborative evidence for or confirmed the credibility of the complaints, nor did they ascertain the credibility of the website complainant himself. Under GMC Imposing Interim Orders: Guidance for the Interim Orders Panel and Fitness to Practise Panel April 2008 Annex 9, it is stated that:

> "The Interim Orders Panel will make no finding of fact but the complaint must be credible and backed by corroborative evidence."

Regarding the B12 complaint, the actual veracity of the complaint is refuted in section 3.2.1 of the defence document, indicating that there must be a lack of valid corroborative evidence. In addition, Professor Bouloux's expert witness report, which was used as corroborative evidence, is discussed at length in section 3.1.9 above, and has been shown to be inadequate for this purpose.

Furthermore, the GMC has not responded adequately to requests by me for details as to how it confirmed the identity of the website complainant. In addition, the GMC has refused to obtain a declaration of interest from the website complainant on the basis of confidentiality (section 5.3). The combination of no evidence from the GMC confirming this complainant's actual identity coupled with the lack of a declaration of interest renders this complainant not credible. This is because neither his credentials nor his motivation for the complaint have been established. This is discussed in more detail in section 4.4, where it is argued that the fact that it is not known whether the website complainant is complaining in his own right or on behalf of a third party adds to the sense that this is a vexatious complaint. The motivation for a complainant is a significant factor in his credibility and therefore the creditability of the complaint itself.

The GMC has not performed sufficient checks to determine either the motivation of the partners in submitting a complaint which has an untruth at its core or of the website complainant as already discussed and pointed out at length.

GMC records of previous failed complaints against me contain many factual errors, and there are a full list of those at 5.7A, B and C, and 5.8B in the defence document.

The existence of these evidential errors meant that the Panel based its decision and findings on an inaccurate evidence base. These records are relevant to the case before me for the same reasons as expanded in section 3.1.1, and so if they were not presented to the Panel then that in itself would constitute a procedural error. This has the effect that either the IOP decision should be set aside if these records were presented to the Panel because the data record which the Panel based its decision on was inaccurate or that the IOP decision should be set aside if these records were not presented to the Panel because the proper procedures of presenting a full GMC past history to the Panel had not therefore been followed.

It should be noted that in the latter case, that of non-disclosure to the Panel, it is not just a case of the GMC not having followed proper procedures but also the vital positive evidence in my favour was denied to the Panel. For example, the following quote is from Mr Tom Kark, GMC Legal Adviser on previous cases:

> "No one can seriously doubt Dr Myhill's good intentions."

In addition, in an internal GMC memo, dated 10 February 2006, it stated that:

> "My main concern with all the Myhill files are that all of the patients appear to be improving and none of them are likely to give witness statements or have complained about their treatment."

There are many more such positive comments on these previous case files which are very relevant to the Panel's understanding of the history of my involvement with the GMC Investigations Department. Further examples can be produced if required.

I have here three expert witness reports with respect to the partners' complaint. I cannot read those reports out without revealing details that the patient's mother has specifically asked me not to reveal. I hope that you have read in detail the expert witness reports of Dr David Freed, of Professor Martin Pall and Dr Norman Booth. I could read out

selected paragraphs which will not compromise the patient's identity, and I think for the purposes of completeness, before I wind up, that is relevant. Have I got time to go through a few selected paragraphs?

THE CHAIRMAN: The decision is yours.

DR MYHILL: As I say, I have been severely handicapped with respect to my defence because Patient X's mother refused to allow her son's notes to come into the public domain. I have already demonstrated the partners' dishonesty as best as I can. The full sequence of events I have laid out. I will not iterate them here, but you have them in my defence document.

I will read out a few comments from Dr David Freed's expert witness report:

> "It is a matter of daily observation, especially in the aftermath of a General Election, that there can be two or three groups of people, none of whom are known to be stronger than the others in intelligence, sincerity or education, or even in greed, who nevertheless disagree with each other vehemently on how we should respond to a certain set of circumstances. It is a source of wonderment, irritation and sometimes fury for all sides that the others can disagree so fundamentally. Nevertheless, it does happen, as we all know, and all civilised societies have evolved some form of voting system to provide at least a modus operandi in the face of conflicting opinions. Ex cathedra statements are therefore for popes, prophets and any others with direct communication lines to heaven. More prosaic creatures such as tribunals and scientists have to rely on evidence. The same goes for doctors, however high up the career ladder they may have reached and in spite of popular opinion in some quarters.
>
> With these reflections in mind, I humbly take liberty to disagree with Professor Bouloux on a number of key points, following in order the points of his submission.
>
> Page 3, line 25-6, neither of whom the neurologist and the haematologist felt there was any clinical benefit to be gained by such treatments but this is a far cry from opining that there was any danger in this approach. Dr B, the consultant haematologist noted in her letter of 3 March '09 that overdose of hydroxocobalamin is non-toxic as excess vitamin B12 is excreted in the urine and did not think that B12 in itself is toxic. In that same letter she also acknowledged that she occasionally gives B12 subcutaneously."

I cannot go through the sequence of the history because I would compromise the patient's identity in doing so, but you have that at your disposal.

> "My criticism of the partners is that they obviously did not show Dr Myhill's scholarly nine-page explanatory letter with its three pages of appendices to the two consultants when they sought their opinions, so their enquiry was really not fair. A bald request for an off-label medicine without any of the explanatory background must indeed have been baffling. I do not believe that the neurologist, had he seen that letter, would or could have made his uncalled for insinuation about Dr Myhill whom obviously he did not know."

There is so much of this that I would like to read out, but I just cannot without compromising the patient's identity.

THE CHAIRMAN: We have already seen it in the papers and we have already read it in detail. Thank you.

DR MYHILL: (Pause) He concludes:

> "Dr Myhill's actions in this case were entirely appropriate, honourable, responsible and in the noblest traditions of medicine. Since this forms a large part of the crime for which she has been tried, humiliated and sanctioned, it is her judges who should be judged.
>
> As for Professor Bouloux, who is presumably an intelligent man, at the very least he should be required, as should all expert witnesses, to disclose all possible conflicts of interest.".

We also have an expert witness report of Professor Martin Pall. Again, it is impossible to read this out verbatim without compromising the identity, but he makes some points here:

> "Dr Bouloux states on page 1 of the document that he is well versed in scientific methodology. He later states on the page, 'My comments regarding CFS are drawn from my own experience in dealing with these patients from published work by Professor Denton White and are drawn on the published NICE guidelines regarding the management of CFS'. He makes it clear from this that he has not done a search of the extensive literature on CFS/ME and therefore has not performed even the first step in obtaining the information needed to assure us that he has the expertise to express an expert opinion. Dr Bouloux produced a document with no quotations from the scientific literature, with no citations to back up any of his statements, he failed to perform an objective search of the literature, and consequently he has no idea whether any of his statements can possibly hold up in the light of what is known about CFS/ME. In other words, the document itself strongly suggests that Professor Bouloux is not in fact well researched in scientific methodology."

