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DEFENCE DOCUMENT

IOP HEARING 29th April 2010

GMC CASE REFERENCE: 2734668

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SECTION 1 - BACKGROUND

1.BACKGROUND

Since 2001 Dr Sarah Myhill ('SM') has faced the prospect of six GMC Fitness to Practise Hearings. No complaint ever came from a patient, all emanating instead from doctors or from the GMC itself. During those investigations SM's website was extensively examined by the GMC, including the use of a commissioned Expert Witness report, and was not found wanting then. All allegations were dropped with no case to answer and no sanctions were placed on her practice. GMC Counsel Mr Tom Kark stated:

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

SM wishes to practise medicine unencumbered by spurious GMC investigations and with this in mind she commissioned an independent QC, Mr John Macdonald, with the remit of reviewing her case history (appended – see section 4.24)for discussion with the GMC. This resulted in a meeting with Head of Investigations Jackie Smith on 12th August 2009. Ms Smith refused to sign minutes of that meeting and has refused all communication with Dr Myhill since.

1.1 The Complaints

On 8 April 2010, SM received a letter from Rebecca Townsley, Assistant Registrar at the General Medical Council ('GMC'), stating that two complaints about her medical practice had been received by the GMC. The GMC considered that these complaints suggested that SM's fitness to practise may be impaired and so instigated an Interim Orders Panel '(IOP') Hearing. The said letter and supporting documentation are attached at Appendix 4.1

Briefly, these complaints were as follows:

- **The 'B12 Complaint' – This concerned a practice of 8 GPs, Dr H L Moss and Partners (the 'Partners'), who complained about SM's advice that they prescribe B12 and magnesium sulphate injections to a patient at their practice who suffered from Batten's Disease. This patient shall be referred to as Patient X.**
- **The 'Website Complaint' – This concerned a complainant, described as a clinical scientist, who considered that SM's website represented a risk to public safety. This complainant was effectively anonymous, although named as Stuart Jones.**

The details of these complaints and their validity are obviously the subject of much of the discussion in this document but for background purposes only they are documented above as they were presented to SM.

These complaints were heard at an IOP Hearing held on 29th April 2010.

SECTION 2 - INTRODUCTION

2. INTRODUCTION

2.1 PURPOSE OF THIS DOCUMENT

The purpose of this document is to present the arguments, and supporting evidence, in defence of SM with regards to the IOP Hearing of 29th April 2010 (the 'Hearing'), the full decision of which is included in the appendices (section 4.2). The decision by the Interim Orders Panel (the 'Panel') of that Hearing was that SM had her prescribing rights removed and certain pages of her website were ordered to be taken down. Other restrictions as detailed in section 4.2 were also imposed.

This document is intended as a summary document, but one which contains enough evidence to substantiate, prima facie, the defence arguments being made. Very many correspondences on these issues have taken place and these need to be taken into account when formulating a full opinion. However, to include all such documentation here would be self-defeating in a document intended to be a summary.

The arguments contained herein, it is contended, are sufficient to render the said decision wrong procedurally, evidentially and legally.

2.2 LAYOUT OF THIS DOCUMENT

This document is laid out as follows, referenced with capital Roman numerals as below:

- **(I)---A procedural or evidential point is presented**
- **(II)---The effect of this point on the IOP decision is detailed and any action required to be taken by the GMC is also listed.**
- **(III)--A reference to any relevant evidential documentation is made to appendices found in section 4.**

2.3 DIVISION OF EVIDENCE IN SECTION 2

The arguments and evidence contained in section 3 are divided into two broad areas: procedural and evidential.

Procedural points are those where the GMC has not complied with its own internal procedures or where other 'points of order' are made.

Evidential points are those where the evidence used at the Hearing is either

- **Insufficient – key points of evidence having been omitted or not considered fully by the Panel. This category includes examples where submitted evidence has not been sufficiently verified by the GMC.**
- **Incorrect – key points of evidence used in the Hearing are wrong on point of fact.**

Clearly there is overlap between these two general forms of evidence and this is dealt with on a case by case basis throughout the document. Generally, the view has been taken that each point should be placed in the section to which there is the most serious error or omission in the GMC prosecution.

For example, the vexatious nature of the B12 complaint represents a procedural piece of evidence. However, this complaint is vexatious because the actual details of it are incorrectly stated by the Partners who told an untruth when bringing this complaint. This untruth represents an evidential argument and in this case the evidential argument is considered stronger than the procedural point and therefore the vexatious nature of the B12 complaint is included in section 3.2 Evidential Defence Points rather than section 3.1 Procedural Defence Points.

SECTION 3 – THE DEFENCE ARGUMENTS

3. THE DEFENCE ARGUMENTS

3.1 PROCEDURAL DEFENCE POINTS

3.1.1 Letters essential to the defence of SM were filleted from the official record

(I) As a result of Data Protection Act (DPA) searches made by SM it became clear that nearly all the letters which SM had written to the GMC were missing from the official GMC data record on SM. In total there were 45 missing. SM complained about this and on the morning of the Hearing received a letter from Julian Graves of the GMC dated 26 April 2010 delivering all those letters to SM's office. Mr Graves lists 38 as not having been previously disclosed, 5 letters as having been previously disclosed and 2 letters as having not been found.

(II) It is a procedural requirement of GMC Hearings that the relevant past GMC record of the defendant has to be considered in the determinations of the Panel overseeing the hearing. These letters are, by their nature clearly relevant, to the Hearing evidence. Clearly, in all probability, this did not happen at the Hearing of SM given that so much evidence relevant to the case in hand was missing from the official GMC record. As well as a procedural point, this is also evidential because the Panel, and indeed GMC investigation Officers, could not avail themselves of the full facts and history of the case against SM. The fact that crucial evidence appears to have been missing from that presented to Panel members has the effect that the IOP decision should be set aside until and unless evidence can be brought forward by the GMC that these letters were available to GMC investigation Officers and Panel members. It is therefore required that each member of the Panel produces a signed affidavit to the effect that they had sight of all these said letters.

