

**GENERAL MEDICAL COUNCIL**

**INTERIM ORDERS PANEL**

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

Thursday 29 April 2010

Chairman: Mrs Angela Macpherson

Panel Members: Mr Amu Devani  
Dr Lewis Morrison

Legal Assessor Mr Sanjay Lal

CASE OF:

**MYHILL, SARAH**

**(IN PUBLIC)**

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MR GARY SUMMERS of counsel, instructed by GMC Legal, appeared on behalf of the General Medical Council.

MR JOHN MACDONALD QC appeared on behalf of Dr Myhill, who was present.

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Transcript of the shorthand notes of T A Reed & Co Ltd  
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THE CHAIRMAN: Good morning. Before I formally open the proceedings, Dr Myhill, I have to ask you to confirm with me, please, that you wish this hearing to be in public.

DR MYHILL: I confirm I do wish it to be in public.

THE CHAIRMAN: Thank you very much. We will now arrange for such as can be accommodated to come into the room. When they are here and settled we will formally open the proceedings.

(The public entered the chamber)

If everybody is settled, before I make the formal opening the proceedings, could I just remind you of the dos and don'ts. I am sure they will be familiar to you. All mobile phones should be switched off. There is a prohibition on the using of any recording equipment audio or visual, including cameras and of course mobile phones. Hopefully I will not have to do this, but anybody who is found to be using them will be asked to leave the room.

(Fire evacuations procedures given)

I think that is all the information I have to pass out to you. Perhaps I should add at this stage that when we make our final determination copies of it will be available once I have read it out at the end of the session.

I am going to formally open the proceedings. This is a hearing of the Interim Orders Panel to hear the new case of Dr Myhill. Dr Myhill is present and is represented by Mr John Macdonald, QC. GMC counsel is Mr Gary Summers appointed by GMC Legal. Our Legal Assessor on my right hand side is Mr Sanjay Lal, counsel.

Dr Myhill, it may help if I set the scene for you as this is your first appearance in this room.  
(Introductions given by Chairman)

I have to start by asking you, please, to give us your full name and your GMC registration number.

DR MYHILL: That is the one thing I have overlooked.

THE CHAIRMAN: Do not worry, we can provide it for you.

DR MYHILL: Jolly good. (Document handed to Dr Myhill) My full name is Sarah Barbara Myhill and my GMC registration number is 2734668.

THE CHAIRMAN: Thank you very much. If there are no other matters, I am going to ask Mr Summers to open the case for the GMC, please.

MR SUMMERS: Thank you, Madam. There is a small rainforest somewhere that has sadly lost all its trees, given the paperwork that is before you today, and there is a blizzard of paperwork before you, much of it at the doctor's request.

There is mention of a previous history of complaints in 2001, 2002, 2005 and 2006, and I want to say at the outset on behalf of the GMC these complaints were properly investigated, looked at and ultimately did not reach the hearing stage. There are some suggestions, assertions and allegations in the paperwork before you that the GMC has embarked on a witch hunt against Dr Myhill, and an internet campaign has been launched on this footing. It needs to be said clearly at the outset that the GMC has received two independent complaints which are before you today, and has not launched a complaint against this doctor of its own motion. The GMC's role is to investigate these complaints without fear or favour, and the GMC will not allow a blizzard of email or web traffic to blow us off course or to blind us. In any event, suggestions of a witch hunt lose credibility in the light of the fact that in previous GMC investigations the matter was properly investigated and did not reach hearing stage.

I say at the outset to you, so that everyone can understand in this room, that the GMC's final submissions today will be suggesting conditional registration and not suspension.

The approach that we are asking this Panel to adopt is to look at the two complaints before you. Hopefully I am going to be remarkably succinct in my address to you and I will invite you to focus on those two complaints, one by one. I am going to turn without further ado to the first complaint.

I wonder if I could ask you to turn into your bundle to page 1. You will see that the first complaint is dated 18 June. It is from a group of doctors at a Yorkshire practice, and their names are given on page 2 of that document. In short, the case was brought to the attention of the GMC by eight GPs in that Yorkshire practice in the letter of 18 June 2009. The mother of the patient had self-referred to Dr Myhill after discovering her website on the web, as a result of which Dr Myhill requested a blood sample in respect of her son, an adult.

Following analysis of the blood sample Dr Myhill wrote to the patient's mother outlining various theories and treatments for chronic fatigue syndrome. In particular, she advised that he be administered B12 and magnesium sulphate injections. Dr Woods advised the mother that he would not be able to prescribe these drugs, being unsure why the patient should be prescribed the drugs in the first place. In particular, the patient was a known sufferer of – and I am going to use the letter “B” – of juvenile [B's] disease. It was now proposed to start him on treatment which Dr Myhill was in the habit of prescribing for CFS patients. The mother requested that a district nurse instruct her to perform injections of B12 on her son. This was refused by the nurse at the practice. The partners at the surgery subsequently sought the advice of a consultant haematologist, a Dr B, and a consultant neurologist, a Dr G, neither of whom felt that there was any clinical benefit to be gained by such treatments. It was suggested that the mother attend the surgery for a case conference which she declined to do.

In their letter at page 2, the group of doctors have decided to refer the matter to the GMC under paragraphs 43 and 44 of *Good Medical Practice* and I know that the Panel will be well familiar with these passages. I think it is right, as we are in a public hearing, just to mention what these passages are. It is under the heading “Conduct and Performance of Colleagues”.

“43. You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take

appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures.

44. If there are no appropriate local systems, or local systems do not resolve the problem, and you are still concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation, or the GMC for advice.”

The doctors at page 2 of their referral letter specifically mention those paragraphs, paragraphs 43 and 44.

The matter has been investigated and the GMC have sought an expert opinion from an independent expert. I am directing your attention to page 957, Appendix X. I think that is in one of the small bundles. It is certainly at page 957.

THE CHAIRMAN: It is Addendum X.

MR SUMMERS: I am very grateful. Thank you very much indeed.

THE CHAIRMAN: Does the doctor have it?

DR MYHILL: It is probably in my head. (Addendum X handed to Dr Myhill)

MR SUMMERS: The author of this report is Professor B at page 962. We can see the details. We can see the status and background and expertise of the doctor at page 957. The particular questions that this expert was asked to address were at 958, and I am going to go through them, if I may.

- “1. Was the process of investigation (obtaining a blood test) sufficient to establish a diagnosis of CFS?
2. Does the information provided by Dr Myhill to the GPs represent evidence based medical advice?
3. Was the treatment proposed by Dr Myhill reasonable and in line with current UK practice?
4. Would the information provided by Dr Myhill to GPs encourage the use of medication in an unlicensed manner?
5. a) Does Dr Myhill’s overall standard of care fall below that expected of a reasonably competent general practitioner?  
b) If so, in what way and to what extent did such care fall seriously below that standard  
c) Other relevant issues in the case.”

I am just going to flag this up, if I may, because you have this letter and I have no doubt in closed session you will read it very carefully indeed. The background to the complaint I have already given, and I am going to direct your attention, if I may, to page 960, the opinion.

“There is no clinical nor biochemical basis on which Dr Myhill could reasonably connect the aetiopathology of [B’s disease] (a well established autosomal recessive ceroid lipofuscinosis) with CFS, and the tenuous connection that Dr Myhill has made between [B’s] disease 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 treatments (based on Dr Myhill’s practice in the management of CFS), which might benefit Mrs X’s son, an established sufferer of [B’s] disease. This course of action was inappropriate; Dr Myhill’s recommendation may also have been fuelled by the fact that the patient’s mother suffered from chronic fatigue syndrome.”

There is then a series of answers to the questions posed by the doctor. We see at 960 that the first question is posed in the bold type: “Was the process of investigation (obtaining a blood test) sufficient to establish a diagnosis of CFS?”

There is the paragraph there – I am not going to tire the Panel by reading it, but in essential short form the expert opines that the test performed on the patient would not have been adequate to make a diagnosis of CFS, or tests performed on the blood sample.

In relation to the second question: “Does the information provided by Dr Myhill to the GPs represent evidence based medical advice,” the expert answers:

“It does not, as there is no evidence based to the treatments recommended. For this to be the case, there would have to be a demonstration that the test used had the necessary sensitivity, specificity, and predictive value in diagnosis. Moreover, evidence base would require that a properly controlled double blind placebo controlled study be conducted to demonstrate the efficacy of the intervention on the one hand...”

And he concludes:

“Dr Myhill does not therefore provide GPs with evidence based medical advice.”

i.e. the complainant GPs.

The next point: “Was the treatment proposed by Dr Myhill reasonable and in line with current UK practice?”

The expert opines:

“Even assuming that the patient was suffering from CFS (there is no evidence that this was the case), the proposed treatments are based purely on anecdotal and a personal experience by Dr Myhill. They are not in line with NICE guidelines for the management of CFS.”

(Laughter from members of the public)

That is NICE guidance.

“Would the information provided by Dr Myhill to GPs encourage the use of medication in an unlicensed manner?”

“This could potentially be the case.”

“Does Dr Myhill’s overall standard of care fall below that expected of a reasonably competent general practitioner?”

He opines, and this is important:

“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 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 juvenile [B’s] disease -

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MALE MEMBER OF THE PUBLIC: Could you possibly speak up?

FEMALE MEMBER OF THE PUBLIC: We cannot hear.

FEMALE MEMBERS OF THE PUBLIC: Please speak up.

MR SUMMERS: I am speaking into the microphone.

THE CHAIRMAN: Can we please not have these interruptions.

MR SUMMERS: Can I ask for no further interruptions and no further laughter, please. This is a serious matter.

I am going to repeat again the last one because we were distracted.

“Does Dr Myhill’s overall standard of care fall below that expected of a reasonably competent general practitioner?”

