FITNESS TO PRACTISE PANEL OF THE
MEDICAL PRACTITIONERS TRIBUNAL SERVICE
17 OCTOBER – 2 NOVEMBER 2011
6 AUGUST – 8 AUGUST 2012
7th Floor, St James's Buildings, 79 Oxford Street, Manchester, M1 6FQ

Name of Respondent Doctor:	Dr Andrew John WRIGHT
Registered Qualifications:	**MB ChB 1983 University of Sheffield**
Area of Registered Address:	Lancashire
Reference Number:	2825184
Type of Case:	New case of impairment by reason of: misconduct
Panel Members:	Mrs Polly Clarke Chairman (Lay) Dr Paul Srinivasan (Medical) Mr Vaughan Bruce (Lay)
Legal Assessor:	Mr Andrew Reid (17 October – 2 November 2011) Mr David Potts (6-8 August 2012)
Secretary to the Panel:	Ms Olivia Pennelle (17 October – 2 November 2011) Miss Patrizia Gargiulo (6-8 August 2012)

Representation:

GMC: Mr Jeremy Donne QC, Counsel, instructed by GMC Legal, represented the Council (17 October – 2 November 2011); Mr Julian Evans, Counsel, instructed by GMC Legal, represented the Council (6-8 August 2012)

Doctor: Present and represented by Mr Malcolm Fortune, Counsel, instructed by RadcliffesLeBrasseur, solicitors

ALLEGATION

"That being registered under the Medical Act 1983, as amended:

1. You have been a General Practitioner since 1987;
Admitted and found proved

2. Between April 2003 and May 2006 you ran a private practice in Bolton, Lancashire, specialising in the management of fatigue disorders;

Admitted and found proved

Patient A

3. Patient A first consulted you in or about April 2003;
Admitted and found proved

4. You instructed the Bowen Research & Training Institute in Florida, USA ("Bowen") to test a sample of the patient's blood despite

a. Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing,
Admitted and found proved

b. Bowen operating as a research laboratory only,
Admitted and found proved

c. the tests conducted by Bowen not to be used for diagnostic purposes;
Admitted and found proved

5. You instructed Walter Tarello in Italy to perform an examination of a sample of the patient's blood despite

a. microscopy not being an appropriate test for tic-borne diseases such as ehrlichiosis or borreliosis,
Admitted and found proved

b. microscopy not being an appropriate method to determine whether blood samples contain bacteria;
Admitted and found proved

6. Your report of high resolution video microscopy on a sample of the Patient's blood was

a. confused,
Admitted and found proved

b. inaccurate;
Admitted and found proved

Patient B

7. Patient B first consulted you in or about June 2003;
Admitted and found proved

8. In June 2003 you diagnosed ME/CFS;
Admitted and found proved

9. In September 2004 you instructed Bowen to test a sample of the patient's blood despite

a. Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing,
Admitted and found proved

b. Bowen operating as a research laboratory only,
Admitted and found proved

c. the tests conducted by Bowen not to be used for diagnostic purposes;
Admitted and found proved

10. Your diagnosis of infection with borrelia burgdorferi was based in part upon the result of the tests conducted by Bowen;
Admitted and found proved

11. You subsequently initiated treatment;
Admitted and found proved

Patient C

12. Patient C first consulted you in or about September 2003;
Admitted and found proved

13. You carried out direct microscopy on a sample of the patient's blood to diagnose a chronic spirochaetal infection described by you as borreliosis;
Admitted and found proved

14. Your diagnosis was made despite

a. direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection,
Admitted and found proved

b. you not having adequate specialist training in microscopy;
Admitted and found proved

15. You subsequently initiated treatment;
Admitted and found proved

16. In October 2004 you instructed Bowen to test a sample of the patient's blood despite

a. Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing,
Admitted and found proved

b. Bowen operating as a research laboratory only,
Admitted and found proved

c. the tests conducted by Bowen not to be used for diagnostic purposes;
Admitted and found proved