(III) There are many letters on SM's own GMC file which she holds herself concerning this issue. The key letter, admitting the error by the GMC, was the said letter from Julian Graves and this is located at section 4.3 in the appendices. Should it be necessary, copies of all 45 letters can be produced for the purposes of ascertaining their relevance.

3.1.2 The GMC did not follow its own guidelines on vexatious complaints.

(I) The Website Complaint is vexatious as defined by GMC Rules. Criteria 8 of 'Vexatious Allegations Guidance on the Application of Rule 4(3)(c) of the GMC (Fitness to Practise) Rules 2004' states that:

8. Broadly, a complaint can be vexatious within rule 4(3)(c) in either its intrinsic nature or in the manner in which it is brought and/or pursued: that is, if there are reasonable grounds to believe that one or more of three criteria apply:

A. The complaint's primary purpose and/or effect is to disturb, disrupt and pressurise the doctor, the GMC and/or another organisation and/or individual.

B. The primary purpose and/or effect of the manner in which the complaint is brought is to disturb, disrupt and/or pressurise the doctor, the GMC and/or another organisation and/or individual.

C. The complaint is otherwise manifestly unreasonable.

The anonymous website complainant was motivated by his own personal belief systems rather than any evidence based scientific concerns. The complainant is a regular and frequent blogger on the web forum Badscience. He consistently takes a negative view of any medical practices which operate outwith National Guidelines and considers all such practice dangerous. There are examples of abuse on that web blog. In addition, very many repeat and trivial allegations have been brought in a short time period by this one complainant. Indeed he is flippant about the whole affair, stating that

*"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 typo's. Amusingly, after submitting my full complaint the GMC decided to use this email to front the complaint to Myhill *sigh*."*

Detailed arguments as to why this complaint is vexatious are detailed in the appendix noted below. It is concluded there that all three thresholds noted in Criterion 8 above were met by this complaint.

(II) Given that this complaint was vexatious, as defined by the GMC's own guidelines, it should be set aside, in accordance with GMC procedures, for the purposes of the determination by the IOP.

(III) Once again, many letters have been sent to the GMC concerning this matter but for illustrative purposes, section 4.4 contains a letter dated 19 July 2010 from SM to Elizabeth Hiley, Information Access Officer at the GMC, and this correspondence provides a detailed summary of the arguments in this context. Section 4.4 A is also included being the Guidance notes on the Application of Rule 4(3) (c).

<u>3.1.3 The GMC did not follow its own guidelines on vexatious complaints.</u>

(I) The GMC has been unable to provide evidence that its Case Officer even considered the vexatious nature of both complaints (see 3.1.2 and also 3.2.1). It is a requirement that such consideration must be made by the GMC before bringing forward any Hearings.

(II) Due to this procedural lapse, the decision by the IOP should be set aside until such time as a detailed account of what the GMC has done in order to determine the vexatious nature or otherwise of these two complaints has been made.

(III) The necessary evidence for this point is contained in:

- **Section 4.4 Letter from Dr Myhill to Elizabeth Hiley (GMC) dated 17 July 2010 concerning the vexatious nature of the website complaint**
- **Section 4.5 Letter of complaint by Dr Y of the Partners dated 18th June 2009**
- **Section 4.6 Letter from Patient X's medical notes dated 4th March 2009**

3.1.4 Independence of the Panel

(I) Dr Lewis Morrison was a member of the Panel in this case. Dr Morrison works for Lothian NHS and is involved in the provision of stroke services in Scotland (reference: http://docs.google.com/viewer?a=v&q+cache:hhx4RUVYasoJ:www.lothianstrokemcn.scot.nhs.uk/network). In January 2006, Dr Charles Swainson Medical Director of Lothian NHS and also involved in the provision of stroke services in Scotland complained about SM to the GMC. In addition, Ms Angela MacPherson, also a Panel member, has spent many years as a senior figure on the Scottish Executive Health Department and may well be known by, or to, either of Drs Morrison or Swainson. Obviously this raises the possibility that Dr Morrison or Ms Angela MacPherson, or indeed both, had prior knowledge of SM's previous cases and were therefore in some way prejudiced. This point has been raised with the GMC (see section 5.1) and Neil Marshall, Assistant Director, GMC Investigations, responded in his letter of 27 May 2010 (see section 5.4) stating that he had contacted Dr Morrison, who had confirmed that he had no knowledge of SM's previous cases, and also that Dr Morrison had not informed the GMC of any potential conflicts of interest prior to the Hearing.

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

(III) Sections 5.1 and 5.4 along with the web address noted above contain the evidence base for this procedural point.

3.1.5 Discussion of the IOP sentence before the hearing of evidence

(I) Discussions of the restrictions to practise to be placed upon SM took place prior to SM giving her statement. This gives the clear impression that the IOP had decided upon the outcome of the case before all evidence had been submitted to the Panel. Whilst the Panel did have written evidence concerning the B12 complaint, there was neither such written evidence nor even an expert witness report about the website complaint.

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

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

(III) Appendices found at sections 5.1 and 5.3 first raised this procedural point.

<u>3.1.6 Lack of fair notice period accorded by GMC to SM</u>

(I) Initially SM was given one full working day's notice period of the IOP Hearing. This notice was received in a letter dated 7th April 2010 (see section 4.1) requiring SM to attend a Hearing on 12th April 2010. GMC (Fitness to Practise) Rules 2004 state that at Rule 11:

"In practice, doctors will normally receive at least 7 days' notice of the hearing, but in exceptional urgency the period of notice may be shorter."

(see section 4.7). Furthermore, a subsequent telephone call between SM and Mr Paul Bridge (GMC) revealed that GMC policy is to reserve periods of notice of just one day normally to cases of suspicion of murder and rape. SM appealed the one day notice period, a course of action only open to her because she happened to be in her office that day. Had SM not opened her mail until the next day then she would have had no chance to appeal this notice period at all. SM appealed in an email of 8th April 2010 (see section 4.8) and received notice that her appeal had been successful in an email of 9th April 2010 from Neil Allwood (GMC) (see section 4.9). This postponed the Hearing until 29th April 2010.