I will not read out his full report, but I will read out his conclusions.

> "In summary, Dr B's April 19th statement to the General Medical Council regarding Dr Sarah Myhill has five major types of flaws:
>
> 1. It is completely undocumented and therefore is completely unacceptable as a scientific document.
>
> 2. It is based on vast areas of ignorance of the scientific literature on CFS/ME, specifically ignorance of the many biochemical physiological changes that occur in CFS/ME patients and ignorance about the literature showing apparent efficacy of agents that lower these physiological ranges. He is also ignorant of the literature on the genetics of

susceptibility, genetic studies that implicate these biochemical/physiological changes as causal elements in CFS/ME. These vast areas of ignorance are in contrast to the assertion that Dr Bouloux provides that he has 'endeavoured in my report and my opinion to be accurate and to have covered all the relevant issues concerning the matter as stated I have been asked to address'.

3. Dr Bouloux has specifically criticised Dr Myhill's utilisation of high dose vitamin B12 injections and also magnesium injections. He is completely ignorant of the literature of both clinical trial studies and clinical observations and the long history of use of these approaches to therapy, all supporting the apparent efficacy of these agents for the treatment of CFS/ME and related patients…"

The emphasis on "related patients".

"4. Dr Bouloux jumps from statements that he knows of no evidence to statements of fact where he concludes positively that there is no contrary evidence. This is of course false logic. For example, on page 5 he concludes that there is no evidence base for the treatments recommended. Furthermore, on page 5 he states that the proposed treatments are based purely on anecdotal and personal experience of Dr Myhill. What we have in Dr Bouloux's document are vast areas of ignorance in 2 and 3 above followed by false logic. On this basis one can of course convict anybody of anything.

5. Dr Bouloux has major inconsistencies in his application of standards, both with respect to requirements for using only agents supported by placebo controlled double blind studies and with regard to care regarding possible encouragement of use by others of off-label utilisation of agents. He provides a completely undocumented statement on page 2 that some 50% of patients respond to the use of seratonin re-uptake inhibitors. This can be viewed as encouragement for off-label use of agents and the agents he advocates are associated with major side effects, including increased suicide rates.

Given that Jason et al have shown that CFS/ME patients already have high rates of death by suicide, perhaps Bouloux should consider his own transgression. And what does Dr Bouloux have to say about such treatments as cognitive behaviour therapy and graded exercise therapy, treatments that are advocated by some of his colleagues, but also treatments that have not been and cannot be tested by double blind placebo controlled trials. Would he argue that they should be called down for practising medicine which is far below the acceptable standard of practice? Where is the expected consistency of application standards?

My own view is that Dr Myhill is a gem of a physician, the only physician in the UK to my knowledge who is using a therapeutic protocol to treat CFS/ME patients that is designed to address the apparent aetiological mechanism of CFS/ME. It is the only protocol to my

knowledge being used to treat CFS/ME in the UK which is truly evidence based. For that reason, her protocol is the only one for CFS/ME being practised in the UK that I have included in my scientific presentation in multiple countries over the past two years.

I first met Dr Myhill at an international meeting in 2003 in which we both spoke, and I was impressed by her personal integrity, scientific acumen and apparent caring for her patients. Everything that I have learnt about her since that time has supported those inferences."

There is a third expert witness report by Dr Norman Booth that reiterates many of the opinions given by Dr Freed and by Professor Martin Pall. (Pause) Again, a point that he makes:

"Does the information provided by Dr Myhill to the GPs represent evidence-based medical advice? The answer to this is yes."

I wrote a scientific paper with Dr John McLaren-Howard and Dr Norman Booth in which we discussed the role of mitochondria in chronic fatigue syndrome/ME.

"Reference 59 is an extensive review of the role of mitochondria in health and disease by Professor Michael Duchen of University College. There are many other references which deal with specific references for CFS concerning mitachondrial disorders in general, as do more recent review papers. Co-factors metabolised and antioxidants discussed in the last paper almost identical to those used by Dr Myhill."

He concludes:

"Dr Myhill is a guiding light in the field of CFS/ME. There is no other doctor or indeed consultant in the UK who has the up to date depth of knowledge, the scientific literature, the understanding of the nature of the illness and the experience and expertise of working with patients to improve their condition. The expert opinion document of Professor X should be rejected and the charges against Dr Myhill dropped."

One last document, you will be pleased. Rebecca Townsley's letter of 8 September 2010 summons me to an IOP. She states that in reviewing the order the IOP is empowered to direct that the order should remain in force, to amend the order or to revoke it. The IOP of 29 April placed serious restrictions on my practice. Furthermore, for the last six months I have been unable to prescribe any medication listed in the BNF, for which my patients have suffered. Furthermore, I have lost my freedom of clinical opinion and been forced to take down sections of my website.

I hereby apply that this order should be revoked for the following reasons. The sanctions on my prescribing rights are illogical, inconsistent and punitive. The sanctions on my website are illogical. The sanctions on my practice have damaged patients directly and have been placed on my practice despite there being no actual evidence that I have erred or that any patient has come to harm. The sanctions on my prescribing are illogical. As a result of my suggesting to another doctor that he

prescribe B12 magnesium injections to a mutual patient, I have lost my right to prescribe any medication from BNF. There is no evidence whatsoever that I am an irresponsible prescriber. Indeed, my considered view is that a smaller percentage of my patients suffer from drug side effects than any other prescribing doctor in the country because I rarely resort to prescription medication. The real irony is that there are several preparations of B12 and magnesium that lie outwith BNF, something the April IOP was clearly ignorant of. The sanctions on my prescribing are inconsistent, and I have given you the example of Dr Jane Barton.

The sanctions on my prescribing are punitive. I note that on the Panel today we have two doctors. Perhaps these two doctors would like to tell us what would be the effect on their practice if they were banned from prescribing medications from BNF. I can tell the IOP the answer: both would be out of a job. A ban on prescribing amounts to suspension. No doctor is employable within the NHS with such draconian sanctions. Doctors in private practice would be similarly handicapped. I have been severely penalised, both financially and also with respect to my professional reputation, by these illogical, inconsistent and punitive sanctions.

The sanctions on my website are illogical. As I have explained, I have evidence based all the statements made on my website. Within 24 hours of the GMC forcing me to remove pages from my website, several copycat Dr Myhill websites were set up all around the world. The problem now is that people do not know which is the real one and which is the copycat. This is a problem for two reasons. Firstly, I cannot possibly update all the copycat websites as I pick up new information. Secondly, I cannot respond to queries that arise from the copycat websites. It is laughable that the GMC did not foresee this situation and shows how out of touch they are with modern technology and the power of the internet.