“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 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 juvenile [B’s] disease, a disorder with an entirely different and distinct aetiology.”

I hope the increase in tone has helped so people hear that.

The next bold question:

“If so, in what way and to what extent did such care fall seriously below that standard.”

“It is incumbent of 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.”

The expert concludes 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.”

I turn to the second complaint. I am directing your attention, please, to 206. In relation to this complaint it is right to say that we have not reached the stage where the GMC has sought an independent expert in relation to this complaint because the date of the complaint is 9 February 2010. I am more than happy to indicate that this complaint will be similarly the subject of expert scrutiny at an appropriate time.

This is a complaint by someone called SJ.

“To whom it may concern, I am UK registered Clinical Scientist and have some concerns regarding a GMC registered general practitioner. Her name is Dr Sarah Myhill”

and the GMC number is given.

“... I find the information in her [website] very worrying. I am concerned that patients are being seriously misled by her advice, both online and most likely in consultation at her practice. In some cases I think her recommendations are a serious risk to patient safety. Some specific examples are listed below but there are many more on her website.

I have not lodged a formal complaint as yet because I am unsure exactly how to proceed with this. I have not contacted Dr Myhill directly as I do not want to open myself to possible harassment.”

(Laughter from members of the public)

The matter is serious. This matter is a serious complaint. It is properly itemised and the headings are given at 206. Examples from the website relate to her treatment of acute chest pain, with magnesium injections, recommendations for daily mineral/ vitamin supplements, actively discouraging routine mammograms in breast cancer screening, actively discouraging the use of the oral contraceptive pill for all patients, actively discouraging the use of routine drug therapy for prevention of cardiovascular disease, doctors' recommendations regarding vaccination for children and actively discouraging parents to receive the MMR.

I am directing your attention to page 207, and what I am proposing to do is not tire you by looking at the website detail, but give you the reference so that you can read it yourselves in closed session.

Essentially we have eight topics of complaint, and the first topic is on 207 and relates to the treatment of acute chest pain and other conditions with IV magnesium. The doctor gives the reference to the website and that is at 219, and you can read it yourselves in closed session. But he has abstracted the website text where Dr Myhill states:

“I have been using i.v. magnesium in my general practice for over 25 years for both acute and chronic problems. I use it for all patients with acute chest pain (unless the blood pressure is very low), acute heart failure, pulmonary embolus and acute asthma.”

The complainant then looks at various sources on which he bases his concern about the use of that treatment. I am not going to tire you by taking you to it, but you will see that he lists three sources, which he uses to complain about the treatment suggested on that website.

The second is the “Recommendations for daily mineral/vitamin supplementation in healthy patients”. I am sure you have got the idea now that in relation to the complainant he uses italics when he is abstracting the material from the website and uses normal lower case text in his analysis. Again he comes to the conclusion, using various sources, recommending such high doses of mineral supplements clearly places healthy patients at risk of unnecessary harm, and he opines that if healthy subjects were to follow Dr Myhill’s recommendations, they would be at a serious risk of mineral toxicity.

Thirdly, “Actively discouraging routine mammograms in breast cancer screening”. I am so sorry, I did not give you the website extract for the second one, as I said I would. It is at 221. The third topic, the reference is at 214, and this is under the breast cancer screening, and the website abstract is as follows in the italics:

“Standard screening tests currently available for breast cancer are not very satisfactory because they lack sensitivity and specificity and because the test involves radiation. We know that radiation can cause cancer and exposures should be kept as low as possible. We now have top cancer specialists telling us that overall routine screening with mammograms barely changes the rate of diagnosis or cure of breast cancer.

Much better is thermal imaging. For cancers to grow they need a blood supply and as they are growing they need more blood than surrounding tissues. This can be picked up by thermal imaging. It is extremely sensitive and the technique is now well established in Germany. The current cost of a scan, comprehensive report and follow up advice is £165.00.

If there is a lump, do not let someone stick a needle in it to biopsy it. This is because the needle spreads the tumour cells up the needle tract and seeds them

elsewhere. Ask what is the point of a biopsy? If, regardless of the result, excision biopsy is required, do not make a situation potentially worse by sticking a needle in!”

The extract of the website follows:

“What is interesting is a recent report that suggests 22% of all breast cancer tumours regress spontaneously. This emphasises the point that the body is well able to cure itself of cancer given the right impetus.”

The complainant points out that this is contrary to NHS cancer screening policy, and he gives the website reference, the basis of which is digital mammography in a selected population followed by fine needle aspiration if indicated.

Then he opines in relation to digital thermal imaging:

“is an unproven screening technique for this population screening for breast cancer is not currently advocated for routine screening of healthy patients as stated in the New Zealand health technology assessment”.

Topic 4 is “Actively discouraging the use of OCP”, the oral contraceptive pill, “for all patients”. The website reference is at 215 and the italicised abstract is there on 210.

“Using the pill as a contraceptive is dangerous medicine. Unprotected sex also puts one at great risk of getting nasty infections which may result in infertility, life long fatal infections (HIV and hepatitis B and C), human papilloma virus (increases risk of cervical cancer) and many other cancers. Furthermore the immunosuppressive effects of the Pill make any infection more virulent.”

The source is given there from NICE, and the complainant points out, on 210, that this guidance is contrary to the NICE guidance.

Topic 5 is “Actively discouraging the use of routine drug therapy for prevention of CVD”. The website reference is at 216:

“None of these drugs prevent or treat the underlying factors which cause heart disease. Indeed there are good reasons to suspect they accelerate the underlying pathology. Statins are a good example - we know a large part of heart failure is caused by mitochondrial failure in the heart cells. The most important antioxidant in mitochondria is coenzyme Q 10 and its production is blocked by statins. We are now seeing an epidemic of heart failure which I believe is caused by statins.”

The complainant points out that this is contrary to various NICE guidance and gives the website links to NICE.org.

Topic 6 is “Recommendations regarding childhood vaccination”. The website reference is at 218. The complainant opines that Dr Myhill believes that most vaccines are ineffective at reducing the incidence of infectious disease and cause more harm than good. I am not going

to read this aspect. I am sure that this page sums up the complaints of the complainant, but the substantial complaint at the last paragraph:

“Dr Myhill appears to have basic misunderstanding of immunisation and infectious disease therefore and the information she provides is clearly misleading for patients and parents.”

DR MYHILL: Can I just ask for one point of clarification?

THE CHAIRMAN: No. I think you must wait until Mr Summers’ submission has finished, and you will have the opportunity when you make your submission, when Mr Macdonald makes his submission.

MR SUMMERS: Topic 7 “Advice regarding travel immunisation for Chronic Fatigue Syndrome patients”. The website reference is at 223. Dr Myhill’s advice on this issue can be summarised by introduction on the subject. This is at 212:

“The best advice is not to do it! Humans evolved in an ecosystem in which the vast majority of people were born, brought up, lived and died in the same environment, eating the same food locally grown.”

The complainant points out Dr Myhill’s specific recommendations in relation to tetanus, typhoid and cholera, hepatitis A, rabies, hepatitis B, “Measles, mumps, rubella – avoid – likely to trigger CFS!”, BCG, Japanese encephalitis, “Meningitis – probably not worth the risk – take precautions”, and the complainant points out this is contrary to Department of Health advice and uses the source from a website.

Topic 8 is on 213. The website reference is 220. Dr Myhill continues to promote the link between MMR and autism in conjunction with her anti-vaccination rhetoric:

“We are currently seeing an epidemic of autism. There must be a cause. My view is autism has many possible cause but that mercury is a major trigger, other heavy metals may also be involved. All vaccines contain adjuvants – these are immune stimulants which wake up the immune system and make it react to the dead or attenuated virus in the vaccine. MMR used to contain mercury, it now contains aluminium – both are know to be toxic to the brain and probably much more so to the developing brain.”

The complainant opines and states:

“This is despite the vast body of literature confirming no link between the vaccine and autism and the proven safety of the MMR and other vaccinations in the protection of children from ... fatal disease”.

He concludes:

“Clearly such advice ... undermines public health policy and is very misleading for parents”.

That concludes my presentation in relation to the second complaint.

Madam, in conclusion may I say this on behalf of the GMC, that in the light of the serious nature of these two independent allegations from two different complainants against Dr Myhill, the GMC submit that it is necessary, in accordance with section 41A, for the protection of members of the public, in the public interest and in Dr Myhill's own interest that her registration should be subject to conditions, and that the Panel can be satisfied that in all the circumstances there may be an impairment of Dr Myhill's fitness to practise which poses a real risk to members of the public, that may adversely affect the public interest and that of the practitioner.

Those are the submissions on behalf of the General Medical Council.

THE CHAIRMAN: Thank you, Mr Summers. As you know, it is open to the Panel to ask questions of you. I am going to invite my colleagues if they wish to put any questions to Mr Summers. Dr Lewis Morrison.

DR MORRISON: Mr Summers, obviously it is a matter for the Panel, but the GMC is suggesting conditions. Has the GMC a view on what manner of conditions it might be seeking?

MR SUMMERS: Yes. Conditions in relation to the supervision of Dr Myhill's practice, something similar to IOP 67 in the conditions bank; secondly, the removal of sections of the website listed at page 214 to 226; thirdly, the removal of such sections of the website as are advised by the supervisor; fourthly, the maintenance of logs in relation to patients that she advises on, IOP 52 in the conditions bank, something similar; and, lastly, to seek prior written approval of all prescription advice, prescriptions and opinions from the supervisor; something similar to those topics, but ultimately it is a matter for the Panel.

DR MORRISON: Thank you. That was the only question I had.

THE CHAIRMAN: Mr Devani.

MR DEVANI: Good morning, Mr Summers. We received the referral letter from the group of GPs from Yorkshire, 18 June 2009.

MR SUMMERS: Yes.