17. On 5 November 2004 you informed Patient C the Bowen result should be interpreted as being approximately double that reported despite there being no scientific basis for such an interpretation;
Admitted and found proved

18. Your diagnosis of infection with borrelia was based in part upon the result of the tests conducted by Bowen;
Admitted and found proved

19. You subsequently initiated further treatment;
Admitted and found proved

Patient D

20. Patient D first consulted you in or around December 2003;
Admitted and found proved

21. You carried out direct microscopy on a sample of the patient's blood to diagnose a chronic borreliosis variant of Lyme disease;
Admitted and found proved

22. Your diagnosis was made despite

a. direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection,
Admitted and found proved

b. you not having adequate specialist training in microscopy;
Admitted and found proved

Patient E

23. Patient E first consulted you in or about July 2004;
Admitted and found proved

24. You carried out direct microscopy on a sample of the patient's blood to diagnose a chronic borreliosis variant of Lyme disease;
Admitted and found proved

25. Your diagnosis was made despite

a. direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection,
Admitted and found proved

b. you not having adequate specialist training in microscopy;
Admitted and found proved

26. You subsequently initiated treatment;
Admitted and found proved

Patient F

27. Patient F first consulted you in or about September 2004;
Admitted and found proved

28. In October 2004 you instructed Bowen to test a sample of the patient's blood despite

a. Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing,
Admitted and found proved

b. Bowen operating as a research laboratory only,
Admitted and found proved

c. the tests conducted by Bowen not to be used for diagnostic purposes;
Admitted and found proved

29. Your diagnosis of borreliosis was based upon

a. irrelevant and/or insufficient clinical factors,
Admitted and found proved

b. the result of the tests conducted by Bowen;
Admitted and found proved

Patient G

30. Patient G first consulted you in or about September 2004;
Admitted and found proved

31. You carried out direct microscopy on a sample of the patient's blood and claimed to identify borrelia-like spirochetes;
Admitted and found proved

32. Your diagnosis was made despite

a. direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection,
Admitted and found proved

b. you not having adequate specialist training in microscopy;
Admitted and found proved

33. In October 2004 you instructed Bowen to test a sample of the patient's blood despite

a. Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing,
Admitted and found proved

b. Bowen operating as a research laboratory only,
Admitted and found proved

c. the tests conducted by Bowen not to be used for diagnostic purposes;
Admitted and found proved

34. Your diagnosis of infection with borrelia burgdorferi was based in part upon the result of the tests conducted by Bowen;
Admitted and found proved

Patient H

35. Patient H consulted you in or about November 2004;
Admitted and found proved

36. Your diagnosis of borreliosis was based upon a fluorescent antibody test which was not generally recognised as validated for such a purpose;
Admitted and found proved

37. You subsequently recommended treatment;
Admitted and found proved

Patient I

38. Patient I first consulted you in or about December 2004;

Admitted and found proved

39. In December 2004 you instructed Bowen to test a sample of the patient's blood despite

a. Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing,
Admitted and found proved

b. Bowen operating as a research laboratory only,
Admitted and found proved

c. the tests conducted by Bowen not to be used for diagnostic purposes;
Admitted and found proved

40. Your diagnosis of borreliosis was based in part upon the result of the tests conducted by Bowen;
Admitted and found proved

41. You subsequently advised treatment;
Admitted and found proved

42. In a report to the patient dated 5 April 2005, purportedly demonstrating that Patient I was suffering from a bacterial illness, you

a. Incorrectly described the structure and function of "granular structures",
Admitted and found proved

b. Incorrectly described cell wall deficient bacteria in white cells,
Admitted and found proved

c. Incorrectly stated the role of vitamin D and angiotensin 2 in "cell wall deficient L form" bacterial illness;
Admitted and found proved