Sanctions on my practice have damaged patients directly and have been placed on my practice despite there being no actual evidence that I have erred or that any patient has come to harm. Patient X and his family have already been damaged by GMC incompetence and continue to suffer. However, they are not the only patients so harmed. For many sufferers of chronic fatigue syndrome and myalgic encephalomyelitis I am the only doctor who takes them seriously and appreciates that they are suffering from a physical disorder which can be treated with physical remedies. Sometimes this necessitates prescription medication, especially in the treatment of sleep disorders, which are very common in CFS/ME, and also in the form of anti-microbial drugs, which may be antibiotics, anti-fungals or anti-virals.

I have a great many patients who have suffered because I cannot prescribe, and they continue to suffer. I know many have written directly to the GMC to tell them how they have suffered, but the GMC seem singularly unperturbed by their plight. This is not a good performance from a body which professes to protect patients. In the way it has handled my case, the GMC is harming patients directly.

Sanctions on my practice have been placed despite there being no actual evidence that I have erred. Sanctions have been placed on my practice on the grounds that I am a potential risk to members of the public. This would be laughable if it were not so serious. If this standard were applied to every doctor in the country, every doctor would also be subject to IOP sanctions.

In pursuing this ridiculous case against me, the GMC have behaved with a total lack of impartiality and complete unfairness in order, I am forced to conclude, to achieve their desired goal.

I have requested cancellation of all GMC proceedings against me under the GMC (Fitness to Practise) Rules Order of Council Part 8, Rule 28(a), (b) and (c) "Cancellation of a hearing". The GMC have no evidence that my fitness to practise is impaired. They have not construed any actual allegations and they have no evidence base on which to continue with these nonsensical interim orders on my practice.

How are we doing for time?

THE CHAIRMAN: That is in your hands.

DR MYHILL: The two IOPs I faced on 29 April 2010 and 7 October 2010 were inherently unfair because the last two hearings were by definition kangaroo courts. Last week's hearing of 7 October 2010 has imposed sanctions on this week's hearing by stating that even should witnesses attend the court today would refuse to hear them. I can find no procedural rules which permit one IOP to make conditions that are binding on a subsequent one.

The hearing I faced in April last week and today, I believe, are in breach of the laws of natural justice. I will go through these points one by one. Under GMC (Fitness to Practise) Rules Order of Council 2004, Part 8, Rule 28 "Cancellation of a hearing", the GMC have no evidence that my fitness to practise is impaired. There is no evidence ---

THE LEGAL ASSESSOR: Mr Chairman, I hesitate to interrupt, Dr Myhill, but I think this goes to the preliminary submissions which were dealt with this morning.

DR MYHILL: Okay.

THE LEGAL ASSESSOR: In which case, you may feel, Dr Myhill, that you are reiterating something that has already been dealt with today.

DR MYHILL: I will skip that bit then. My opinion is that the last two hearings were by definition kangaroo courts. A kangaroo court is a colloquial term for a sham legal proceeding or court. The outcome of a trial by a kangaroo court is essentially determined in advance, usually for the purpose of providing a conviction, either by going through the motions of a manipulated procedure or by allowing no defence at all. A kangaroo court's proceedings deny due process rights in the name of expediency. Such rights include the right to summon witnesses, the right of cross-examination, the right not to incriminate oneself, the right not to be tried on secret evidence, the right to control one's own defence, the right to exclude evidence that is improperly obtained, irrelevant or inherently inadmissible, the right to exclude judges or jurors on the grounds of partiality or conflict of interest, and the right of appeal. The GMC have erred in all these respects.

A

Determined in advance

At my IOP hearing on 29 April 2010, the sentence was discussed before the hearing heard the evidence.

Manipulated procedure

B

The GMC were forced to adjourn last week's IOP hearing because they were in breach of their own procedures. The GMC failed to inform me of my legal right to call witnesses and broke the Data Protection Act by using patient notes without their knowledge or consent in their attempted prosecution of me. Furthermore, the GMC deliberately withheld evidence from me which I believed was essential to my defence.

C

I had already received three written apologies from the GMC for breaches of the Data Protection Act. Indeed, the day after my hearing I received a further letter of apology from the GMC and I had a fifth letter arrive this week.

Expediency

D

The GMC are forced to conduct a further kangaroo court IOP hearing today because they are out of time. The GMC had to act before 28 October 2010, and I have been unable to ascertain what happens should the GMC overrun this schedule.

E

The GMC have allowed themselves 15 months to investigate the partners' complaint and 8 months to investigate the website complaint, but did next to nothing until one week before my 7 October 2010 IOP. They then served me three expert witness reports within four days, one of which I received just ten hours before making my court appearances.

The right to summon witnesses and the right to cross-examine those witnesses

F

Last week I successfully appealed against the GMC's IOP and was granted adjournment. The GMC had misled me with respect to my legal right to subpoena witnesses for cross-examination at last week's hearing. However, the GMC then informed me that for the purposes of today's hearing, even if I should go ahead and subpoena witnesses, they would refuse to allow those witnesses to be called. The reasons they give for this is that the IOP is not there to check facts nor test the veracity of evidence. They have the powers again to apply sanctions to my practice simply on suspicion.

The right not to incriminate oneself or to be tried on secret evidence

G

Even now the GMC refuse to tell me what allegations I face. I face a hearing today on the grounds that I am a potential risk to public safety and that I have potentially breached sanctions imposed by the GMC at my last hearing in April. As I pointed out to the GMC last week, every doctor in the country represents a potential threat to patients and is potentially at risk of breaching the GMC's code of conduct. However, I have seen no evidence to suggest that I have done either. Neither have the GMC given me any evidence to suggest I have erred. I can only assume that the GMC has secret evidence that it is not divulging to me.

H

A The right to exclude evidence that is improperly obtained, irrelevant or inherently inadmissible

In their prosecution of me, the GMC used the notes of Patient X. These notes have been taken without consent or knowledge, illegally, against the Data Protection Act and in contravention of the GMC's own procedures.

B By contrast, I asked the patient for permission to use his private and confidential medical records, but this permission was refused. I respected the patient's desires and refused to use the very information that was essential to my defence and which would have entirely exonerated my actions.

The right to exclude judges or jurors on the grounds of partiality or conflict of interest

C At my April GMC hearing the Panel was chaired by Mrs Angela Macpherson. For every other type of GMC hearing the Panel has to be renewed for each hearing. Last week Mrs Macpherson was again present. I appealed to the Panel that this was unfair on the ground that ---

THE CHAIRMAN: I am sorry, but that is not correct. That is absolutely not correct for an interim orders.