MR DEVANI: It has taken quite some time to investigate the matter and there is a delay. Is there any reason for this?

MR SUMMERS: No. The matter has been carefully investigated and these matters do take time.

MR DEVANI: Thank you.

THE CHAIRMAN: Could I just really clarify one issue, and that relates to page 961, which was the expert report, and the expert says:

“I see no evidence that Dr Myhill has seen the patient, nor collated and scrutinised all the previous medical records/dossier prior to formulating the proposed course of treatment for this patient.”

He said “I can see no evidence”. We have no other evidence to counter that suggestion?

MR SUMMERS: That is correct. As I understand the position, Dr Myhill did not see the patient and did not see the medical notes. The medical notes are in your bundle in fact at page 28 and 204.

THE CHAIRMAN: Just really clarification again: secondly, in relation to the second complainant SJ, we have no indication that SJ was a patient at any time of Dr Myhill?

MR SUMMERS: That is correct.

THE CHAIRMAN: Thank you. If there are no further questions from the Panel, then, Mr Macdonald, it is now for you to address the Panel, please.

MR MACDONALD: Madam, may I make a few preliminary remarks, but I am sure that what you really would like to hear is from Dr Myhill herself as to what she says about the specific matters. Dr Myhill accepts that the Panel has an important and responsible duty, and that when complaints are made about doctors it is very important that they should be properly investigated. It is a very serious matter for the doctor as well.

My friend has drawn your attention to the fact that Dr Myhill has over the last ten years had a number of complaints which have been made against her, including complaints about the nature of her website, which have been fully and carefully investigated by other Panels and by other Committees, who have in the end, in every case, decided that no action should be taken.

I would also draw the Panel’s attention to the fact that, as far as we are aware, no complaint about this doctor has ever been made by a patient to the GMC. All the complaints have either been made by other doctors or by members of the public. While it is a very important matter for the public that matters should be investigated, it is also very important for the doctor that he or she should not have to spend endless time dealing with and answering complaints which have little or no substance, and that if over a period of years investigations take place and nothing is found to be seriously wrong, that is a matter which needs to be taken into account.

From the forest of documents to which my friend refers, to which I am not going to take you in any detail, two matters speak out. One is that Dr Myhill is a practitioner who is widely respected by those who also practice in this area of medicine, and, two, that she has a large and faithful body of patients, and, until we just heard a moment ago, the GMC’s position was that this doctor might be suspended from practice. If she is suspended from practice, that has an adverse effect on her patients, which partly explains why there has been such a reaction to

these proceedings, and the Panel may well conclude that that is a reasonable reaction for them to have reached.

I want, before coming to the details of this case, just to ask you to put it in its legal context. The House of Lords in the *American Cyanamid* case laid down the rules (the old rules we now have to call them) for when it is appropriate to make interim injunctions and orders in ordinary civil actions, and what the House of Lords decided then was that the first question which always has to be asked is whether there is a serious question to be tried. If there is no serious question to be tried as to whether this doctor is fit to practise, then this Panel should not consider imposing any interim order.

We say that the way in which this charge has been presented is interesting. The complaint by the partners (the first complaint) was made on 18 June 2009. Six months later, on 11 December, Dr Myhill was informed of the complaint. She responded on 18 December. The expert, Professor Bouloux, was not instructed until 18 March. On 7 April my client was given notice of the hearing. Professor Bouloux's report was not available until 19 April, which is its date; that would have been some two weeks after the original date for the hearing of this complaint. If, we ask rhetorically, although we should not do that, I know, if there is a serious threat to members of the public which now justifies an interim order, why has nothing been done for ten months?

Dr Myhill has two broad answers to the complaints which have been made. As far as her website is concerned, we now alas live in the year 2010 and much information is now given to us individuals by means of the website. When I started practising in 1955, it would have been unheard of for my local general practitioner to have advertised in this way, and to have given out information about whether you should take one aspirin a day or one aspirin a week, and whether or not that posed any risk. We have moved away from that. Dr Myhill will tell you that she practised in the National Health Service as a general practitioner for many years, and she found that her specialty, it was difficult to command the treatments which she thought were appropriate, and so she has moved into private practice.

In private practice she is very much in demand, and therefore she has found it appropriate and helpful to her patients to put advice, and particular advice which she has gleaned and learned in her practice and in her research and in her scientific work, on to her website, but she is always ready and is keen to respond to criticism of it, and if there are any specific matters which the Panel thinks are in any way objectionable, she will remove them.

As to the first complaint, under rule 26(c) the General Medical Council, in giving the notice to the doctor, should have set out briefly the reasons why it is necessary to make an interim order. That is rule 26(c). The letter of 7 April encloses the complaints, but it sets out the reasons in one sentence:

“The Case Examiner has reached this decision after considering there is a potential risk to public safety.”

Madam, that is not an adequate statement of the reasons why the GMC considers that the public has been put at risk.

Dr Myhill has prepared a short statement, which I will invite her to read to you, and when she has concluded that statement I will ask her one or two questions relating to the specific questions which were posed to the expert, because I think it is right that if you are going to look at the expert's report, you should hear something which she has to say about it. We do not accept the expert's report. If this matter goes further, then we shall certainly wish to cross-examine the expert, and Dr Myhill will seek to have further expert evidence available.

So what I would like to do is to ask Dr Myhill to read you---

THE LEGAL ASSESSOR: Mr Macdonald, can I just say, as the independent legal adviser to the Panel, and obviously both you and your client need to consider this, that as an Interim Orders Panel no questions of fact are resolved today. That must be right because that is the very nature of an interim order. That resolution of questions of fact may well, if at all, take place later on if the matter goes to a full hearing. If Dr Myhill gives evidence, then that will be on oath, and of course Mr Summers will then have an opportunity to ask her questions – I do not know whether he has any questions of her – but of course there is no factual resolution today because of the nature of an Interim Orders Panel. It is unusual for doctors to give evidence at the interim stage, so please bear that in mind, that if your client does give evidence from the witness box, as it were, then she quite properly could be asked questions by GMC counsel.

I contrast that with, of course, a submission made through you as her representative in terms of what she may wish to say, and that will of course be a submission which will be given a different evidential weight. So please bear that in mind.

MR MACDONALD: We certainly bear that in mind, and we are well aware that no questions of fact can be determined at this time. Our primary position is that there are no serious charges here which merit investigation at all, but we are not prepared to risk all on that bold statement, and while it would no doubt be shorter and quicker if I was to say what Dr Myhill says more briefly, I do not think it would be nearly as helpful to the Panel, so we would, if you will allow us, prefer to proceed by Dr Myhill giving evidence, reading her statement, and I will ask her a few supplementary questions, and then of course if they wish to cross-examine her, she will be cross-examined.

THE LEGAL ASSESSOR: Mr Macdonald, it is entirely a matter for yourself and the way you present your case, of course, but I simply make that warning, as it were, in public session as you have heard, and you have responded to it. I do not know if Mr Summers has anything in terms of receipt of oral evidence.

MR SUMMERS: I have no difficulty if the doctor wants to read a statement which effectively would be part of her advocate's submission, and, if that is the position, it is presentationally more appropriate for Dr Myhill to make that part of the address, then I for my part will not be taking any point on it, and nor will I be wishing to question Dr Myhill on it, but if it goes beyond that, if it goes truly into the territory of giving evidence, then obviously we will make an assessment as to whether we wish to cross-examine Dr Myhill.

THE LEGAL ASSESSOR: Can I just say for both of you, perhaps Mr Macdonald more so; of course, you will be aware that under the procedure rules that govern these hearings there is

a presumption that no evidence will be given unless, of course, the Panel considers it desirable for evidence to be given. Mr Macdonald, you are submitting, I take it, that it is desirable for the Panel to hear Dr Myhill's evidence because your assertion, as you have said in your submission, may not be enough. Is that right?

MR MACDONALD: Yes.

THE CHAIRMAN: Thank you. I would just add, I think, two comments. One, as the Legal Assessor has mentioned, it is for the Panel to decide whether they wish to take a witness's statement or contribution. I think in this particular case I am probably right in assuming that we are content to hear the doctor. Is that right? (The Chairman conferred with the Panel, who so confirmed) That has cleared that bit.

The other bit perhaps I should mention. It is still open to the Panel to ask questions both of Mr Macdonald at some stage and of the doctor, so in addition to Mr Summers being given the opportunity it is open to the Panel as well.

We are then to proceed with Dr Myhill, but before we do so, I have to invite you, Doctor, please to take an oath.

SARAH BARBARA MYHILL, Affirmed

THE CHAIRMAN: Thank you, Doctor.

DR MYHILL: Before I read my statement, could I just ask Mr Summers to withdraw a word he used in connection with the bundle of letters from my patients. Could you withdraw that word "witch hunt", please?

THE CHAIRMAN: I do not think we can take that as a question to Mr Summers, but it will be noted in the transcript.

DR MYHILL: Thank you very much. I am grateful for that.

#### STATEMENT

I come from a large family of doctors and indeed my grandmother was one of the first lady doctors. I was brought up with an analytical approach to medicine, which emphasised diagnosing the causes of disease rather than merely the prescription of drugs to treat the associated symptoms. This sparked my interest in a branch of medicine which looks for the root causes of disease and uses diet and nutritional supplements to treat those root causes. We call this Ecological Medicine and in 1979 the British Society for Ecological Medicine (BSEM) was founded. It is made up of practising GPs and consultants with similar aims. Shortly after I qualified as a doctor in 1981, I joined this Society.

Between 1992 and 2009 I was the Honorary Meetings Secretary of the BSEM and for the latter ten years of my tenure I was also the Honorary Secretary. During that time I organised bi-annual scientific conferences, a five day international conference at Oxford together with training days for other doctors – up to six days a year. I continue to lecture regularly at those sessions and indeed more widely.