<u>Patient J</u>

43. Patient J first consulted you in or about October 2005;
Admitted and found proved

44. You carried out direct microscopy on a sample of the patient's blood to diagnose a borrelia-like spirochaetal infection;
Admitted and found proved

45. Your diagnosis was made despite

a. direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection,
Admitted and found proved

b. you not having adequate specialist training in microscopy;
Admitted and found proved

46. You subsequently recommended treatment;
Admitted and found proved

Patient K

47. Patient K first consulted you in or around March 2006;
Admitted and found proved

48. You carried out direct microscopy on a sample of the patient's blood to diagnose borrelia burgdorferi;
Admitted and found proved

49. Your diagnosis was made despite

a. direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection,
Admitted and found proved

b. you not having adequate specialist training in microscopy;
Admitted and found proved

50. Your diagnosis in paragraphs 10, 14, 18, 21, 24, 29, 31, 34, 36, 40, 44 and 48 above was based upon inadequate evidence.
Admitted and found proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct." **Found proved"**

Determination on impairment:

"Dr Wright:

At the outset of these proceedings, Mr Fortune, on your behalf, admitted each of the heads of charge in their entirety and the Panel has announced these as found proved.

The facts of this case are as follows: You have been a General Practitioner since 1987. Between April 2003 and May 2006 you ran a private practice in Bolton, Lancashire, specialising in the management of fatigue disorders.

Patient A

Patient A first consulted you in or about April 2003. You instructed the Bowen Research & Training Institute in Florida, USA ("Bowen") to test a sample of the patient's blood despite: Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing; Bowen operating as a research laboratory only and the tests conducted by Bowen not to be used for diagnostic purposes.

You instructed Mr L in XXX to perform an examination of a sample of the patient's blood despite microscopy not being an appropriate test for tic-borne diseases such as ehrlichiosis or borreliosis, and microscopy not being an appropriate method to determine whether blood samples contain bacteria.

Your report of high resolution video microscopy on a sample of the patient's blood was confused and inaccurate.

Patient B

Patient B first consulted you in or about June 2003, when you diagnosed ME/CFS. In September 2004 you instructed Bowen to test a sample of the patient's blood despite Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing; Bowen operating as a research laboratory only and the tests conducted by Bowen not to be used for diagnostic purposes. Your diagnosis of infection with borrelia burgdorferi was based in part upon the result of the tests conducted by Bowen and you subsequently initiated treatment. Your diagnosis was based on inadequate evidence.

Patient C

Patient C first consulted you in or about September 2003. You carried out direct microscopy on a sample of the patient's blood to diagnose a chronic spirochaetal infection described by you as borreliosis. Your diagnosis was made despite direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection and you not having adequate specialist training in microscopy. You subsequently initiated treatment. Your diagnosis was based on inadequate evidence.

In October 2004, you instructed Bowen to test a sample of the patient's blood despite Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing; Bowen operating as a research laboratory only and the tests conducted by Bowen not to be used for diagnostic purposes.

On 5 November 2004, you informed Patient C the Bowen result should be interpreted as being approximately double that reported despite there being no scientific basis for such an interpretation. Your diagnosis of infection with borrelia was based in part upon the result of the tests conducted by Bowen and you

subsequently initiated further treatment. Your diagnosis was based on inadequate evidence.

Patient D

Patient D first consulted you in or around December 2003. You carried out direct microscopy on a sample of the patient's blood to diagnose a chronic borreliosis variant of Lyme disease. Your diagnosis was made despite direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection and you not having adequate specialist training in microscopy. Your diagnosis was based on inadequate evidence.

Patient E

Patient E first consulted you in or about July 2004. You carried out direct microscopy on a sample of the patient's blood to diagnose a chronic borreliosis variant of Lyme disease. Your diagnosis was based on inadequate evidence and was made despite direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection and you not having adequate specialist training in microscopy. You subsequently initiated treatment.