Whilst sufficient notice was, eventually, granted to SM for the IOP, no such notice was granted with respect to her ability to review the Expert Witness report submitted by Professor Bouloux. After the postponement in the initial IOP Hearing date was granted, SM received said Expert Witness report on 26th April 2010 (see section 4.10). This gave SM just 3 days to formulate a rebuttal to this report and effectively no time to commission an Expert Witness to be briefed on her behalf.

The GMC had 10 months in which to investigate the B12 complaint and 14 weeks to investigate the website complaint. There was therefore a significant asymmetry in the time allowed to prepare prosecution and defence papers. By contrast Harold Shipman was given one full month to prepare his defence papers for a GMC Hearing, even after he had been found guilty of murder.

(II) There has been no explanation by the GMC of the reason for the late arrival of the Expert Witness report. It is a basic tenet of English Law that Natural Justice should prevail. SM did not have sufficient time to prepare her defence against the Expert Witness Report and coupled with the original notice period of just one day for the initial date of the Hearing, there is sufficient evidence to conclude that the GMC did not take SM's rights as a defendant seriously. Moreover, having given no reason at to why her case was originally designated 'exceptional urgency', it is concluded that the sum of all these factors leads to

the conclusion that the IOP decision should be set aside on the grounds that it was not fair. SM should be given the time necessary to prepare a full defence and must have sight of all the evidence that the GMC intend to produce in support of their case in good time before such hearing.

(III) As noted above evidence for these points is contained in the following sections:

- **Section 4.1 Letter from Rebecca Townsley (GMC) dated 7 April 2010 requiring SM attendance at initially scheduled IOP Hearing for 12th April 2010**
- **Section 4.7 IOP Rules**
- **Section 4.8 Email date 8th April 2010 from SM to GMC appealing the notice period of one day for her original IOP Hearing date**
- **Section 4.9 Email dated 9th April 2010 from Neil Allwood (GMC) to SM granting a postponement of her IOP Hearing until 29th April 2010**
- **Section 4.10 Letter dated 26th April 2010 accompanying Expert Witness report from Professor Bouloux**

3.1.7 GMC Counsel revealed the identities of the Partners and also of Patient X during the course of his public presentation.

(I) Mr. Gary Summers, Counsel for the GMC, presented his case in such a way as to reveal the identities of both the Partners and Patient X to a determined observer. This knowledge is now public. The most relevant paragraph in Mr Summers' presentation is reproduced below but there are other examples within his presentation where basic errors in the protection of the Partners' and Patient X's identities were made.

"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 suffer of – and I am going to use the letter "B" – of juvenile [B's] disease."

(II) The effect on the IOP decision is that the GMC has broken its duty of care to patients and complainants in preserving their public anonymity. Mr. Gary Summers' presentation is in the public domain. There is little that can now be done to undo this breach of trust by the GMC in terms of the position of the Partners and Patient X but this cavalier approach by the GMC to its general duties of care do cast doubt on how seriously the GMC takes its other more specific duties such as the conducting of thorough and fair investigations. It is concluded that when the weight of evidence of other points contained herein is considered, this lack of exercising by the GMC of its duty of care in this instance should be taken into account.

(III) Evidential documentation attached at section 4.11 is a copy of Mr. Gary Summers' presentation. In addition the decided cases of H (a Health Care Worker) v Associated Newspapers Ltd and H (a Health Care Worker) v N (a Health Authority) came to the conclusion that:

'Where information can identify a particular patient because their symptoms are very rare or the patient is one of a very small community, an obligation of confidence would be owed.'

This case applies directly to Patient X and so confidentiality was both owed to Patient X and also not granted by GMC Legal Counsel. It can be concluded that Mr Gary Summers did break his duty of care of anonymity to Patient X. A summary of this case is included at section 4.37.

3.1.8 Full consideration by the Panel of the level of support for SM was not given

(I) SM submitted thousands of emails, letters and online petition comments in her support to be used as evidence by the Panel. In her letter to the GMC of 5th May 2010 (section 5.1) SM asked for confirmation that the Panel had had sufficient time to read and digest these many comments from patients and members of the general public alike. SM also asked when Panel members first saw these letters, emails and petition comments and when they were read – see section 5.3. In response, Neil Marshall, in his letter of 27th May 2010 – see section 5.4 – responded that:

"I can also confirm that we did include, in the information put before the Panel, all letters received by us (in good time before the hearing) in support of your case."

It will be noted that Mr. Marshall has not fully answered the question. There has been no confirmation by the GMC that these letters were full taken into account by the IOP in its deliberations and indeed this seems highly unlikely in view of the volume of comments made and the speed with which a decision was arrived at.

(II) Without these letters, emails and petition comments of support having been properly read and digested, SM did not receive a fair Hearing. Unless and until receipt of signed affidavits from each member of the Panel that they had read, digested and taken into account these thousands of comments of support is received, the IOP decision should be set aside. In this context, also, full consideration of the Patient Experiences Document should be given, where not only letters of support are included but also details from patients and the general public alike of the adverse effects on their health that have resulted from the restrictions placed on SM's medical practice by the IOP decision.

(III) The online petition can be found at:

http://www.ipetitions.com/petition/witchhuntofdrsarahmyhill/signatures

and a copy of all the letters and emails of support can be provided if necessary. The Support Dr Sarah Myhill facebook group can be viewed at

http://www.facebook.com/home.php?#!/group.php?gid=108048875899603&ref=ts

See also sections 5.1, 5.3 and 5.4 for correspondence on these issues.

3.1.9 SM has the right to be judged by her peers

(I) SM has a right to be judged by her peers. Professor Bouloux, by his own admission, has no expertise in the diagnosis and treatment of either chronic fatigue syndromes or mitochondrial disorders. Indeed he states that he refers this group of patients to specialists rather than treat them himself. Within the GMC case notes on SM there is a piece of advice dated 16th February 2010 from an expert GP witness which states that:

"..did not have sufficient knowledge of CFS to be in a position to answer questions posed and that in view of Dr Myhill's background he feels that the GMC should instruct an expert not just with mainstream knowledge of CFS but an expert with a special knowledge or interest in CFS"

By instructing Profesor Bouloux who is neither expert in nor has a special interest in CFS, the GMC has ignored its own expert advice. Indeed the GMC are confused about the manner in which SM should be assessed and the standard against which she should be judged. In his case notes, the relevant Case Examiner states that:

"Dr Myhill has provided opinions which would not be supported by the wider medical profession."