This ecological approach has proven particularly helpful in the management and treatment of myalgic encephalomyelitis (ME), otherwise known as chronic fatigue syndrome (CFS).

The BSEM has its own Special Interest Register and I was one of the first doctors to qualify for this in 2004, a process which required both my presenting long and short case histories and also my being subject to audit. My association with the Society is detailed in President Dr Damien Downing's letter of 23.4.10, a copy of which you have. I am lead author of a January 2009 paper published in the *International Journal of Clinical and Experimental Medicine* 2009 2 (1-16) entitled "Chronic fatigue syndrome and mitochondrial dysfunction". Joint authors included Dr Norman Booth PhD of Oxford University and Dr John McLaren Howard DSc FACN. That paper was well received world wide and Dr Booth flew to the United States of America to present it at the International CFS/ME conference March 12-15 in Reno, Nevada in 2009. The Panel has a copy of this paper together with a letter to the GMC from Dr Norman Booth.

In that letter he states:

"Dr Myhill is a guiding light in the field of CFS/ME. There is no other doctor, on indeed consultant, in the UK who has the up-to-date depth of knowledge of the scientific literature, the understanding of the nature of this illness, and the experience and expertise of working with patients to improve their condition."

Much of the previous six GMC hearings I have faced were concerned with my prescribing of thyroid hormones. In order to clarify the issue I prepared a position statement with respect to the safe and effective prescribing of thyroid hormones. You have a copy of this position statement and also a covering letter signed by myself and another twelve doctors. As you can see it is extensively referenced and we hope that this will provide a stimulus for wider debate of this important issue within the scientific community.

I have been seeing and treating patients with CFS/ME since 1982 when I first started work in NHS general practice. During this time I increasingly found that I did not have the clinical freedoms I needed to treat my patients effectively. For example to properly assess thyroid function one needs to measure a TSH, a free T4 and a free T3. The NHS laboratories would often refuse to do more than a TSH. A red cell magnesium is a very useful test – but the laboratories would only do a serum magnesium which is not helpful except in acute emergency situations. So, after 20 years of NHS practice, I finally moved to full time private practice in 2000.

During the last ten years, my private practice has built up and soon I was unable to accommodate all the patients wishing to see me. So I decided to set up a website where I could post all the advice and management techniques I had learned over the years. That website was subject to GMC scrutiny between 2005 and 2007 and was not found wanting at that time. Indeed I have been under almost constant GMC investigation during my time in private practice and have faced six fitness to practice hearings, all of which were cancelled with no case to answer. No complaints came from patients. No patient was harmed or put at risk. No allegations were upheld. No conditions have ever been placed on my practice.

An independent account of the investigations conducted by the GMC into my practice between 2001 and 2007 has been documented by Mr John Macdonald QC and you have a copy of his opinion. I would like to repeat the opinion of the GMC's own QC, Mr Tom Kark who, with respect to my case, advised the GMC on 04.10.07 as follows:

“Dr Myhill’s good intentions are not seriously in doubt and it is known that she has very substantial patient support.”

John Macdonald went on to opine:

“Anyone who has had any dealings with Dr Myhill is not likely to doubt her good intentions. I find it very surprising that these four charges were persisted with for so long. If Dr Myhill had been interviewed at an early stage by a senior member of the GMC’s investigating team and proper records had been kept, the overwhelming probability is that all four of these complaints would have been dismissed in short order. That, in my opinion, is what should have happened”.

On the basis of this advice to the GMC by its own counsel and also Mr John Macdonald’s opinion I requested a private meeting with Jackie Smith, head of GMC Fitness to Practice Investigations, and this meeting finally took place on August 12, 2009. I wished to request that the two QCs’ opinion be observed by the GMC and that I be left to practise medicine in peace. Jackie Smith refused to allow Mr Macdonald QC to attend that meeting and so I attended alone. At the meeting she refused to address any of the concerns in Mr Macdonald’s opinion. She also refused to sign the minutes of that meeting, a copy of which has been passed to the Panel. Indeed she has refused all further communication with me either by email or letter despite being prompted.

I apologise for speaking at length about my history of GMC investigations but I draw the Panel’s attention to GMC Guidance “Imposing Interim Orders”, April 2008, section 24, concerning interim conditions of interim suspension

The following factors may also be relevant

a) Whether the practitioner has complied with any undertaking given to the GMC or conditions previously imposed under GMC Fitness to Practice procedures, b) the practitioner’s history with the GMC (if any).

I reiterate that there have never been any conditions imposed on my practice by the GMC.

As stated above, as I have learned new information which I believe, through direct clinical experience, to be helpful to patients in general and ME/CFS sufferers in particular I have posted it on my website. I do this because there is much that can be done to improve the health of these sick people using simple dietary, nutritional and lifestyle interventions without ‘high tech’ medical interventions. Indeed I have received much positive feedback from people whose health has been improved as a result of the information contained on my website, information which is of course available without charge. This includes the ability to download my book on the management of CFS /ME from the website, again free of charge.

There is a standing invitation on the website for professionals and patients to send me ideas and indeed this has greatly improved the website content. I am always happy to change the content of the website given good reason.

The new Wikipedia look alike website

Many patients found my old website not to be user friendly and one of these patients, Mr Terry Ellison, built me a new site using a Wikipedia template. Mr Ellison did this without charge as a way of thanking me for the help I had been able to give him regarding his own chronic fatigue syndrome diagnosis. This new website has greatly improved access to information and has generally been well received. Moving many hundreds of files from one site to another has been an arduous business, largely done by volunteers, and inevitably there

have been mistakes and typographical errors. I have received many constructive comments from doctors, health professionals and patients from all over the world and this has helped me to correct these errors. Areas where I have been unclear as well as suggestions for further pages have been made and I am deeply grateful to all those people for their constructive input, which has undoubtedly enabled me to improve the quality of information on the site.

This is why it was particularly distressing to receive news of an anonymous complaint about my website made to the offices of the General Medical Council. I received the details of this complaint on March 31 2010 and the GMC granted me four weeks to comment. As such, I started to prepare my response. However, four working days later, my office received a further communication from the GMC on Thursday April 8 to inform me that an Interim Orders Panel was to convene on Monday April 12. I had one working day in which to respond. Had I been away from the office that day I should have returned to a fait accompli.

The GMC has concerns over two complaints – one complaint was detailed in a letter to the GMC dated June 18th 2009. The second came to the GMC in an email dated February 9th 2010. The GMC had allowed themselves ten months to consider the first complaint and eight weeks to consider the second complaint but I was permitted just one working day to respond to the GMC's call for an Interim Orders Panel (IOP) and respond to both complaints.

The GMC's own rules are that a doctor should receive seven days' notice for an IOP. So I appealed at once to the GMC and was relieved that I was granted a further 13 working days to prepare my defence.

#### The Complainant must be credible

I do understand that this is not a Fitness to Practise hearing and therefore that there should be no examination of the content of either complaint. However I do have concerns about the credibility of both complainants and this is an issue I would like to address now.

I note that under GMC Imposing Interim Orders: Guidance for the Interim Orders Panel and the Fitness to Practise Panel, April 2008, Annex 9 states:

“The Interim Orders Panel will make no finding of fact but the complaint must be credible and backed up where possible by corroborative evidence.”

#### The First Complaint

There are discrepancies contained within the first complaint which should have been apparent to the GMC last August. The complainant's letter to the GMC was dated June 18, 2009 concerning a patient. The GMC was sent the patient's entire NHS medical records on August 29, 2009. It should have been clear then to the GMC that there were serious discrepancies between the allegations in the complainant's letter and the contemporary medical records.

Furthermore I pointed out some of those discrepancies to the GMC in my letter, copied to the complainant, dated December 18, 2009. You have a copy of that letter in your bundle of documents.

In his letter of complaint to the GMC dated June 18, 2009, Dr Y stated:

“On 24th March I had a further telephone conversation with X. I reiterated that we had not agreed to administer or train X to administer the injections”

But this is at odds with the patient's medical records in which there is a letter from Dr Z to the district nurse which reads ---

THE CHAIRMAN: I wonder, Doctor, if we can actually find that, because it should be in our bundle with the medical records. Do you have a page reference for that medical record?

MR MACDONALD: No, I am afraid we do not have a page reference because we were only handed the paginated documents at 9 o'clock.

THE CHAIRMAN: This was in the original bundle.

DR MYHILL: The GMC received the patient's notes on 29 August, 2009.

THE CHAIRMAN: What I am saying is, it is a set of notes that we have in our case bundle that would have been sent to you with the notice of the hearing. I think you have the bundle there – the pink bundle on the table. It would have been helpful if you could actually direct us to which of the medical notes in that bundle.

DR MYHILL: I can lay my hands on it fairly easily.

MR MACDONALD: I am very sorry.

THE CHAIRMAN: If you think it is going to be too difficult, then we will just take your quote, but it would have been helpful to have them.

DR MYHILL: I will certainly get to find it for you anyway. Can I continue for the time being? Thank you.

THE CHAIRMAN: For the time being. It was supposed to be a short statement. Are we getting through?

DR MYHILL: I am only addressing the issues that I have stated. I am not going to address any issues of fact.

THE CHAIRMAN: Good. Thank you.

DR MYHILL: The GMC acknowledged receipt of my letter on January 18, 2010 pointing out this discrepancy and confirmed that the complainant had also been sent a copy. The complainant was asked to respond to the GMC within two weeks. I do not know if the complainant complied with this request made by the GMC but he did not afford me the courtesy of even an acknowledgement nor was I copied in on any subsequent correspondence regarding this matter between the GMC and the complainant.

The GMC sent me that patient's full NHS medical records on April 8, 2010 and within a few minutes of perusal it was clear that there were further discrepancies. I wrote as a matter of urgency both to the GMC and also to the complainant but both have refused to take any further actions to clarify these discrepancies.