D

DR MYHILL: I know, but the spirit of the ---

THE CHAIRMAN: Absolutely not. It is at each stage of adjudication where Panels are guaranteed to be different. Where a panellist adjudicates on any doctor within interim orders, that panellist shall never be involved with their fitness to practise hearing, but it does not mean that a panellist should not review an interim order.

E

DR MYHILL: So the GMC put, but I still consider that is against the rules of natural justice.

THE CHAIRMAN: You may consider that, but that is the way it is. I am sorry.

DR MYHILL: It is indeed laughable that in last week's determination the Panel should

F seek to portray themselves as fair and proportionate by allowing further time to consider documentation presented before me just a few hours before my GMC appearance, when at the same time ruling that I was not allowed to subpoena witnesses, would not be permitted to cross-examine GMC's witnesses whose written testimony is flawed and inconsistent, would not be allowed to cross-examine doctors for whom I have evidence that their own notes prove that they laid false testimony to the GMC, would not be allowed to cross-examine the GMC expert witness who has claimed to be expert in my

G specialism when he clearly is not, will not be permitted to cross-examine members of the GMC prosecution team who have so seriously got their facts wrong with respect to past and present dealings with the GMC that I am still unsure whether they are dealing with my case or someone else's. Furthermore, the GMC have disregarded my complaint that the GMC Legal Team unlawfully used confidential information relating to a patient at a hearing in April which I was not permitted to use under the Data Protection Act.

H

A The GMC appear unconcerned at the range of discrepancies brought to their attention by me with respect to the work of GMC staff. The most absurd example is, of course, of the member of the GMC Legal Team briefing an expert witness by describing me in the male gender and as a "consultant anaesthetic". A further example of this comes from the Chairman of the Adjudication Committee, Professor Roger Green, who opined that I had broken GMC sanctions by prescribing medication outwith the British National Formulary. His interpretation of the GMC sanctions applied to my practice was
B completely wrong. Actually, the only thing I am permitted to prescribe are medications outwith BNF. Had I not pointed out this serious error to the Panel, then I would have been considered in breach of GMC sanctions for completely false reasons.

The GMC is in no position to complain if the members of the public formed the opinion that the GMC is actively protecting doctors and expert witnesses whose work is sloppy, unprofessional and cobbled together at the last moment simply for reasons of
C expediency.

Indeed, I believe the GMC's conduct has been disproportionate, oppressive and breached my basic human right to a fair hearing, "innocent unless proved guilty", right to property that is by an effective and viable medical registration and licence to earn my livelihood, to which the GMC is committed by law. According to your website:

D "The law gives us four main functions under the Medical Act 1983:

- keeping up to date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education

E

- dealing firmly and fairly with doctors whose fitness to practise is in doubt."

The GMC has presented no objective evidence on the basis of which you could say that I am a doctor whose fitness to practise is in doubt. The evidence I am presenting now shows that the GMC has been and continues to act unfairly.

F Additionally, GMC procedures have hindered my clinical freedoms and they have breached my human rights guaranteed by Article 10 of the UK Statute Human Rights Act 1998. It is your statutory duty and responsibility to see that all GMC procedures comply to all current UK Statutes and EU Directives.

In summary, the review of the GMC's proceeding against me, supported by the
G transcript of the IOP hearing of 29 April 2010, clearly indicates the GMC never had any case against me.

In conclusion, I apply for this IOP to revoke the orders against me for the following reasons. The sanctions on my prescribing are illogical, inconsistent and punitive. The GMC have no evidence that my fitness to practise is impaired. They have not construed any allegations and they have no evidence base on which to make or review an interim
H order. The IOPs I faced on 29 April, 7 October and today are inherently unfair for all

A the reasons I have given. The hearings I faced last week and today are in breach of the laws of natural justice.

Thank you for your attention.

THE CHAIRMAN: Thank you, Dr Myhill. The members of the Panel may have questions for you, and I am going to start with a question, please, in relation to
B page 3318, which is a question that was asked from Dr Morrison at the last hearing. It was in relation to resuscitation courses. I wondered, since your hearing in April what courses of any kind or what CME have you done?

DR MYHIL: My practice is appraised annually, as per normal, and I regularly attend British Society of Ecological Medicine meetings. There was a three-day meeting in June that I attended and lectured at. I also attended a conference in London on the
C treatment of chronic fatigue syndrome where… what is his name? Well, there were many international speakers that spoke. I will be at a meeting in three weeks' time, again of the BSEM, at the Royal College of General Practitioners, which is again a three-day scientific meeting. If you want full details of the meetings that I have attended, then I can let you have those.

THE CHAIRMAN: It was just to have a general scope or an idea of what you had done
D in the past few months.

DR MYHILL: Three times a year I regularly attend British Society of Ecological Medicine meetings, which are usually three-day meetings, so that is usually nine days a year of interaction with likeminded colleagues. Then I go to other medical meetings which are of interest to me and relevance to my practice.

E THE CHAIRMAN: Thank you very much. I turn to colleagues to see if they have any questions. Mr Devaux is a lay member of the Panel.

MR DEVAUX: I am glad you mentioned appraisal because it was a question I was going to ask you. You mentioned that you are appraised once a year. How is that done?

DR MYHILL: Because at the British Society of Ecological Medicine, it is not that we
F have a specialist area of medicine, it is approach specific. So our particular approach is looking at environmental cause of illness with respect to diet and nutrition and supplements. We have a specialist appraiser for that Society who appraises doctors who practise that style of medicine. That appraiser is Dr Chris Dawkins, who is actually a GP in Oxfordshire, and he is a regular attender at our meetings and he is my appraiser and I meet with him regularly.

G MR DEVAUX: There is a form that you complete, a checklist ---

DR MYHILL: Yes, absolutely, and then I have to submit lists of… I do patient case histories, significant events in the practice, researches, books that I have read recently, documents that I have researched or whatever.

MR DEVAUX: What about your own practice? How do you do auditing within your
H own practice?

DR MYHILL: There is actually an audit within the bundle of documents that you have there that has been conducted again recently with the BSEM. We have a practitioner register that we are invited to join. To join that, we have to write two long case histories, four short case histories, we have to submit the practice to audit, which is usually of 20 consecutive patients, and a practice inspection, so a senior doctor comes and sits in with the day to make sure that you are practising at a good standard of medicine. I can submit patient testimonials from patients who feel that they have been well dealt with. Of course, any patient complaints that I received are also submitted to the board of registration.

MR DEVAUX: I have to be very careful how I put this to you. There are currently conditions on your registration.

DR MYHILL: Yes.