This is not the standard against which SM should be judged. It is a defence in law that if a doctor practises a technique which is generally accepted by his peers, then that is sufficient. 'Peers' are defined not by reference to the '*wider medical profession',* as the GMC has done so but rather by reference to *'a responsible body of medical opinion'* as defined by the Bolam principle. The Bolam principle is laid out below:

Bolam v Friern Hospital Management Committee [1957] 1 WLR 583 is an English tort law case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals (e.g. doctors): the "Bolam test". Where the defendant has represented him or herself as having more than average skills and abilities, this test expects standards which must be in accordance with a responsible body of opinion, even if others differ in opinion. In other words, Bolam test states that "If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent"

This test is passed even in the presence of others who '*differ in opinion'.* SM's peers are the group of doctors involved in the practice of allergy, environmental and nutritional medicine. It is from within this group of doctors that the GMC should have sought expert witness reports. These doctors certainly represent a responsible body of medical opinion and are best placed to judge SM's practicing of medicine.

(II) The GMC has made two crucial errors in its assessment of SM by the expert witness report of Professor Bouloux:

1---It has not followed its own received expert advice that the assessment should be made by a doctor expert in the field of CFS

2--- It has not followed the Bolam Principle in determining whether SM's practice is negligent by making that assessment against the *'wider medical profession'* rather than against *'a responsible body of medical opinion'.*

The effect of these errors is to render the expert witness report by Professor Bouloux inadmissible and so this report should be set aside. This in turn has the effect of rendering the GMC case effectively without corroborative evidence (as noted in section 3.2.2). This has the direct corollary that the IOP decision should be set aside both because of the procedural errors made by the GMC in its obtaining of expert witness evidence and also because of the impact this has on the corroborative evidence base for the case against SM – that is to say, such evidence base is effectively withdrawn.

(III) The evidence base for this point is:

- **4.13 Professor Bouloux's Expert Witness report**
- **4.14 GMC case notes dated 16th February 2010- advice from GP expert concerning the selection of an expert witnes**
- **4.15 GMC case notes regarding the basis against which SM should be judged**
- **4.15A Expert Witness Reports authored by Dr David Freed, Professor Martin Pall and Dr Norman Booth.**

In addition, these points are discussed at length in the correspondences at sections 5.1, 5.2, 5.3, 5.5, 5.6, 5.7 and 5.9.

<u>3.1.10 Underlying Principles of GMC's extent of jurisdiction.</u>

(I) The complaints against SM arise from the belief that her treatments do not conform to National Guidelines, in the case of the website complaint, and that SM's recommended treatments in the case of the B12 complaint were off licence and therefore in some way not generally recommended. In a letter to SM, dated 7th August 2006, Neil Jinks, then GMC Assistant Registrar, stated that:

"It is not the place of the GMC to take a position on the correctness or otherwise of generally recommended or of possible 'cutting edge' treatment……"

Professor Wendy Savage, erstwhile elected member of the GMC Council from 1989 to 2005, wrote a book concerning her experiences with the GMC principles regarding the above point. In that book, 'A Savage Enquiry' she states that:

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

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

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

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

The Blue Book 1990 included an identically worded section.

(II) The GMC is acting outwith its capacity of jurisdiction. These complaints are based on disagreements with SM about the correctness or otherwise of '*generally recommended or of possible cutting edge treatment*' and judgement on this is not within the remit of the GMC as evidenced above. Given that the GMC is acting outwith its capacity, the IOP decision should be set aside in its entirety.

(III) The evidence base for this point is contained within:

- **Section 4.16 Letter dated 7th August from Neil Jinks (GMC) to SM**
- **Copies of the Blue Book or Wendy Savage's book will be made available should this be necessary.**
- **Section 4.17 Letter to Adam Elliot (GMC) dated 15th May 2010**

In addition see correspondences at sections 5.3 and 5.9.

<u>3.1.11 Patient X's notes were taken without their permission or knowledge</u>

(I) A number of issues have arisen concerning this point.

- **(a) The GMC has not disputed that it has taken Patient X's medical notes without their permission. Instead the GMC has argued that this practice is in no way improper. Indeed, in his letter of 27th May 2010 (see section 5.4), Neil Marshall comments that:**

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

Mr Marshall continues in his letter of 16th June 2010 (see section 5.6) with the comment that:

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

Notwithstanding for the time being whether the GMC is correct in its assertion, the manner in which this access of information was carried out did not even comply with internal GMC Disclosure requirements. In a letter from Dr Y of the Partners to Mr Bridge (GMC) dated 1st September 2009 the following point was made:

"I enclose the completed Disclosure Consent Form. You will see that I have not completed sections (6) and (7). The patient is not capable of understanding the matter, and his mother has not expressed dissatisfaction with Dr Myhill. We understand we have a professional obligation to bring the matter to your attention nonetheless, however unpleasant that action may seem to us. As requested I enclose anonymised copies of the medial records, and of all other documentation".

Dr. Y filled in the GMC Disclosure Consent Form improperly. Dr. Y failed to complete paragraph 6 or 7. He has failed to get the approval of the patient's mother. She had no idea the GP was complaining, she had no idea that her son's private and confidential medical records were being sent to the GMC. Furthermore, there is no letter of consent from the patient's mother. So, even if the GMC argument regarding the justification for the removal of Patient X's notes without their permission is correct, the internal GMC procedures for doing this were not properly followed.