The complainant has had more than enough time and warning to put the record straight. I have asked the complainant directly to attend this IOP to put the record straight but have received no response. I have also asked the GMC to subpoena the complainant for this express purpose but I am not aware whether the GMC has taken any such action.

In the course of investigating this complaint, the GMC took the confidential NHS medical records of the patient involved. This they did without knowledge of the patient, without consent of the patient and without anonymising the medical notes. These medical notes have been sent on to me from the GMC, again without patient permission or knowledge.

This in direct contravention of the GMC's own policy in taking patient medical records as stated to me in a letter from GMC officer Patricia Collins, 12 June, 2007.

Over the nine years that I have been subject to GMC investigation my patients' NHS notes have been taken by the GMC without knowledge, permission or anonymising the notes. I am not informed by the GMC when this has been done.

On Monday April 26 this week I received an expert witness report. This report has required my response because it forms part of the GMC submission placed before the Panel at my IOP hearing today Thursday April 29.

On June 18, 2009 the GMC received the above complaint concerning my recommending vitamin B12 injections to a patient. The letter of instruction to the expert witness, Professor Bouloux, is dated 18 March, 2010. His report is dated 22 April, 2010.

It has taken the GMC over ten months to obtain this expert witness report. By contrast I was initially given two days in which to respond. Once again, I am astounded by the lack of fairness and natural justice displayed by the GMC, particularly with respect to the time given by itself to prepare the case and the haste with which I have been forced to prepare my defence.

I apologise for the detailed analysis of Professor Bouloux's report which follows, but I consider this document to be so seriously flawed that the IOP needs to be aware of my most pressing concerns about it.

Professor Bouloux is an endocrinologist. By his own admission he is not an expert in mitochondrial disorders. In compiling his report he has deemed it adequate to conduct only an on-line perusal of Pub Med for his information on mitochondrial disorders. He is not an expert on chronic fatigue syndrome. He has, by his own admission drawn upon the published NICE guidelines regarding the management of chronic fatigue syndrome. Using these sources of information Professor Bouloux concludes 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”

Professor Bouloux does not list my paper, published in the *International Journal of Clinical and Experimental Medicine* as one of the six documents he studied in the preparation of his report. This paper looks in depth at the biochemical lesions in mitochondria which underpin energy supply to the cell and relates this to patients with chronic fatigue syndrome.

Essentially the worse the mitochondrial function, the more fatigued the patient and vice versa. This is the first paper in the history of chronic fatigue syndrome which clearly shows that chronic fatigue syndrome has a measurable physical basis. The degree of correlation between mitochondrial function and levels of fatigue stands very well against rigorous statistical analysis and is significant to an extremely high degree of confidence. My subsequent clinical experience suggests that nutritional and other interventions are highly effective in correcting this mitochondrial dysfunction. The Panel has before them the testament of many thousands of chronic fatigue syndrome sufferers, and relatives and friends of chronic fatigue syndrome, who vouch for this effectiveness. Whilst it could be argued that this represents only anecdotal evidence, there comes a point where the sheer volume of

success stories from individuals represents substantive evidence as to the efficacy of a treatment protocol. I believe this point has been reached and, coupled with my paper, contest that there is a firm evidence base for my interventions.

However, despite apparently not looking at this paper, and presumably not having sight of the many thousands of aforementioned testaments, Professor Bouloux goes on to comment about it and make derogatory comments that are simply not true. This paper was published in a highly reputable journal and was peer reviewed.

The report layout is unprofessional. Professor Bouloux's report was sent to me pinned together by a paper clip. It was not sent on headed paper. The paragraphs and pages are not numbered. The last page with Professor Bouloux's signature was sent to the GMC by fax, the rest of the pages apparently not. The report contains grammatical errors, such as the use of the verb 'advise' rather than the noun 'advice' where Professor Bouloux is discussing the background to the complaint. Whilst the strength, or otherwise, of Professor Bouloux's report should not be judged solely on its grammatical accuracy, the existence of such basic errors does indicate a lack of care in its preparation.

I am used to reading medical papers which, when facts are made, are referenced. Professor Bouloux states in his expert witness report that:

“Some 50% of [CFS] patients respond to the use of serotonin reuptake inhibitors”.

This assertion is not referenced and I believe has no evidence base. Indeed his report has other unsubstantiated assertions and statements based on pure supposition. A combined example of assertion and supposition comes where he states:

“Many patients have turned their back on allopathic approaches, preferring instead to seek treatment in an unconventional setting, where they not infrequently get greater support and understanding, and in some cases hope.”

Professor Bouloux was given by the GMC a full copy of the patient's NHS records. Clearly he has not read these carefully and as a result his report is based upon misinformation. The important point here is that he has accepted unquestioningly the GP's version of events instead of checking on the facts for himself. In this sense, his report does not constitute new evidence but rather merely a reiteration of previously submitted evidence. I have already rebutted these points in detail and would refer the Panel to my letter of December 18, 2009. But additionally Professor Bouloux has a third version of events. As you have read, Dr Y says that the practise never agreed to train X to administer the injections. The letter to the district nurse says it did, but Professor Bouloux states that:

“... patient X requested that a District Nurse instruct X to perform B12 injections.”

I can only infer that he has another source of information that he has not referenced. Clearly the Panel will need to see that reference and in the interest of fairness I also would like to have sight of this new information.

In the event no injections were supplied to X nor were any administered.

I would also like the Panel to observe that there is no letter of patient consent within those notes permitting them to be released to the GMC and third parties. Professor Bouloux should have been aware of this.

In his report Professor Bouloux states that another member of the family has a chronic fatigue syndrome. In the context of this comment the identity of the person is obvious. In preparing this report therefore he has breached yet another patient's right to confidentiality.

Professor Bouloux states that my advice does not represent evidence based medicine. What he has clearly failed to do is to read my paper. This is the evidence base for the treatments that I recommend. As I have already said, the testament of many thousands of CFS sufferers and their relatives and friends who have written to the GMC in my defence strengthens this evidence base.

In response to a question from the GMC vis –

“Does the information provided by Dr Myhill to the GPs represent evidence based medicine?”

Professor Bouloux’s answer is a categorical:

“It does not, as there is no evidence base for the treatments recommended.”

He goes on to say:

“.....evidence base would require that a properly controlled double blind placebo controlled study be conducted to demonstrate the efficacy of the intervention.”

These assertions by Professor Bouloux would be laughable if they were not so serious. Many highly effective medical interventions are practised in daily NHS work that are not proven by placebo controlled double blind trial. In his own area of expertise, namely endocrinology, on which I have written a position paper as listed above, I have seen no paper in which thyroid replacement therapy has been subject to placebo controlled double blind study. By Professor Bouloux’s standards, no one in the country should receive thyroid hormones and if such a bizarre policy were carried through, the Panel will be aware that many very sick patients would suffer and die as a consequence.

On receipt of this report, I had numerous immediate concerns and so I telephoned the GMC to ask if Professor Bouloux would be present at this hearing. Mr Bridge, the GMC Case Officer assigned with the task of dealing with the details of this hearing, was not answering emails or the telephone. I spoke with GMC officers Alison Thompson and Scott Geddes, neither of whom could answer my question. I was referred to Neil Marshall who was not answering his phone and, despite prompting from Scott Geddes, has not contacted me.

So I remain unaware as to whether Professor Bouloux is here today to respond to my concerns.

The Second Complaint is Anonymous

My new Wikipedia look-alike website was launched in February 2010. The GMC received a complaint about that website on February 9, just a few days later.

It is of great concern to me that this anonymous complainant chose not to contact me directly with any of his concerns. I would have been very happy to address those and, given good reason, changed the details in my website. Indeed this is the best way for science to progress. I am very mindful that I do not know all the answers and indeed the pleasure is in discovering new techniques to help patients.

I do understand and respect the complainant’s request for anonymity and have no desire to know his name or whereabouts. However I did wish to know whether he was acting out of personal concerns or if he was acting for a third party. I wanted to know this because in the past other practitioners of nutritional medicine have been harassed by investigative journalists.

With this in mind I asked the GMC to approach the complainant and request a Declaration of Interest statement. The GMC refused even to contact the complainant let alone request such a statement. This refusal was given for, as the GMC put it “reasons of confidentiality”.

However the complainant has identified himself on line in a website which goes under the name of “Bad Science”.

I reproduce below, verbatim, online quotes from the ‘anonymous’ complainant. This was posted on Thursday April 15th at 2.20 a.m.:

“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 Badscience 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 (IOP) hearing on 29th April at which she could have her license to practise suspended for 18 months.

Those who live in glass houses should masturbate in the basement ...”

At a further post he states:

“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 actually be worth submitting another complaint given the failure of the previous 6 efforts. This was written with some haste during a 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\*.”

These posts are accompanied by a photograph which I presume to be of the complainant himself. It pictures him underwater drinking a can of Coca-Cola.

Because of the design of the website it is possible to track who is looking at the web pages and for how long. The GMC received the complaint about my website at 5.42 a.m. on February 9th 2010. Six days later on February 15th the GMC accessed the very web pages flagged up by the complainant between 13.16 and 13.28. That is to say the GMC spent 12 minutes looking at my website.

I do not know who looked at those web pages, nor whether they had any medical qualifications, nor if they had any knowledge of diet or nutrition. I have received no expert witness report on those web pages and so I am led to believe that the GMC upheld the need for an IOP hearing regarding this anonymous complaint on the basis of a 12 minute perusal by, for all I know, an unqualified GMC officer.

The GMC state that it is their primary duty to protect the general public and I entirely concur with this. The letter I received on April 8th from Assistant Registrar Rebecca Townsley of the GMC stated that I should be subject to this hearing because the Case Examiner considered “there is a potential risk to public safety”.