MR DEVAUX: I have heard very clearly from you that you think that there should be no order at all on your registration. You have given a number of reasons why that should be the case. But we know that there are conditions. The Panel today will obviously have to bear in mind all the issues that you have raised and have also heard what the GMC have had to say, and look at the new information, to come to a view. Normally, what tends to happen is that doctors appearing, or a lawyer appearing on behalf of the doctor, will say "As an alternative you can give conditions", and they often give an idea of what these conditions might be. In your case, I know you are saying no order at all. Do you have any view at all as to if the Panel, for example - as I say, I have to be careful how I put that to you - were to think about conditions, your own thoughts about how the conditions which are currently on your registration can be changed? I am putting that to you because I am only raising it on my own experience sitting here for a long time that if a doctor appeared and said "If you are not with me, you can consider conditions. This is what I suggest", a lawyer on behalf of the doctor might say "I think there should not be an order, but if you are not with me, conditions, and this is what I suggest". I am very careful how I put that because it is not to show you that I have come to a view. I have not come to a view. I am trying to be helpful to you by putting that to you.

THE CHAIRMAN: Dr Myhill, first of all, can I say that you do not have to answer that question. It is just Mr Devaux expressing his thoughts.

DR MYHILL: I do not mind answering.

THE CHAIRMAN: The second thing is, if I can supplement that, one of the things that you said was the current ban on your prescribing drugs from within the BNF could almost be considered tantamount to suspension.

DR MYHILL: Yes.

MR DEVAUX: That is why I raised it.

THE CHAIRMAN: What I am going to add in terms of Mr Devaux's question - and I add that the answer is optional - is can you think, if the Panel were minded, of any

conditions which would restrict your registration but would not be tantamount to suspension? Mr Devaux, does that help?

MR DEVAUX: This is why I was said I was very careful how I put that to you. I think you have put it in a better way than I would have done, I think. That is what I was thinking.

DR MYHILL: I am not sure what you have got in mind. The first point is that I am very happy to face a Fitness to Practise hearing and I am very happy for my practice to be examined in detail. I do not think I have got anything to hide and I am perfectly happy to be open about it. The biggest difficulty for me has been not being able to prescribe for patients because, as I have said, many of them have problems with a sleep disorder. I do use anti-microbials. Many of my patients have been denied treatment as a result of that. If they go to their general practitioners, who maybe are not sympathetic, then they have missed out. What I really want back today are my rights to prescribe medication for my patients.

I think my website is an important source of information to my patients, but it will not make much difference to my practice if I cannot restore those pages that have been taken down. I am not too bothered about that, I have to say. Those are the two main sanctions that have been applied. Very happy to face a Fitness to Practise hearing. No problem.

MR DEVAUX: I just wanted again to say to you that what I was trying to do was trying to be helpful in trying to move forward if the Panel was thinking about what sort of order *if any*, *if any*.

DR MYHILL: I just do not know what the options are. I do not know what sort of things you have in mind, so I would hate to say.

THE CHAIRMAN: This is a complete and comprehensive review. Therefore, the Panel has the options - and the Legal Assessor will give us legal advice on this in detail, I have no doubt - to (1) revoke the order, (2) maintain or vary the current order of conditions. That is why Mr Devaux has asked in the open session if you have got any thoughts on the conditions in the light of you mentioning that your current ban on prescribing was tantamount to suspension. The third option open to the Panel is to suspend your registration for the remainder of the duration of the order. Those are the three effective options.

DR MYHILL: I would rather you did not do the latter, of course.

THE CHAIRMAN: At this stage, if there are no further questions from Panel members, Mr Branston, do you wish to come back on anything?

THE LEGAL ASSESSOR: Mr Chairman, forgive me for interrupting and certainly for raising a personal note. I wonder if I could be excused for a couple of minutes. I need to go and give this tracheotomy a little love and tender care!

THE CHAIRMAN: May I ask that we have an adjournment until 4 o'clock, please?

DR MYHILL: Yes.

(Short adjournment)

THE LEGAL ASSESSOR: Mr Chairman, could I please thank you and Dr Myhill and everyone else in the room for allowing me to escape just for a few minutes? Thank you.

THE CHAIRMAN: Mr Branston, I am going to turn to you for any comments or observations you may have on Dr Myhill's submissions and I will then turn to Dr Myhill for the final word before I get the Legal Assessor's independent advice.

MR BRANSTON: Thank you, sir. I have some short points to make. The first point, though, is perhaps a question I should ask Dr Myhill, with your leave. In relates to the document that she read out concerning kangaroo courts. I wanted to clarify that the doctor was the author of that document and indeed the author of a press release that was released by Dr Myhill on 8 October 2010. I wonder if the doctor would confirm that.

DR MYHILL: No. I was not the author of the press release. That was written by a member in the public hearing. The definition of a kangaroo court is an Oxford English Dictionary definition of a kangaroo court. I was just illustrating that many of the procedures that the GMC had gone through seemed to tick many of those boxes.

MR BRANSTON: Thank you. I am grateful for that clarification.

THE CHAIRMAN: May I ask, was it by implication in the press release that it was your view that the last Interim Orders Panel was a kangaroo court?

DR MYHILL: It was the view of a member in the public gallery that that was the case.

THE CHAIRMAN: Thank you. Mr Branston?

MR BRANSTON: Then I have, I think, seven short points to make. First of all, the doctor asks rhetorically in what capacity am I acting when it comes to the website. That was an issue for Professor Harker in his report. It may not be determinative for this Panel whether the doctor was acting as a general practitioner directly with her own patient or not. The position before this Panel is that the doctor is a member of the medical profession, a practitioner holding registration under the Medical Act, and it is within that capacity that you will consider her registration today.

Secondly, the doctor made reference to the letters from and two Su Green of the Shropshire County Primary Care Trust. The only observation made by the doctor about those was that the prescription to one or more patients concerned or was outwith BNF prescribing. That was not the issue on which that letter has been submitted at pages 3742 and 4054. It is the fact that there appears to be a failure to inform the Shropshire County PCT of the conditions on her registration and the PCT were an organisation with which she was contracting.

Thirdly, reference was made to the email from CB at page 3721, concerning the ungagged website. The doctor observed that she could hardly be held responsible for

other people copying her website. That of course may be so, but there are differences between that and providing a link on her own website to such a copy.

Fourthly, the doctor refers to the website complainant as the "anonymous" website complainant. This is page 206. I highlighted in my submissions that the complainant was not "anonymous". The complainant gives his name as Stuart Jones. It is established that he is the Senior Clinical Scientist at the Queen's Hospital in Romford. The doctor made a number of observations about the Badscience website and an anonymous or pseudonym blogger on that website. But her observations or the quotes from that website, which included at various stages the quote about "living in glass houses", that blogger or poster complained anonymously, according to his own or her own posts. That is very different, you might think, from the clear naming of Mr Jones in his own complaint. Therefore, the observations about the Badscience website, for example, may hold little relevance.