- **(b) Putting aside for the time being the correctness or otherwise of the GMC action in this context, the fact that the GMC used Patient X's notes in its prosecution raises a further issue of the unfairness of the trial. SM asked permission quite properly and correctly to use her own private medical notes on Patient X for her defence case. This permission was denied on the grounds that the patient's mother did not want her son's identity potentially to be compromised. At this time, the patient's mother did not realise that the GMC had already taken her son's notes without any permission, knowledge or without even having followed their own internal procedures properly. This meant that there was an asymmetry in the evidence available to the GMC and that available to SM at the Hearing. This compromised SM's defence because she could not repudiate claims made concerning Patient X's medical notes as this would have meant her going against the wishes of her patient and his mother. This is manifestly unfair and contrary to Natural Justice.**

- **(c) Returning now to the correctness of the GMC assertion that it can access notes in this way under provisions in the Medical Act 1983 (the 'Medical Act'). The fact that the Medical Act is contrary to certain subsequent legislations is well documented. Indeed, Mr Marshall states in his letter of 16th June 2010 (see section 5.6) that**

"..it would be open to any party offended by our use of personal information in our fitness to practise procedures to make a case before the Courts…"

As Mr Marshall knows full well, this would be a line open only to those with very deep pockets, which SM does not have. However, further to the general point, there are two

issues which should be considered. The taking of confidential medical notes in this way is almost certainly contrary to the Data Protection Act and likewise almost certainly breached Patient X's rights under Human Rights legislation. It is neither within the remit of this case nor within the power of SM to challenge such wide-ranging issues but these factors should be taken into account 'in the round'. The fact that the Office of Health Professions Adjudicator ('OHPA') has been set up (see http://ohpa.org.uk/) is further evidence of these issues with the Medical Act. OHPA will have the function of being responsible for taking decisions on fitness to practise cases brought by the GMC, amongst others. This is a direct response to the fact that the provisions under the Medical Act breach Human Rights legislation in that a defendant is prosecuted, judged and sentenced by the same agency, namely in this case, the GMC.

(II) Taking each point in turn:

(a) The GMC has not properly followed its internal procedures for the use of confidential patient notes and so the use of these notes in this Hearing should not have happened. Striking these notes and the use they were put to from the evidence submitted by the GMC in its prosecution renders the GMC case regarding the B12 complaint untenable. Therefore the B12 complaint should be set aside.

(b) The unfairness in the utilisation of Patient X's private medical notes renders the Hearing unfair to the extent of the B12 Complaint. Therefore the B12 complaint should be set aside.

(c) Note should be taken of the possible illegality of GMC actions with regard to Data Protection and Human Right legislation. It is not possible for SM to contest this but this point is one which should be taken into account, particularly with respect to comments made in section 3.3.

(III) The evidence base for these points is as follows:

- **Section 4.18 Letter from Dr Y of the Partners to Mr Bridge (GMC) dated 1st September 2009**
- **Section 4.19 http://ohpa.org.uk/**

In addition, see correspondences at sections 5.1, 5.2, 5.3, 5.4, 5.5, 5.6 and 5.7

3.1.12 Hearing Proceedings were flawed and unfair in that neither cross examination nor the calling of witnesses was permitted.

(I) No partner from the Partners, and in particular Dr Y (see section 3.2.1), was present at the Hearing for cross examination. Professor Bouloux was not present for cross examination of his flawed Expert Witness report. Of course, the website complainant, being anonymous, was not present for cross examination. SM asked for Dr Y to be subpoenaed to attend the Hearing but this request was denied. SM asked for Professor Bouloux to be present at the Hearing and this again was denied. Many requests were made for persons relevant to the Hearing to be present, for example an email from SM to

Mr Paul Bridge (GMC) dated 21st April 2010 requested the presence of Dr Woods. This again was refused and SM was told that only the GMC could subpoena witnesses.

(II) The lack of relevant witnesses being available for cross examination renders the Hearing unfair. Evidence used by the prosecution for its case was not capable of being challenged in any meaningful way and evidence vital for SM's defence could not be adequately presented without the presence of key witnesses. In addition, the asymmetry in the power of the GMC to subpoena witnesses juxtaposed with SM's inability to do so renders the Hearing procedurally unfair. As a consequence of this unfairness, the IOP decision should be set aside in its entirety.

(III) The evidence base for this point is as follows:

- **Section 5.3 L and M**
- **Section 4.21 Email from SM to Paul Bridge (GMC) dated 21st April 2010**
- **Section 4.22 GMC records of attendees at the IOP Hearing**

In addition a detailed appendix of the requests for attendance and the denials received or otherwise is included at section 4.35-- Correspondence exchanges regarding the attendances of witnesses for cross examination

<u>3.1.13 The prescription only medicine restriction placed on SM by the IOP is illogical and disproportionate.</u>

(I) Whilst disagreeing with the procedures followed and evidence based used in arriving at its conclusions, the IOP requirement for SM to take down certain web pages is at least logical and proportionate to the complaint made, even though it has been shown that this complaint should be set aside. However, the restriction that SM should not prescribe prescription only medicine, as detailed in the British National Formulary (BNF), is wholly illogical and totally disproportionate. The concerns, even if taken to be true, raised by the complainants do not involve SM inappropriately prescribing medicines from the BNF. The web pages complained about and the B12 complaint do not implicate SM at all in the wrongful prescribing of prescription only medicines.

(II) The illogical and disproportionate nature of the restriction on SM from prescribing prescription only medicine is such that this restriction should be lifted.

(III) The evidence base for this point is as follows:

- **Section 4.1 Letter from Rebecca Townsley (GMC) dated 7 April 2010, and supporting documentation, detailing the nature of the complaints against Dr Myhill**
- **See also sections 5.1, 5.2, 5.3 and 5.5 where this point is repeatedly raised**
- **Section 4.23 List of GMC cases demonstrating the inconsistency of the IOP prescription sanction against SM**

3.1.14 The letter of instruction from Ms TS, GMC Legal Department to Professor Bouloux is littered with factual inaccuracies.

(i) The said letter of instruction contained so many errors as to make it inadmissible. The full detail of the errors is laid out in the letter referenced in the evidence section below. However, by way of example as to how poor the construction of this document was, the following comment was made by Ms TS to Professor Bouloux:

"*In this letter I set out some instructions for you to provide your opinion on whether the doctor's actions and treatment fell short of what could be expected of a reasonably competent Consultant Anaesthetic and if so in what ways and to what extent*" (sic).

and also

".....if the facts alleged against Dr Myhill are proved, his fitness to practise is impaired to a degree that would justify action on his registration.....