I repeat I am very mindful that this is not a fitness to practise hearing and therefore there should be no examination of the content of either complaint. However, I do have concerns about the credibility of one complainant and the complete lack of any corroborative evidence in both cases.

The GMC has been sent over 800 letters from patients and doctors, which the Panel has before them. These letters collectively present a picture of support for my website and treatment protocols whilst at the same time expressing incredulity at the manner in which the GMC has behaved. The Panel also has a copy of the on-line petition which on April 27th had 3,345 signatories but also many thoughtful and incisive comments. This overwhelming show of support has happened in a relatively short period of time and emanates from not only within the United Kingdom but also from all around the world. I have been humbled by the level of support which in some cases comes from very sick patients who I know will have expended considerable reserves of their limited energy to put their point across in this way.

I am fed up with the way that I have been endlessly investigated by the GMC over the last nine years with issues that I can only describe as trifling. It is about time the GMC recognised that I have become expert in the application of nutritional medicine to simple and complex disease modalities for which this approach has much to offer.

In this field of nutritional and environmental medicine I am seen as a pioneer. The methods used are logical, scientific and evidence based. An understanding of this approach empowers patients to help themselves and, as evidenced by the pile of testimonies laid before it, seeing great success.

I fail to see how this can be construed, as the GMC case officer puts it, as posing “a threat to public health”. Indeed, should I not speak out and keep this hard earned knowledge under wraps for fear of GMC prosecution, then I would indeed be putting patients and the wider public at risk.

Whatever the outcome of this hearing I shall continue to put the patients’ best interests at the heart of my medical practice.

(Applause from members of the public)

THE CHAIRMAN: Sorry, I think you have been told there must be no contribution from members of the public. I realise your strong feelings on this, but please will you not make any noise or interrupt the proceedings. Thank you, Doctor. I think Mr Macdonald first wishes to ask questions of you.

MR MACDONALD: No, madam, I think we have had a very full statement and I do not wish to. As far as the mass of paper is concerned, I would invite the Panel to look at the statements of Dr Pouria and Dr Sharma, who would be willing to give evidence in support (but not today), and also to read the letter from Dr Norman Booth, who is Emeritus Professor

Fellow of Mansfield College, Oxford, who co-wrote the paper to which the doctor has referred, and also Dr Damien Downing, who is the President of the British Society of Ecological Medicine, who underline the importance of the work which Dr Myhill does.

THE CHAIRMAN: Perhaps I should say, before I invite questions from the rest of the Panel, you did say we could have a copy of your statement and I think it is important we should do that. Have you already got any copies ready or not? If not, I will get someone to take that and get copies. We will need probably half a dozen copies, so, yes, that is going to be copied for us. Thank you. Mr Summers, I think I should invite you first of all whether you wish to ask any questions of the doctor.

MR SUMMERS: I think at this stage my preference would be to reply at the conclusion of Mr Macdonald's address in relation to inaccuracy.

THE CHAIRMAN: Thank you. I am therefore going to throw it open to my Panel colleagues as to whether they wish to first of all ask questions I think of Dr Myhill, but, secondly, I think we should then have the opportunity to ask questions of Mr Macdonald. So any questions for Dr Myhill? Mr Devani.

#### Questioned by THE PANEL

MR DEVANI: Good morning, Doctor. I just want to know a brief background of your practice. You say that you have been in private practice for the last ten years. Just give us a brief background – your speciality.

A Well, as I say, I spent 20 years in NHS general practice, and I was always asking the question “Why?”, so if a patient came with migraine, or irritable bowel syndrome, or whatever, rather than give them analgesic painkillers for migraine, I would be asking the question “Why have they got the migraine?” Migraine is often due to allergies to foods, mineral deficiencies, and people could often cure their problems through very simple nutritional interventions. As a result of that, I then found friends and families of my NHS patients saying, “Oh, that is interesting. Can you help me with my arthritis?”, or “my fatigue”, or “my irritable bowel syndrome”, or whatever. So actually there was not a crisp finish to NHS practice and then I started in private practice. There was a time when I ran the two together, and I would see private patients in my private clinic and NHS patients in my normal NHS way, and then eventually it was too much for me to deal with, so then it became fully private in 2000.

Q So in a nutshell you were just providing private medical services to your patients?

A Yes.

Q How many patients do you have on your list?

A Well, it is not really like a GP's list, because---

Q Just a rough idea.

A I think since 2000 I have had about 5,000 new patients. It is of that order anyway.

Q Thank you for that. Can I just ask you about how do you keep up to date with your continued professional development and medical knowledge?

A Well, as I say, I am a very active member of the British Society for Ecological Medicine and we have bi-annual scientific meetings at the Royal College of General Practitioners, and we have six days a year of training sessions, and I do not think I have missed a single session since the mid-1980s.

Q The other question I have is have you in the last ten years been appraised of your professional practice?

A Indeed, yes. I can show you my appraisal file if you so wish to see it.

Q You have not got it today with you?

A No, no, I thought you had enough paperwork already.

Q Do you know who carried out those appraisals?

A Dr Chris Dawkins from Oxford.

Q The other question I have is you mentioned about the British Society for Ecological Medicine. How many members are there and how many practitioners within that Society?

A I should say there are roughly 100 to 120 members. The membership fluctuates. It is restricted to professionals, so you can only be a doctor or similarly qualified to be a full member, and we have some associate members, some scientific members and some special interest members. It is largely made up of GPs and consultants.

Q BSEM, it says "care of New Medicine Group". Can you tell us anything about the New Medicine Group?

A No, I cannot tell you about that.

Q The other question I have is how many patients do you see face to face in comparison to patients getting either advice from or information from your website?

A I have no idea how many patients access my website. Do you mean in my day to day general practice how many people I see face to face?

Q Yes.

A I would say it is about 50/50, but every time I have a consultation with a patient, whether it is face to face or whether it is on the telephone, I always write to the GP and explain exactly what I am doing and why I am doing that, and indeed it then becomes part of the care package for the patient because then they are very clear as to what has been said and what is expected of both parties.

Q My final question is about chronic fatigue syndrome and you have made references to that, including your paper. What sort of experience and training did you have in that particular area, particular interest?

A Well, as I am sure you are aware, if you look at any patients in general practice, "tired all the time" is a well recognised diagnosis, or well recognised thing that GPs write, and the point about fatigue is I see that as a symptom which may have many causes, and my job is to address those causes, and chronic fatigue syndrome is a very particularly severe version of that. One can be tired for lots of reasons. A very common and overlooked one is simply lack of sleep. Just lack of sleep will cause chronic fatigue. Micronutrient deficiencies

can certainly cause fatigue. My job as a practitioner is to try to identify as many of those causes as possible to allow the patient to get well.

Q You would see the patients face to face, investigate the matter and advice accordingly?

A Indeed, and inform the general practitioner.

MR DEVANI: Thank you for that.

THE CHAIRMAN: Thank you. Dr Morrison.

DR MORRISON: Thank you, Doctor. Just for the purposes of clarity, you have made mention of the BSEM's qualification system.

A Yes.

Q My understanding is that you are not on the GMC's Specialist Register with a qualification having been obtained either through CCST or equivalent.

A We are affiliated to the Institute of Biology, and via the Institute of Biology to the GMC.

Q Let me just be absolutely clear about this: are you on the GMC's Specialist Register?

A No, not the GMC's Specialist Register.

Q Thank you.

A The thing about ecological medicine is it is a relatively new and evolving way that we look at medicine, and it has not had the---

Q I do not need to know more detail now. I just wanted, for the purposes of clarity to the Panel, to know if you were on the Specialist Register. That was all.

A Okay, but do you appreciate the reasons why, which is that we are not sufficiently mature as a Society to come under the GMC's umbrella. It is something we would very much look forward to and welcome, but it is simply a case of maturity.

Q I think, again for the purposes of the Panel, it is around the legal definition of a specialty and whether or not there is a European qualification to which one can attain that, and that would then lead to the Specialist Register. So that is why I asked. It was just so we had clarity about that. I would ordinarily address other questions through your representative, and the questions I am going to ask, you would probably have to inform Mr Macdonald in order for him to tell me, so that is I think why I am taking the opportunity to ask you directly. Can I ask you to go to the original orange bundle that you have in front of you, and it is in respect of what Mr Summers has referred to as the second complaint, the most recent one about the website.

A Yes.

Q I wonder if I can ask you to turn to page 207.

A Yes.

Q Mr Summers has taken us through in some detail I think the eight points that were raised in terms of areas of concern by that complainant, and I just wanted in some of the areas to get some clarity, to some extent as Mr Devani has done on your background. The first on 207, “Treatment of acute chest pain (and other conditions) with [intravenous] magnesium”, the quote from your website states:

“I have been using i.v. magnesium in my ... practice for over 25 years”.

I just wanted to get a feel for how many patients you might have administered intravenous magnesium to during your time in full private practice.

A Well, the thing is I do not do acute on-call work, so the answer is considerably less than when I was in NHS general practice. I learned this technique from a GP called Dr Sam Brown, who published in the journal, and he then came and showed me how to do it and we discussed cases.

Q Would it be the order of one or two a year, one or two a month?

A Well, for acute chest pain it would be virtually none. I can think of maybe two in the last ten years where I have been involved. But it is also a useful treatment for angina, and I find it clinically very useful for heart failure, and I do have one or two patients who come on a regular basis and gain benefit.

Q Can I ask in what sort of clinical environment that infusion of intravenous magnesium would take place?

A Oh, in my surgery.

Q Can I ask what resuscitative facilities would be available?

A Normal oxygen is available, but it is an intrinsically very safe thing to do.

Q Can I ask if there is a defibrillator in your practice?

A No.