Patient F

Patient F first consulted you in or about September 2004. In October 2004 you instructed Bowen to test a sample of the patient's blood despite Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing; Bowen operating as a research laboratory only and the tests conducted by Bowen not to be used for diagnostic purposes.

Your diagnosis of borreliosis was based upon irrelevant and/or insufficient clinical factors and evidence which were the result of the tests conducted by Bowen.

Patient G

Patient G first consulted you in or about September 2004. You carried out direct microscopy on a sample of the patient's blood and claimed to identify borrelia-like spirochetes. Your diagnosis was made despite direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection and you not having adequate specialist training in microscopy.

In October 2004, you instructed Bowen to test a sample of the patient's blood despite Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing; Bowen operating as a research laboratory only and the tests conducted by Bowen not to be used for diagnostic purposes.

Your diagnosis of infection with borrelia burgdorferi was based in part upon the result of the tests conducted by Bowen. Your diagnosis was based on inadequate evidence.

Patient H

Patient H consulted you in or about November 2004. Your diagnosis of borreliosis was based upon a fluorescent antibody test which was not generally recognised as validated for such a purpose and was insufficient evidence. You subsequently recommended treatment. Your diagnosis was based on inadequate evidence.

Patient I

Patient I first consulted you in or about December 2004, when you instructed Bowen to test a sample of the patient's blood despite Bowen not being licensed by State or Federal authorities for the performance of clinical laboratory testing; Bowen operating as a research laboratory only and the tests conducted by Bowen not to be used for diagnostic purposes.

Your diagnosis of borreliosis was based on insufficient evidence. It was based in part upon the result of the tests conducted by Bowen and you subsequently advised treatment.

In a report to the patient, dated 5 April 2005, purportedly demonstrating that Patient I was suffering from a bacterial illness, you incorrectly described the structure and function of "granular structures"; incorrectly described cell wall deficient bacteria in white cells; and incorrectly stated the role of vitamin D and angiotensin 2 in "cell wall deficient L form" bacterial illness.

Patient J

Patient J first consulted you in or about October 2005, and you carried out direct microscopy on a sample of the patient's blood to diagnose a borrelia-like spirochaetal infection. Your diagnosis was based on insufficient evidence and made despite direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection and you not having adequate specialist training in microscopy. You subsequently recommended treatment.

Patient K

Patient K first consulted you in or around March 2006, and you carried out direct microscopy on a sample of the patient's blood to diagnose borrelia burgdorferi. Your diagnosis was made despite direct microscopy not being an appropriate test for the diagnosis of Lyme disease or other borrelia infection and you not having adequate specialist training in microscopy. Your diagnosis was based on inadequate evidence.

Background

Mr Fortune, on your behalf, outlined the background to this case as follows:
There is no doubt that you are and have been a GP committed to the care of your patients both in ordinary general practice and in your out of hours work (OOH). Your knowledge of Chronic Fatigue Syndrome (CFS)/myalgic encephalomyelitis (ME) is greater than that of most of your GP colleagues.

You allowed yourself to be persuaded by clinicians who promoted the possibility of a link between CFS/ME and Borrelia burgdorferi (amongst other hypothetical microbial causes). In so doing, you did not listen sufficiently, or at all, or allow yourself to be persuaded by those clinicians who would be considered as practising in the mainstream of medicine.

In doing so, you became isolated and/or isolated yourself from those clinicians. You allowed yourself to get into a mind set, as you repeated from time to time in the course of your evidence. You did not appraise critically the evidence available to you that your views at that time on the causation of, the diagnosis and the treatment of CFS/ME were, or even could be wrong. You were misguided.

In becoming misguided, you have acknowledged that you let down your patients at a time when they were vulnerable and at a time when they were looking for hope and for a diagnosis. You have acknowledged that you put your patients at risk of harm or injury, whether actual or perceived, by your diagnostic regimens and treatment modalities. You have also acknowledged that you put your patients to unnecessary expense.