Dr Myhill is described as a male consultant anaesthetic. This may seem laughable but when taken with all the other factual errors listed in the evidence letter, it becomes apparent that the letter of instruction for Professor Bouloux was wholly inadequate.

(ii) Given the level of factual errors in Ms TS's letter of instruction, Professor Bouloux's Expert Witness should be set aside and given that this is the only evidence produced by the prosecution team regarding the B12 complaint, that complaint also should be set aside.

(iii) The evidence base is:

- **Section 4.28 Letter from SM to Ms TS dated 14 August 2010**

In addition a complaint has been made by SM to the Bar Council concerning Ms TS's conduct in this matter. At present this matter is under investigation. Any developments will be presented to the IOP as and when they arise.

3.1.15 Professor Bouloux's Expert Witness report does not follow GMC guidance on Expert Witness Reports

(i) Professor Bouloux has broken virtually every one of the guidelines contained within the GMC document 'Guidance on acting as an Expert Witness'. This breaching of the guidance is laid out in detail in the letter from SM to Scott Geddes, Head of Investigations GMC, noted below as section 4.32. SM has asked the GMC to investigate Professor Bouloux's actions in this respect. In addition, it reflects poorly on the GMC that they accepted this Expert Witness report given its lack of compliance with its own guidance document. Professor Bouloux's only defence would be that the letter of instruction from Ms TS, GMC legal department, was so poor (see section 3.1.14) that he was ill-instructed and acted accordingly.

(ii) Given that the Expert Witness report from Professor Bouloux does not conform to GMC guidance on such matters, it should be set aside. Given further that this report is the only evidence base for the B12 complaint, this complaint also should be set aside.

(iii) The evidence base is contained in

- **Section 4.32 Letter from SM to Scott Geddes, Head of Investigation GMC dated 1 September 2010 asking for Professor Bouloux to be investigated by the GMC for not following Expert Witness report guidance.**
- **Section 4.33 GMC Guidance on the production of Expert Witness reports**

3.2 EVIDENTIAL DEFENCE POINTS

3.2.1 The B12 complaint is based on an untruth

(I) In his letter of complaint to the GMC of 18th June 2009 Dr Y of the Partners states that:

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

However, in Patient X's medical notes there is a letter dated 4th March 2009 from Dr P of the Partners to the district nurse at K Road Health Centre stating that:

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

It is clear then that the Partners' B12 complaint is based on an untruth about the actual facts of the complaint. Making an untrue complaint is also vexatious as detailed in the GMC rules noted at section 3.1.2 above and so the GMC has also broken its own rules on vexatious complaints by even accepting to investigate this complaint meaning that this point is a procedural defence as well as evidential.

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

(III) As evidence of this point the relevant letters noted above are included as

- **section 4.5 – letter of complaint by Dr Y of the Partners dated 18th June 2009**
- **section 4.6 – letter from Patient X's medical notes dated 4th March 2009**

Further letters have been exchanged between SM and the GMC on this point and these are included here for the sake of completeness

- **Section 4.29 Letter, dated 17 July 2010, from SM to Stephen Farnworth, Investigation Manger at the GMC, complaining about the dishonest behaviour of the Partners in this respect and requesting a GMC investigation of this matter.**
- **Section 4.30 Further letter from SM to Stephen Farnworth, dated 1 September 2010, making further legal points on the definition of dishonesty.**
- **Section 4.31 Email from Neil Marshall, GMC, dated 5 September 2010 which incredulously makes the following statement:**

'…it is not my intention to engage in any further semantic debate about the meaning of the word 'dishonesty'

The definition of dishonesty is key to this complaint and for Mr Marshall to refuse to discuss it seems rather churlish.

The full arguments with respect to this point are summarised in the most recent letter by SM to Adam Elliot, GMC, dated 15 September 2010 and this is attached as further evidence:

- **Section 4.34 Letter dated 15 September 2010 from SM to Adam Elliot**

The definition which Mr Marshall was not prepared to discuss the semantics of is as follows and is taken from the decided case, R v Ghosh (1982) 75 CR App. R. 154, which is considered the defining case law on the definition of dishonesty in English Criminal Law:

- *"Were the person's actions honest according to the standards of reasonable and honest people?" If a jury decides that they were, then the defendant's claim to be honest will be credible. But, if the court decides that the actions were dishonest, the further question is:*
- *"Did the person concerned believe that what he did was dishonest at the time?"*

Sections 4.30 and 4.34, as noted above, show how the Partners pass both of these tests. Moreover, this definition of dishonesty is accepted by the GMC, despite Mr Marshall's protestations. Here is an excerpt from the Publishable Minutes of the FITNESS TO PRACTISE PANEL dated 9-11 June 2010 concerning Dr Asim Raza Zaidi in which the following definition of dishonesty was used:

The Panel has accepted the advice given by the Legal Assessor with regard to the definition of misleading and the test for dishonesty. The Legal Assessor advised the Panel that, when considering the issue of dishonesty, the Panel should apply the following two stage test:

1. *Was what the doctor did dishonest by the ordinary standards of reasonable and honest people?*

2. *Did the doctor realise what he was doing was dishonest by those standards?*

It can be seen that this is exactly the test that has been applied by SM to the Partners. The full text of these minutes is included at section 4.36.

3.2.2 The GMC did not obtain either adequate corroborative evidence for, or confirm the credibility of, the complaints nor did they ascertain the credibility of the website complainant himself.