Q Thank you. Can I ask whether or not you have done an ALS course, an advanced life support course, within the last three to five years?

A I have done basic resuscitation courses, we do those every three years as part of the BSEM training, but we do not do advanced life support because it is not considered appropriate in such a low-tech setting. Intravenous magnesium is a very, very safe intervention and the potential for harm is really very, very tiny.

Q Mr Devani asked about continuing medical education. The final question I would ask at this point is what continuing medical education have you done in the areas of acute coronary syndrome, heart failure, pulmonary embolism or asthma in the last two to three years?

A Well, what I specialise in is not the condition but the approach. So the techniques that I am describing we would discuss very regularly at our bi-annual meetings and our training sessions. So we talk about the techniques that we have for treating things which would have a wider application. So it is not a disease-focused approach, it is technique based if you like. So, for example, essential fatty acids can be used to treat a wide range of

conditions from neurological disorders to chronic fatigue syndrome to skin disorders, but that does not mean we have a whole day on dermatology, for example. So we would touch upon those issues very regularly but from another perspective.

Q Just for clarify, have you attended, for example, a Royal College symposium which might have presentations by cardiologists on the subject of acute coronary syndrome.

A I have not attended but I read widely.

Q Thank you. That is helpful. Can I ask you to turn to page 209. It is the area that starts at the bottom of 208 in fact regarding breast cancer screening.

A Yes.

Q This is probably my last area of questions, and I ask something similar about what formal training you have had in diagnosis or management of oncological breast disease, and to ask what CME or CPD you might have done in that area recently too?

A I am a clinician and I am inevitably influenced by what I see in my clinical practice, and in the last few years I have had two women who have presented to me with secondary tumours, seedlings on their skin, where their original tumour was biopsied, and there is a very good mechanism by which that could take place, and it was that that prompted me to make those observations in my web page. If that is of concern to you, then I am very happy to withdraw that web page, but that is what provoked that page.

Q Thank you. However, just for clarity I do need an answer to my question. Perhaps I can put it slightly more succinctly: have you attended any CAPD, whether that be in person, on-line, which has been hosted, if I can put it that way, by either a breast surgeon or an oncologist who is a specialist in the management of breast cancer?

A I have attended two seminars which have been conducted by a Greek doctor called Dr Papatiriou, who is an acknowledged expert in the management of cancer using these nutritional therapies and conventional therapies. Now, again it is approach based rather than disease based, so it was not with reference particularly to breast cancer, or leukaemia, or brain tumours, or whatever, it was a more generalised but very evidence based and scientific approach to the management of cancer in general. So that is two in the last year I have attended.

DR MORRISON: Thank you very much, Doctor.

THE CHAIRMAN: Thank you. I have a few questions for you. Relating to the first complaint and the son of Mrs X, who in effect was the patient, is it right that you prescribed without seeing the patient?

A My recommendations were to the general practitioner, and I did not prescribe anything to the patient. I merely requested that the GP oversee the provision of B12 and magnesium injections. The GP agreed to do the blood test originally in order that the patient could have the relevant test. I then made the recommendations to the GP to provide the B12 and magnesium injections and show how these should be administered. In the event the patient did not receive any B12 or any magnesium injections from anybody.

Q Would your normal practice be to prescribe yourself but then inform the GP what you have done? How does it work out---

A It depends very much on the circumstances. I use B12 injections and magnesium injections very widely in my practice, I find them very helpful for a range of conditions, and my normal policy is I always inform the GP, I always ask the GP if they would be prepared to oversee these injections and do them. In the event of that GP refusing, and if the patient still wants to go ahead with them, then they have to find a trained professional who can show them how to do the injections, which is often me, and then I supply them with the necessary to do them and again keep the GP informed.

Q I am trying to tease out why there were some cases where you would do the injections yourself and some cases where you would refer them to their GP.

A Well, I always refer them to their GP. The only point of me doing the injection is to show them the technique and then they do it themselves. It is a little bit like a diabetic having insulin injections; they need to be shown once or twice how to do them and then they can go away with the little fine syringes and the necessary to do the injections themselves. It makes it very inexpensive and convenient for them, especially when they are doing daily injections.

Q So is it really an issue of cost, that if you were to administer or provide the prescriptions they would have to pay?

A And convenience, correct.

Q On a separate issue, you heard Mr Summers suggest that there should be restrictions on your practice in the nature of conditions, and I would just like to run through I think most of the possible conditions he mentioned just to see whether they, in your view, would be workable, or the effect they would have on your practice. So if I could just run through those with you.

A Yes.

Q The first one related to supervision, that you should practice only under supervision.

A Yes.

Q Is that a possibility for you?

A I practice in the middle of Wales in a very remote surgery, so it would be very difficult to find somebody to be physically there. Is that what you had in mind?

Q Are you a single-handed practitioner?

A Yes.

Q You are the only doctor in the surgery?

A Yes.

Q You see, the second leg of that is that you should get prior written approval from your supervisor for any prescriptions you authorise.

A Well, it would be an inconvenience to me and it would take up an enormous amount of paperwork, but it would indirectly harm patients because I simply would not then have the time to spend on clinical stuff. I mean, my time is already very full and I try to work as efficiently as I can so that I can see as many patients as I can. What you are suggesting

would encumber me with vast amounts of paperwork and I would just simply be a less efficient doctor as a result and less people would be seen. I have a waiting list already of several months.

Q Maintaining a log of treated patients: I imagine that would not be a---

A Well, the same argument applies: of course I can do it, but I would rather not have that administrative burden.

Q Then the final one I noted that Mr Summers suggested was the websites that have been gone through at this hearing should be removed, and you have already indicated, I think in relation to the breast cancer case, that you would be prepared to withdraw all of that website?

A Yes, of course, and, I mean, the website will never be finished, it will never be perfect, and the problem is it went up very quickly at the beginning of February and there was subsequent to that a lot of movement and changes as typographical errors were spotted, or the pages did not link neatly, and the complaint came in a few days after. Now, what the normal professional and scientific approach is, if anybody has a concern then they can contact me directly, they can voice those concerns and I am only too happy to make changes given a good evidence base. The information on the website is not just based on the scientific literature. There is a large slice of practical reality in there as well, and my job as a clinician is to interpret the science that is out there to a workable and usable and patient-friendly form that they can understand, and if that means sometimes a little lack of definition or precision, well, you will have to forgive me.

Q Mr Macdonald referred to the change in culture that websites are now freely available. Is there not a potential for vulnerable patients, looking at something like the breast cancer website which we have on page 214, taking that as gospel, if I can call it that, and---

A Well, I hope that the nature of the website and the friendly way in which information is given, and the easy access that people have, because they can email me directly from the website, will make it very unlikely that that would happen, and if the Panel has any concerns over that, then I am very happy to rephrase that in a way that you feel might be less threatening.

THE CHAIRMAN: Thank you. Mr Devani has a further question.

MR DEVANI: I have just got one or two if you do not mind. On page 326 of addenda IX---

THE CHAIRMAN: That is the expert's report, is it?

MR DEVANI: No, it is this bundle *here*, I think your papers to the GMC. What I am trying to get at is you wrote a letter to Jackie Smith on 30 August 2009, but you said "Record of our meeting on August 12<sup>th</sup> 2008", so which is the correct date?

A No, no, 2009. If that is the case, I apologise, that is a typographical error. I met her last August, the glorious 12<sup>th</sup>, 2009, and the minutes of the meeting I submitted at the end of August.

Q Can I just pick one item from that.

A Please do.

Q You raise the issue about various points. Point 2 is:

“As a result of GMC actions, I have been unable to obtain full medical insurance since 2004.”

I wonder whether you have full medical insurance now.

A I have full medical insurance except for GMC proceedings, and that is why I have conducted my own defence for all the recent hearings after the first hearing I faced.

Q Are you covered for professional indemnity?

A Oh, yes.

THE CHAIRMAN: If we wish to ask Mr Macdonald questions, this would be the opportunity before proceeding further.

We are going to be handed a copy of the Doctor’s statement. (Same handed)

THE LEGAL ASSESSOR: Doctor, you have concluded your evidence, and if that is the case you can be released from your oath and you can sit next to Mr Macdonald and pass him instructions, as your representative, as you feel fit. You are now released from your oath. The evidential part of your evidence is now finished.

(The witness withdrew)

DR MORRISON: Mr Macdonald, you opened your submission with a number of statements, including one that no complaint had ever been made by a patient. Can I ask you to turn to addendum 10, page 966? It is the same addendum that contains the expert report from Professor Bouloux. That is from an individual, RM. I recognise that it pertains to matters some time ago, but I simply wanted to bring to your attention that within our bundles we have information that in essence contains what appears to be a complaint from somebody who used to be a patient.

MR MACDONALD: I am sorry if I was not aware of that.

THE CHAIRMAN: Any responses must be through Mr Macdonald.

MR MACDONALD: It was received on 15 April 2010, and it is very recent; and I was not aware of it.

DR MORRISON: The only reason I raised it as part of a question was merely to hear any observations you might have because you have made a statement that there had not been a complaint.

MR MACDONALD: There has now been one.

THE CHAIRMAN: I will now ask Mr Macdonald to make his final submission, and then Mr Summers – or Mr Summers first?

MR SUMMERS: I think it should be Mr Macdonald who completes his submission. I am so sorry.

THE LEGAL ASSESSOR: I thought, Mr Macdonald, you had completed your submission. Mr Summers, you indicated that you wanted to come back.

MR MACDONALD: I have completed my submission. I do not wish to add -----

THE CHAIRMAN: You have said all that you wish to say to us.

THE LEGAL ASSESSOR: Mr Summers, you indicated that you wanted to come back; I am just conscious that Mr Macdonald should have the last say, as it were. That is the fairest way of doing it. If you come back with your observations, then if Mr Macdonald wants to reply, he can have that right.