Fifthly, you will have observed the doctor's own observations about B12 and magnesium preparations outwith the BNF, and the doctor indicating that the previous Panel was ignorant about that fact that there are such preparations that are outside of the BNF. That may be a factor that you wish to consider if you decide to impose an order of conditions and if you have concerns, for example, about the prescription of B12 and magnesium. It is a matter to which the anonymous thyroid patient referred in his or her email at page 3738, in which that patient observed that there were certain preparations or compounds that contained other substances that were within the BNF.

Sixthly, there needs to be a clarification, in my submission, of the observations of the doctor or the report of Professor Hunter and the observations made by Dr Myhill about that report. (Pause) Apologies for the fact that I have just mislaid that. I have the report now.

THE CHAIRMAN: Addendum (I)?

MR BRANSTON: Indeed, particularly pages 3752 and 3753. I would ask you to turn those pages up. The pages I have just referred you to would appear to be a print-out from the doctor's own website, dated or taken on 19 September 2010. You will see that given there is the make-up of 1 g of Myhill's Magic Minerals. Dr Myhill observed that Professor Hunter had got his numbers wrong in the calculations that he made and that he must have taken his numbers directly from the complainant's numbers. It is important to note that in coming to the calculations one is not only concerned with the exact contents of 1 g of MMM, but you will also see towards the top of page 3752 that the recommendation for everybody to take all the time, even if nothing is wrong, includes a BioCare multivitamin/mineral, one daily. That particular multivitamin includes other substances, including zinc, manganese and iodine, which add to the overall daily intake. But, more substantially, it is important to note that although the doctor's observations about the numbers are accurate when one takes the September print-out, one should look at the print-out that was provided originally in February to the GMC. You have this at pages 221 and 222 in the bundle. I am afraid I need to ask you to turn that up. Sir, there you have the print-out of the website as it was at some point prior to 19 February, in which you see again set out, particularly towards the bottom as you turn it horizontally, Myhill's Magic Minerals.

THE CHAIRMAN: "Throughout the day, drink Myhill's Magic Minerals" and then some text.

MR BRANSTON: Indeed. The list of what 1 g of minerals contain, which does in fact go over the other page - you only need to look at page 221.

THE CHAIRMAN: Ms Durning, are you with us there? It is quite near the front of the original bundle. It is 221. (Pause) Mr Branston, can you take us through this, please?

MR BRANSTON: Certainly. The list contains zinc (fourth line down) and there is no issue as to zinc. I accept that Professor Hunter and indeed Stuart Jones appear to have made a simple error in calculation. Five lots of 6 mg will be 30 mg, plus the 7.8 mg contained in the BioCare multivitamin would make 37.8 rather than 47.8 that was alleged. That figure, though, is still outside the stated figures contained in Professor Hunter's report as being safe. More importantly, though, you see iodine on page 221, that is potassium iodate 3 mg. That compares to the September print-out of the website as 0.3 mg. You see manganese as manganese chloride 2 mg on the February print-out and as 0.2 mg on the September print-out. Boron is the same. Cobalt you see in the February print-out as 1 mg. You do not in fact, I think, see it at all in the September print-out. Therefore, sir, in fact Professor Hunter took his figures accurately from those provided to him in the February print-out of the website rather than from the September print-out of the website. There is clearly a difference that has taken place over those seven months.

Finally, sir, a significant issue has been made by the doctor that the patient who is the subject of the original referral to this Panel, the identity of that patient is now in the public domain. Indeed, you will have seen a letter from the patient's mother about that, and indeed in that letter observations about the Badscience website. I know not whether that patient's mother herself was monitoring the Badscience website or whether her attention was directed to it, but you have that letter.

It is said by the doctor that to a determined observer the identity of the patient is in the public domain and can be established and that that patient continues to suffer. The reason she says it is in the public domain is because the nature of the patient's disease, the number of practitioners in the partnership and the location of the practice which were outlined in April would allow someone who was determined to find out who that patient was were they so minded. The effect of that, says the doctor, is that the GMC, she says, has broken its duty of care to that patient. It describes the GMC's approach as cavalier to that patient.

You, sir, and your colleagues may need or wish to consider why that information is in the public domain. The hearing in April was held in public, as pursuant to the wishes of the doctor, which is her right to hold it in public. There were people present at that hearing supporting the doctor, which, as it was her right, she was able to have there. The GMC does not print out or publish the transcript of such an IOP hearing on its website. It may publish a determination, but it does not publish the transcript.

The determination in April of 2010 did not include any information with which a determined observer could establish, if they so desired, the identity of that patient. It was of course the doctor who has published the full transcript of April's hearing. When

she describes the approach of the GMC as "cavalier" towards patient confidentiality, one is reminded of course again of the phrase that those in glass houses should not throw stones.

Sir, those are the only observations I wish to make. Thank you.

THE CHAIRMAN: Thank you Mr Branston. I now turn to you for the final word, Dr Myhill.

DR MYHILL: With respect to the website, I was given 14 days with which to comply with GMC regulations and I complied with GMC regulations to the letter. There are no links to any other website, copycat or otherwise, on my website, and that was confirmed by Mr Paul Bridge.

Today is the first time that I have heard that Mr Stuart Jones is a Senior Clinical Officer working at Romford. When I asked the GMC specifically for his identity, I was told that all they had was an email contact from him. I asked the GMC to request a declaration of intent from Mr Stuart Jones and they refused to even ask him for a declaration of interest. As I say, today is the first time I know that that is his job title and that is where he is working.

With respect to Jonas blogging on the website, on the Badscience website, are you suggesting that that blog is not of Mr Stuart Jones of Romford? Is that the implication?

THE CHAIRMAN: I do not know whether I want to get into cross-examination. I do not think that is particularly helpful. I might add that the Stuart Jones information was in the papers, so the Panel knew it before today. If you had a detailed reading of the papers before you came here, you would have known that information, Dr Myhill. Can I ask you to continue, please?

DR MYHILL: I do not see the relevance of B12 and magnesium being outwith British National Formulary. Again, I was told specifically by Mr Paul Bridge that if there were any preparations that were outside British National Formulary I was entirely entitled to prescribe, and that is exactly what I have done.

With respect to the doses of minerals in the mix, I set up a new website which is a Wikipedia look-alike website at the beginning of February. I had a team of people who helped me move pages from my old website to the new website, and as an inevitable result there were typos. I was contacted very soon after that to say that I had got the constituents of the MMMs incorrect and I corrected that within a few days. That is a simple typographical error. If Mr Jones had had the courtesy to contact me directly, I could have pointed that out to him. Indeed, I pointed this out to Paul Bridge in an email in a very early state of proceedings.