(I) Under GMC Imposing Interim Orders: Guidance for the Interim Orders Panel and Fitness to Practise Panel April 2008 Annex 9 (see section 4.12) it is stated that:

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

Regarding the B12 complaint, the actual veracity of the complaint is refuted in section 3.2.1 indicating that there must be a lack of valid corroborative evidence. In addition Professor Bouloux's Expert Witness report (see section 4.13), which was used as corroborative evidence, is discussed at length in section 3.1.9 above and has been shown to be inadequate for this purpose. Furthermore, the GMC has not responded adequately to requests by SM for details as to how it confirmed the identity of the website complainant – see sections 5.1, 5.3 and 5.4 for SM's question and the lack of an appropriate answer from the GMC. In addition, the GMC has refused to obtain a Declaration of Interest from the website complainant on the basis of confidentiality - see section 5.3. The combination of no evidence from the GMC confirming this complainant's actual identity coupled with the lack of a Declaration of Interest renders this complainant not credible. This is because neither his credentials nor his motivation for the complaint have been established. This is discussed in more detail in section 4.4, where it is argued that the fact that it is not known whether the website complainant is complaining in his own right or on behalf of a third party adds to the sense that this is a vexatious complaint – see section 3.1.2. The motivation for a complainant is a significant factor in his credibility and therefore the credibility of the complaint itself. The GMC has not performed sufficient checks to determine either the motivation of the Partners, in submitting a complaint which has an untruth at its core, or of the website complainant as already discussed and pointed out at length in section 4.4.

(II) The B12 complaint is not credible, primarily because it has at its core an untruth. The website complaint is not credible because the credentials and motivation of the complainant have not been established by the GMC despite repeated requests by SM. In addition, the corroborative evidence in the form of Professor Bouloux's report has been shown to be inadequate. Therefore, the IOP should not have been called because the GMC did not follow its own internal procedures in the context of Annex 9 above. In these circumstances the IOP decision should be set aside. In this context, also, full consideration should be given to the Medical Reports Document, where a full scientific evidence base supporting SM's medical practice has been accumulated.

(III) The evidence base for this conclusion can be found at

- **section 4.4 Letter from SM to Elizabeth Hiley (GMC) dated 17 July 2010 concerning the vexatious nature of the website complaint**
- **section 4.12 GMC Imposing Interim Orders: Guidance for the Interim Orders Panel and Fitness to Practise Panel April 2008 Annex 9**
- **section 4.13 Professor Bouloux's Expert Witness report**

and also in sections 5.1, 5.3 and 5.4.

<u>3.2.3 GMC records of previous failed cases against SM contain many factual errors.</u>

(I) The full list of these factual errors can be found at sections 5.7 A, B and C and 5.8 B.

(II) The existence of these evidential errors means that the Panel based its decision and findings on an inaccurate evidence base. These records are relevant to the case before SM for the same reasons as expounded in section 3.1.1 and so if they were not presented to the Panel then that in itself would constitute a procedural error, also. This has the effect that either the IOP decision should be set aside, if these records were presented to the Panel, because the data record which the Panel based its decision on was inaccurate, or that the IOP decision should be set aside, if these records were not presented to the Panel, because the proper procedures of presenting a full GMC past history to the Panel had not therefore been followed. It should be noted that in the latter case, that of non-disclosure to the Panel, it is not just a case of the GMC having not followed proper procedures but also that vital positive evidence in SM's favour was thereby denied to the Panel. For example the following quote is from Mr Tom Kark GMC legal adviser on previous cases:

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

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

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

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

(III) The evidence base for this point is as follows:

- **Section 5.7 and section 5.8 B. References to other documents within these two sections are made and should the production of these other documents so mentioned be required then this shall also be done and will in this case represent a second layer of evidence base.**
- **Section 4.20 Internal GMC memo dated 10th February 2006**

- **In addition, other evidence of positive supportive comments within these previous cases date records can be produced if so required.**

3.2.4 GMC records of the current case against SM contain many factual errors.

(I) The full list of these factual errors can be found at sections 5.7 D and 5.8 A and D

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

(III) The evidence base for this point is as follows:

- **Section 5.7 D and section 5.8 A and D. References to other documents within these two sections are made and should the production of these other documents so mentioned be required then this shall also be done and will in this case represent a second layer of evidence base.**

3.2.5 The Website complaint is based on a false assumption

(i) As noted in section 3.1.2, the website complaint is based on a personal belief system. This complainant believes that NICE guidelines are in some way mandatory and that doctors who do not abide by them should be investigated for malpractice. This is not the case. Letters have been received from both NICE and the Department of Health stating that NICE guidelines are guidance only. In particular the letter received from NICE states that:

'NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales. Clinical guidelines represent the view of NICE, and are arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.'

And the letter from the Department of Health states that:

'It is important to emphasise that the National Institute for Health and Clinical Excellence (NICE) clinical guidelines are just that – guidelines for healthcare professionals. The guideline emphasises a collaborative relationship between clinician and patient and recognises there is no one form of treatment to suit every patient but that what is needed is a personalised, holistic approach.'

(ii) The website complaint is based on a false assumption and should be set aside.

(iii) Evidence is contained in

- **Section 4.25 – Letter from Teresa Birch, NICE, to Pat Endicott.**
- **Section 4.26 – letter from Kay Ellis, Department of Health Officer, to Invest in ME charity dated 28 May 2010**

3.2.6 Concerns regarding the website are medically out of date

(i) The website complainant made complaints about many pages of the website. Notwithstanding the comments made in section 3.2.5 above, these complaints can be shown to be medically out of date. For example regarding the complaint about breast cancer screening contained in the website, the following was reported in the Belfast Telegraph on 4 August 2010:

'Breast screening harms as many as it saves: report

Wednesday, 4 August 2010

- *The UK's national breast screening programme is harming almost as many women as it helps and must be urgently re-evaluated, a review in England has claimed.*

The benefits of breast screening — early detection of cancer followed by rapid treatment — are finely balanced against the harms of over-diagnosis followed by unnecessary treatment and suffering, the review says.

Breast screening has divided the medical establishment for more than 20 years.

The central drawback of screening is that in some cases the cancer (or other disease) detected does not need treating, either because it is a false alarm, because it resolves naturally or because it is very slow growing (so you die of something else).

Supporters say it prevents an estimated 1,400 deaths a year. They claim that breast screening saves two women's lives for every one who gets unnecessary treatment.

Critics dispute these figures, claiming that for every woman saved, as many as 10 undergo unnecessary treatment.

Last March, the British Medical Journal (BMJ) published a paper on breast screening in Denmark which showed that deaths had fallen faster in areas without screening.

Researchers were accused of "undermining trust".

Fi Godlee, editor of the BMJ, asked Professor Klim McPherson, public health epidemiologist of Oxford University, to review the evidence, and the results are published in the BMJ's current issue.