MR SUMMERS: I am so sorry, I thought that Mr Macdonald had not finished his submission. It is my fault entirely.

Can I make a handful of points in relation to the theme of accuracy? First, my instructions are that there have been no hearings before any panel at all. Secondly, in relation to the material itself there is the section of more negative material at pages 964 to 968. We have the one reference to the patient but there is also at page 967 someone from the United States in relation to the website.

Thirdly, in relation to the point that the website complaint is anonymous, if one looks at page 206 obviously we can see the boxes, and some of the material in relation to the complainant has been anonymised, but his name has been disclosed in the document.

Fourthly, in relation to medical records – I wonder if there could be silence, please, in the public gallery while I address the panel!

THE LEGAL ASSESSOR: As the independent legal adviser to this Panel, can I say to those that sit in the public gallery that of course this Panel has discretion under its procedure rules to exclude members of the public. I am afraid this is not Friday Night at the Palladium; this is actually a judicial hearing, and the Panel has an important judicial function to carry out; so applause, booing, criticism and that sort of thing is wholly inappropriate while counsel is putting forward his case. You may disagree with it – that is your right – but let counsel put his case fairly.

MR SUMMER: Fourthly, in relation to patients' medical records and the complaint about their use, the use in this case is entirely in line with legal advice received by the GMC.

Fifthly, in relation to the posting on the Internet purporting to be Mr Jones at 206, there is no evidence that it is.

Sixthly, in relation to the point about being asked to withdraw the expression "witch hunt" could I direct your attention to page 362, appendix 9, please? I am just directing your

attention to the top of it. This is an I-petition, material that has been provided to the GMC by Dr Myhill. At the very top of it under “I-Petition” – “Witch Hunt of Dr Sarah Myhill; the petition has collected 3,000 signatures using the on-line tools of I-Petitions.”

DR MYHILL: That is the petition not the letters.

MR SUMMERS: I wonder if I could just deal with it uninterrupted, please? Thank you.

“We the undersigned wish to register our strong objections to the GMC over the witch hunt campaign to discredit Dr Sarah Myhill.”

That was the reference that I was particularly alluding to when I was making my address to you. Thank you very much.

THE CHAIRMAN: Mr Macdonald, do you wish to respond?

MR MACDONALD: I just wish to say that the Panel will be aware that whenever one is subjected to a professional inquiry of any kind, it is a very traumatic and difficult experience - I speak from personal experience - and it is understandable that strong language is used.

We accept and know that the Panel has an important public duty to perform, and we are confident that you will perform it. We submit that this is not a case in which it would be appropriate to make any interim order at all.

THE CHAIRMAN: Before I ask for final legal advice, because we have two documents tabled, one being your statement, we should call that D1. An additional letter was tabled, which was not in our bundle, from somebody called I. Logan to the GMC dated 28<sup>th</sup>. I think that was probably faxed. As that has not been attached to the bundle, we must call that D2.

Legal Assessor, all the comments and questions have been concluded and I am now going to ask you for your legal advice before we retire to consider.

MR SUMMERS: I am so sorry, Madam, in relation to the documentation could we see D2, please, before the Legal Assessor closes? (Same handed)

THE LEGAL ASSESSOR: Madam Chairman, my advice to the Panel in terms of the legal position is as follows. First, you are an Interim Orders Panel, and therefore must not make and resolve questions of fact; that is not your function today.

Secondly, you have heard submissions advanced by both sides in respect of the issue before you, and of course I remind you that it is a matter for your own judgment in terms of what approach you take.

You must start with the test that is set down by Parliament in section 41A of the Medical Act 1983 because that is your starting point. The test is, for an interim panel, whether to impose an order if, in all the circumstances, there may be an impairment of a doctor’s fitness to practise that poses a real risk to members of the public or may adversely affect the public interest or the interests of the practitioner; and, after balancing the interests of the doctor and

the interests of the public, if an interim order is necessary to guard against such risk an appropriate order should be made.

I remind you of that test in full because Mr Macdonald referred to a House of Lords case in respect of a different area of the law that referred to serious questions to be tried.

That is not the test. The test is contained within the Act itself and the guidance that you have before you.

In reaching a decision whether to impose an interim order, an IOP should consider the following issues: (1) the seriousness of risk to members of the public if the doctor continues to hold unrestricted registration; and in assessing this risk the IOP should consider the seriousness of the allegations, the weight of the information, including information about the likelihood of a further incident or incidents occurring during the relevant period; (2) whether public confidence in the medical profession is likely to be seriously damaged if the doctor continues to hold unrestricted registration during the relevant period; (3) whether it is in the doctor's own interests to hold unrestricted registration, for example if the doctor may lack insight and need to be protected from him or herself.

It is for the IOP to decide what weight to give to these factors in any case.

I direct the Panel of course to consider in full the IOP guidance it has in the files on the desks because that does provide a helpful guidance, and I think Dr Myhill has referred to it in her address - it is the April 2008 guidance – in terms of the approach you should take.

I remind the Panel of the duty of proportionality, and that is to act in a proportionate way. In practical terms that means doing no more than is necessary in order to meet any risk, if a risk is identified in the first place.

In terms of conditions, I remind the Panel that conditions must be appropriate, proportionate, workable and measurable. The Panel should have due regard to those factors, and of course the IOP conditions bank, which again you have in your file.

Madam Chairman, that is my advice.

THE CHAIRMAN: The Panel will now go into private session. It will be at least an hour and probably longer before we are able to make our determination and call everyone back to read out the determination. I now ask that the room be cleared, and the Panel will go into private session.

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

STRANGERS HAVING BEEN READMITTED

THE CHAIRMAN: I am going to read the Panel's determination. Obviously, a copy will be given to you at the end of that.

Can I just say, before I start reading – and I am sure you will respect this – that any disturbance or noise during my decision will mean that I will have to stop reading and the room will have to be cleared of the public area, so I would appreciate it very much if you would remain silent while I read the determination.

### DETERMINATION

Dr Myhill, the Panel has considered all the information presented. It has taken account of the submissions made on behalf of the GMC and those made on your behalf. On behalf of the GMC, Mr Summers referred to two complaints. The first complaint was made by a group of general practitioners regarding your suggested management of a patient with a neurological disease. The second complaint related to the content of your website. Mr Summers submitted that an order for interim conditions was necessary in all the circumstances.

Mr Macdonald, on your behalf, submitted that no order was necessary and that the concerns raised were unfounded, particularly in light of the large number of testimonials, supportive of your practice. It has noted your evidence to the Panel that you deny the allegations, and has taken into account your concerns raised regarding the accuracy of the GMC's case.

The circumstances surrounding this case relate to concerns regarding your clinical and professional practice, and concerns regarding your website, your promotion of treatments and consequently your potential failure to recognise and work within the limits of your competence. At all times, a doctor is responsible for ensuring their own good medical practice, and it is their responsibility to practise safely and in accordance with the requisite guidance.

The Panel has determined that in accordance with Section 41A of the Medical Act 1983, as amended, it is necessary for the protection of members of the public and in the public interest to make an order imposing the following interim conditions on your registration for a period of 18 months, with effect from today.

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).

In reaching its decision 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 impose any interim order. It is not the Panel's purpose to test the veracity of any information put before it. It has reminded itself of the test it must apply and of its nature, function and powers, as well as its duty to consider each case on its individual merits. The Panel's function is not one of fact-finding and the Panel must impose the order it determines necessary, notwithstanding any potential for loss or hardship.

In considering the protection of members of the public and the public interest, the Panel is concerned by the allegations made and is satisfied that, if substantiated, your actions could indicate a potentially serious limitation on your insight into your fitness to practise and the consequences of your actions, particularly for vulnerable people who may be accessing your website. As a consequence, if the allegations are proven your behaviour could have an adverse effect on the confidence and trust that the members of the public are entitled to place in the profession and its practitioners.

The Panel was concerned that some of the information contained within your website may indicate that you are practising outwith your area of expertise and therefore are potentially putting patients at risk by providing misleading or inaccurate information. The Panel was also troubled that on the basis of your statement and evidence today, you may lack insight into the issues raised by the GMC. In considering the GMC's document *Good Medical Practice* the Panel has borne in mind that it is a fundamental duty of a doctor to recognise and work within the limits of your competence. Furthermore, the Panel notes that, as a doctor, if you publish information about your medical services you must make sure the information is factual and verifiable.

Accordingly, the Panel is satisfied that 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 members of the public, and may adversely affect the public interest. You are a registered medical practitioner and are expected to behave in a manner that justifies the public trust in the profession and its practitioners at all times.

Having determined that an interim order is necessary, the Panel then went on to consider if an interim order for conditions would be workable, practicable, sufficient and appropriate. In all

the circumstances, the Panel is satisfied that a restriction, by way of interim conditions, is appropriate and sufficient to guard against the risk that your actions potentially have for patients, the public, and the public interest. The public interest includes not only upholding and declaring the appropriate standards of professional behaviour, but also maintaining trust in the profession. Trust is crucial to the doctor/patient relationship.

The Panel is required to consider for what duration an interim order is necessary. The Panel notes that there are a number of issues to investigate and that the GMC's final consideration of your case may take some time. Therefore, it is necessary to impose the above conditions on your registration for a period of 18 months. In doing so the Panel notes that the order will be reviewed within six months, or earlier should circumstances surrounding your case change.

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 restricts your ability to practise medicine, the Panel has determined that, given the nature of this case, imposing conditions on your registration, at this time, is a necessary and proportionate response to the risks posed by you practising medicine unrestricted.

Notification of this decision will be served upon you in accordance with the Medical Act 1983, as amended.

That concludes our hearing. Thank you for coming, Dr Myhill and Mr Macdonald.

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