My view is that justice should be done and should be seen to be done. There are people in the public gallery who it was immediately obvious to them from attending who Mr Gary Summers was referring to. They did not have to have the whole transcript of the meeting to see where the partners' practice was or the fact that it was a rare neurological condition. It did not have to be my actions in pasting the IOP transcript in a public area that let that information out. As soon as Mr Gary Summers started to

speak, it was very obvious that confidential information was in a public arena for all to hear.

THE CHAIRMAN: Thank you very much.

DR MYHILL: Oh, yes, the Su Green one. I do beg your pardon. I have a few patients who are funded to come and see me by their Primary Care Trusts. As I say, they are infrequent attenders and the two patients involved I had not seen for some years and then they turned up at my office. If I did not inform the PCT at that moment they turned up, well, that was, as I say, pure oversight. I explained that to the GMC immediately and Mr Paul Bridge said that it was of no concern.

THE CHAIRMAN: Thank you. Now I turn to Mr Wallis for his independent legal advice, following which the Panel shall go into private session.

THE LEGAL ASSESSOR: Mr Chairman, in your determination earlier today you concluded that there was no lack of jurisdiction or procedural impropriety in this Panel. Nonetheless, Dr Myhill did this afternoon in her submissions reiterate or revisit those complaints again. Likewise, she revisited what she described as the refusal of the GMC to compel the attendance of witnesses, something which was dealt with again this morning in your earlier determination.

Insofar as it is necessary for me to do so, I advise you that this is a properly constituted Panel which has followed the rules laid down under the Fitness to Practise Rules and indeed under the Medical Act.

With those prefatory remarks, I turn now to the considerations that the Panel should bear in mind in reaching its decision. The power of a Panel to make an interim order is contained in section 41A of the Medical Act 1983 as amended. This provides that an interim order may be made:

> "…where the Panel is satisfied that it is necessary for the protection of members of the public, or is otherwise in the public interest or is in the interests of the doctor."

In that event, the Panel may either suspend or impose conditions, in both cases for a maximum of 18 months.

I wish to make two observations on section 41A. The first is that the public interest includes maintenance of the public's confidence in the medical profession and the declaring and upholding of proper standards of behaviour and conduct. The second observation is that I emphasise that you must be satisfied that it is necessary to affect the doctor's registration for the protection of the public. Merely considering that it might be desirable to do so is not sufficient. For the other grounds mentioned in section 41A there is no such requirement, although the courts' decisions on appeal indicate that the bar is nonetheless set high.

The Panel will be aware of and will doubtless take heed of the guidance for the Interim Orders Panel, to which Mr Branston has referred you to three paragraphs in particular. I should like to read out, if I may, paragraph 18 of the guidance. It is in these terms:

"If the IOP is satisfied that:

(a) in all the circumstances that there may be an impairment of the doctor's fitness to practise which poses a real risk to members of the public or may adversely affect the public interest or the interest of the practitioner; and

(b) after balancing the interests of the doctor and the interests of the public that an interim order is necessary to guard against such risk, the appropriate order should be made."

Paragraph 19 states that the Panel should consider the seriousness of the risk to the public, damage to the public confidence in the medical profession and the doctor's own interests. Paragraph 20 makes it clear that it is for the Panel to decide what weight should be given to these factors.

As is well known, the IOP does not make findings or resolve disputes of fact or determine the allegations against the doctor. This means that the decision has to be reached on inevitably limited and untested material, in contrast for example to a Fitness to Practise Panel. Clearly, this makes it vitally important that the statutory test is met.

The Panel should be able to state why an interim order is required at all and upon which one or more of the three conditions set out in section 41A.

In reaching its decision the Panel should have regard to all the information before it. As critical comment has been made about the experts' reports, it might be helpful if I were specifically to mention them. The purpose of expert evidence generally is to provide a tribunal with specialist information and opinion which is within the expert's expertise but which may be outside some or all of the members' experience and knowledge, although it always remains for the tribunal to decide what weight to attach to it. Because an Interim Orders Panel cannot determine the correctness or otherwise of an expert's opinion, it should be regarded as no more than information that the Panel is entitled to consider, in exactly the same way as the other information before it.

If the Panel is satisfied that an interim order should be made, it should of course have regard to proportionality and the suitability and workability of any sanction that is imposed.

Finally, as this is a review hearing, I add that the Panel should have regard to all the information before it, including any that is new; and, in exercising its own judgment, it must determine whether the statutory test is satisfied today.

If the Panel is satisfied the test is met, it may maintain, vary or replace the terms of the previous order. If the Panel is satisfied that the test is not met, it should revoke the order.

Mr Chairman, unless I can assist the Panel further, that concludes my advice.

THE CHAIRMAN: Thank you Mr Wallis. I shall see if the Panel members have any questions for you. There are no questions for you, so the Panel shall now go into private session and shall recall you in due course.

Does either advocate have any questions for the Legal Assessor?

MR BRANSTON: No, thank you.

DR MYHILL: No, thank you, sir.

THE CHAIRMAN: We shall now go into private session and we shall recall you in due course.

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

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: Dr Myhill, I am now going to read you the Panel determination. By the time I have finished reading the determination, copies will be made available for all today.

DETERMINATION

THE CHAIRMAN: Dr Myhill, the Panel has already given its determination in relation to your submissions made in preliminary legal argument. It notes your concerns and the issues which you have reiterated.

For the avoidance of doubt this Panel is satisfied that:

- there are no restrictions regarding members of the IOP considering the same case at multiple hearings;

- your referral to the IOP was properly made and you have not legally challenged the referral;

- you have not legally challenged the previous IOP's determination to impose conditions on your registration;

- you have not been misled by the Panel or the GMC;

- you were not prevented from arranging the attendance of any witnesses to the hearing today; and

- it is a matter for the Panel on the day to determine pursuant to Rule 27(2) whether it will hear from any witness.

When the Interim Orders Panel considered your case 29 April 2010 it determined that it was necessary for the protection of members of the public and in the public interest to make an order imposing conditions on your registration for a period of 18 months. That Panel reminded you that as a registered medical practitioner you are expected to practise in a manner that justifies the public trust in the profession and its practitioners at all times.

The Panel has comprehensively reviewed the order today. It has considered the transcripts of the previous hearings and all the documentation presented. It has taken account of the submissions made by GMC counsel and by you. Mr Branston, on behalf of the GMC, has submitted that it is necessary for the Panel to maintain an interim order restricting your registration by way of at least interim conditions. You have submitted that no order is necessary.