Prof McPherson, citing US evidence, says breast screening reduces the death rate by 14% in the under-60s — "marginal statistical significance" — and by 32% in under-70s. But this is a small benefit because at age 60 the risk of death from breast cancer over the next 15 years is just 1.2% — 259 women in the UK would have to be screened to avoid one death.

He calls for a "full examination of all the data" and more honesty from the NHS about the scientific uncertainties. '

(ii) Claims made by the website complainant were lacking in foundation in the first place given the comments made in section 3.2.5 but in addition, even if these claims were accepted as justified complaints to be made, they are medically out of date and so should be set aside. This has the effect that the website complaint itself should be set aside.

(iii) Evidence base for this is contained within

- http://www.belfasttelegraph.co.uk/news/health/breast-screening-harms-as-many-as-it-saves-report-14897265.html
- **Section 4.27 BMJ paper, dated March 2010, on breast screening in Denmark**

3.3 CONCLUSION

3.3.1 General

Each of the individual points above come to their own separate conclusions ranging from setting aside the IOP decision in its totality through to setting aside one or other of the complaints subject to the submission of various required documentation through to the required receipt of certain reassurances from the GMC. Whether or not any or all of these points are considered valid, there is one further point to be made. The summation of so many procedural and evidential points, even if not absolute evidence in their own individual right, indicates that this IOP Hearing was poorly run, with GMC internal procedures not followed, that good practice in general was not followed, that there was a very poor evidential base and that possible issues with Data Protection and Human Rights legislation exist. In this context alone, the IOP decision should be set aside on the basis of unfairness to SM.

3.3.2 Special Relevance of section 3.2.3 and 3.2.4 to an Appeal Hearing.

All of the above procedural and evidential points are relevant both to the overturning of the IOP decision as it stands but also to any future Appeals. In particular, it is essential that the errors noted in section 3.2.3 and 3.2.4 are corrected before any future Hearings because it is absolutely necessary that the data record which forms the foundation of the evidence base upon which the Panel will base future decisions is accurate.

SECTION 4 – APPENDICES

Section 4.23 List of GMC cases demonstrating the inconsistency of the IOP prescription sanction against SM

DR JANE BARTON

BRIEF SUMMARY – Dr Barton was investigated over 12 years for the deaths of 92 patients in her care of which 5 were clearly shown to be due to morphine overdose. At her Hearing on 29th January 2010, she lost her rights to prescribe opiates for the next three years, whilst ALL other drug prescribing was permitted. This shows just how draconian and inconsistent the decision to lift all of SM's prescribing rights is, in a situation where no harm to patients, let alone death, has been proven against SM.

[GMC CASE REFERENCE- 1587920]

DR STUART RUTHVEN

BRIEF SUMMARY –In 2003, the then Royal Navy surgeon was convicted of making indecent photographs of children. He was sentenced to an 18-month community rehabilitation order and made to sign the Sex Offenders Register for five years. A review panel of the General Medical Council (GMC) ruled that Dr Ruthven could continue to practise, with the condition he did not treat under-16s. But in December 2008 that condition was revoked, meaning that he can now work with children.He has since worked at Alder Hey Children's Hospital. Children's charity Kidscape says they have grave concerns about the medic's freedom to practise. Director Claude Knights said: "The possession of indecent images of children represents a vile crime, which is even more despicable when the perpetrator is a doctor. The downloading of indecent images of children is never a victimless crime and encourages this deplorable trade. Some people would question whether this doctor's sentence reflects fully the horror of his crimes."

DR MICHAEL ORMISTON

BRIEF SUMMARY - A Dr Ormiston performed a botched operation which resulted in the death of 27 year old Louise Field. However, Dr Ormiston walked away from a General Medical Council hearing. Ms Field died two days after vascular surgeon Dr Michael Ormiston accidentally punctured her lung and pumped gas into her stomach at the BUPA Hospital, Harpenden, Herts. Dr Ormiston admitted making inaccurate records after the operation and the GMC panel noted that he had committed "significant departures from good medical practice". The panel cleared him, however, of serious misconduct and found that his fitness to practise was not impaired. The panel also decided against issuing the surgeon with a warning.

DR SINHA

BRIEF SUMMARY – Dr Suman Sinha, who admitted making mistakes after a feeding tube was accidentally inserted into a man's lung instead of his stomach, was cleared of misconduct by the GMC .Dr Suman Sinha failed to spot the tube was in the wrong place when she checked Benjamin Richards' X-ray. Mr Richards, 48, started coughing, but nurses continued with the feed for two hours until the error was discovered. He was transferred to the high dependency unit at the now closed Oldchurch Hospital, but died of severe pneumonia several days later. The General Medical Council heard Dr Sinha made the decision to begin feeding after checking an X-ray on October 26, 2004. She then wrote in the notes: "The naso-gastric tube is in the correct position. It's a little high and needs to be pushed down a little further."

Dr Freddy Patel

Newspaper Seller Ian Tomlinson, Deadly Police Battering
(Caption & Pic Courtesy Of One Click)
The Home Office pathologist criticised for suggesting the newspaper seller Ian Tomlinson died of a heart attack during the G20 protests in 2009 has been suspended from practice for three months. The disciplinary ruling imposed by the General Medical Council on Dr Freddy Patel came after he was found guilty of misconduct or "deficient professional performance" in three earlier autopsy cases. The Crown Prosecution Service subsequently announced that its lawyer reviewing evidence in the Tomlinson case would now "consider the GMC's findings". Tomlinson died after being struck and shoved to the ground by riot police during protests in the City of London in April 2009. Patel was the first pathologist to examine his body. Patel said Tomlinson died of a heart attack, implying that his death was due to natural causes. A second examination contradicted that finding, suggesting instead that the newspaper vendor had died from internal bleedi ng. In July Keir Starmer QC, the director of public prosecutions, announced that no charges would be brought against any police officers. The latest CPS move stops short of suggesting it will reopen the whole file into Tomlinson's death.
Owen Bowcott, The Guardian

SECTION 5 – SELECTED CORRESPONDENCE