The issues in your case relate to concerns raised regarding your clinical practice and your professional conduct. There are repeated and significant concerns raised by former patients, medical practitioners and other members of the public. Whilst it would not be practicable to list each individual concern raised, what is apparent is that all the issues essentially concern significant and repeated departure from the tenets and specific requirements of *Good Medical Practice* (November 2006). Specifically, in addition to the two complaints received which were considered in April 2010, concerns have been highlighted regarding your:

1. website and the contents therein, including the recommendation that patients obtain prescription only medication (POM as depicted in the BNF) from untested, unmonitored and approved overseas sources

bypassing qualified registered medical practitioners either on the NHS or privately;

2. the medical treatment of patients remotely and without face to face or any consultation, examination or history taking;

3. continuing to act in an unprofessional manner notwithstanding the formal warning given to you by the GMC in 2005;

4. your promotion of clinically unsubstantiated treatments to vulnerable patients;

5. your promotion of personal opinions in relation to nutrition, use of oral contraceptive medicines, patient investigation specifically breast biopsy, and advice in relation to vaccinations;

6. your failure to engage with approved medical practice and appropriate continuing medical education;

7. using your status as a registered medical practitioner to re-enforce your personal beliefs and to promote private treatments;

8. your potential failure to recognise and work within the limits of your competence;

9. your disregard for the conditions imposed by this Panel;

10. the potentially serious limitation on your insight into your fitness to practise and the consequences of your actions, especially in light of your correspondence with and behaviour towards both your professional regulator and the IOP;

11. your breach of interim conditions, specifically that you failed to notify an organisation contracting with you to undertake medical work;

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12. your attempts apparently to circumvent, or having the effect of circumventing, the conditions restricting your prescribing practice and restricting the information you were allowed to publish on your website;

13. your lack of familiarity with the principles of *Good Medical Practice* and of modern up to date medical treatments;

14. your ability to practise safely;

15. your general understanding and awareness of the effect your attitude, behaviour and conduct has on others and on the profession;

16. your comprehension and perception as to the consequences of your actions in relation not only to professional colleagues and patients but to the general public; and

17. the provision by you of medical care which may fail to meet the requirements of *Good Medical Practice*.

The Panel has noted the areas of *Good Medical Practice* highlighted by Mr Branston and has considered the up to date version carefully. The requirement of *Good Medical Practice* includes, amongst other things:

- not expressing your personal beliefs to patients in ways that may exploit vulnerability or are likely to cause distress;

- ensuring that if you publish information about your services making sure the information is factually verifiable;

- not making unjustifiable claims about the quality or outcomes of your services;

- not providing information which might exploit any vulnerability or lack of patient knowledge;

- not putting pressure on people to use a service, for example, by arousing ill-founded fears for their future health;

- taking reasonable steps to verify information and documents and not deliberately leaving out relevant information;

- keeping your professional knowledge and skills up to date;

- recognising and working within your limits of competence;

- adequately assessing your patient's condition;

- prescribing drugs for treatment only when you have adequate knowledge of patient's health.

As has been enumerated on a number of occasions, it is not the Panel's function to determine issues of fact, nor is the Panel empowered to go behind the information submitted, expert or otherwise, or the comments you have provided. Rather it is a matter for the Panel to place what weight it determines appropriate on the information presented. The Panel has not been assisted by your submissions or your unsubstantiated reference to outdated medical journals and reports.

The Panel has taken account of the advice of the Legal Assessor, particularly in regard to paragraphs 18 to 20 of the GMC's document *Imposing Interim Orders.* In considering your case today the Panel has also reminded itself that it is for the GMC to make its case and that any order must be necessary.

In comprehensively reviewing the order today the Panel first considered whether it was necessary for the protection of members of the public, in the public interest or in your own interests to maintain any interim order restricting your registration. In considering

this issue the Panel reminded itself that it is not sufficient that an interim order be desirable or useful, rather it is the statutory test of necessity which is applicable today.

In considering the protection of members of the public, the Panel is satisfied that based on the complaints made, and the concerns raised, there is sufficient information before it to indicate that there may be impairment of your fitness to practise and that such impairment may pose a real risk to patients and, as a result, to members of the public.

The Panel notes that the circumstances which bring patients to your practice by their very nature make your patients vulnerable, notwithstanding any actual health issues. Accordingly, the Panel is satisfied that, if substantiated, the concerns raised do necessitate the maintenance of an interim order in the public interest. In considering the public interest the Panel notes that not only does the public interest relate to the confidence that members of the public are entitled to have in the medical profession but also the need to ensure that proper standards are upheld and, crucially, the principles of *Good Medical Practice* are adhered to. Trust is fundamental to the doctor/patient relationship.

In considering your own interests, the Panel is satisfied that in the light of your conduct and behaviour since your initial hearing the order to be imposed is also in your own interests. The Panel has been extremely concerned by your possible lack of understanding of the requirements of modern day best practice as well as a seeming lack of perception and understanding of the consequences of your actions. Accordingly, the Panel, exercising its own judgment, has determined, based on the representations made today and the documentation provided, that an interim order is also necessary in your own interests.

Having determined that an interim order remains necessary, the Panel then considered whether the interim order for conditions remained workable or was in any event sufficient.

In considering this issue, the Panel has again exercised its own judgment. The Panel is very concerned that you appear over a period of time to have had a clear disregard for *Good Medical Practice*. Your clinical actions and professional behaviour, if

substantiated, would indicate that your professional standards may seriously fall short of those expected by the public and *Good Medical Practice*. Indeed, if proved, these allegations could jeopardise the public's confidence in the medical profession and its practitioners. You are personally accountable for your professional practice. In considering this issue the Panel notes the submission of the GMC that the concerns you raise regarding the disclosure of confidential information actually stems from your actions and your publication of hearing transcripts on your website.

In all the circumstances, the Panel is satisfied that there are no interim conditions which are workable and which would address adequately all the issues in this case, or in any event be sufficient to protect adequately patients' interests, the interests of the public or your own interests. Furthermore, in light of your seeming lack of insight and disregard for the GMC and for this Panel, the IOP cannot be confident that you would abide by any condition imposed.

The Interim Orders Panel is satisfied that it is necessary to suspend your registration with effect from today. Accordingly, your registration will now be suspended for the remainder of the duration of the order.

The Panel has taken account of the issue of proportionality in that it must act in a way which is fair and reasonable. Whilst it notes that its order removes your ability to practise medicine, the Panel has determined that, given the nature of this case, suspending your registration at this time is a necessary and proportionate response to the risks posed by you practising medicine and, importantly, exercising the rights and powers of a registered medical practitioner.

The order will be reviewed within three months and notification of this decision will be served on you in accordance with the Medical Act 1983 as amended.

Dr Myhill, this concludes your case. Many thanks for coming to assist the Panel today. We shall hand you out our determination in a very short time. Good evening, everybody.

FROM THE PUBLIC GALLERY: Shame on you!

FROM THE PUBLIC GALLERY: Absolutely! Shame!