There is no doubt that you, by your actions and your then unwavering mind set, are wholly responsible for Professor M's and/or Dr N's referral of you to the GMC, something which was completely avoidable had you listened to the message given you by Professor M in December 2005.

You have however recanted, albeit late in the overall time line of this hearing. You have admitted all the heads of charge and have given evidence that not only do you now regret your actions but you now support the position set out by International Diseases Society of America (IDSA) and the British Infection Association (BIA).

Submissions

The Panel received submissions by Mr Donne, on behalf of the GMC and those by Mr Fortune, on your behalf.

Mr Donne submitted that the facts admitted are inherently sufficiently serious for the issue of impaired fitness to practise to be raised and therefore amount to misconduct. Furthermore, he submitted that the facts are to be considered in the context that they are representative of your practice for a considerable number of years, and involve a large number of patients. In essence, Mr Donne submitted that

you have practised beyond your competence, utilised inappropriate and ineffective tests to make a diagnosis and instituted or recommended inappropriate and harmful treatments. He submitted that all the experts in this case, including your own, agree that patients were harmed or were placed at risk of harm. Mr Donne listed the major criticisms of your practice in relation to CFS/ME as:

- diagnosis based on inadequate evidence including non-validated laboratory tests and inappropriate methods such as direct microscopy, for which you were, in any event, inadequately trained;
- a lack of knowledge of microbiology and infectious diseases and practising well beyond your level of competence in the field of infection;
- advising or prescribing inappropriate and potentially hazardous (and possibly even dangerous) treatments;
- your inappropriate diagnoses potentially causing further risk to patients through lost opportunities for correct diagnosis and treatment;
- providing patients, their carers and medical practitioners with inaccurate and misleading information about many aspects of Lyme disease and other infections;
- causing patients expense in the use of inappropriate and ineffective tests;
- the indiscriminate use of prolonged courses of broad spectrum antibiotics having a potentially adverse public health effects by contributing to the development of antibiotic resistant bacteria in the community;
- the creation of false hope in some of your patients;
- creating tension and, in some cases, distrust between patients and orthodox medical practitioners.

In addition, Mr Donne submitted that damage was undoubtedly caused to the standing of the profession by the conflicts that arose between patients and their orthodox medical advisors, as well as by the undermining of trust in conventional diagnostic techniques. Mr Donne submitted that, for all these reasons, your acts and omissions amount to misconduct and that such a finding is inevitable and required in the public interest.

In relation to impairment, Mr Donne submitted that your current fitness to practise must be considered in the context of your acceptance that the admitted misconduct is representative of your practice over an extensive period and in relation to a large number of patients; and, in the context of your continuing your aberrant practice despite explicit advice and warnings from Professor M, the Inspector of Microbiology and Infection Control at the Department of Health. Mr Donne submitted that, whilst you have shown some evidence of insight, you have done nothing to put things right with your former patients. In relation to remediation, he submitted that your views were deeply entrenched and apart from discontinuing your practice, no suggestion has been made as to how the misconduct can be remedied and that it has certainly not been.

In conclusion, Mr Donne submitted that the level of criticism levelled against you by the experts is of a magnitude that requires intervention to maintain professional standards and public confidence in the profession. He referred the Panel to Lady Justice Smith's fifth Shipman report [2004], and in particular her test for Panels considering impairment of fitness to practise which was recently endorsed in the case of CHRE v NMC & Grant [2011] EWHC 927 (Admin), and which asks:

> "Do our findings of fact in respect of the doctor's misconduct…show that his/her fitness to practise is impaired in the sense that s/he:
>
> a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;
>
> and/or (b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute;
>
> and/or (c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;
>
> and/or (d) has in the past acted dishonestly and/or is liable to act dishonestly in the future."

He submitted that (a), (b) and (c) are engaged in this case.

The Panel then heard submissions from Mr Fortune. He submitted that you have ceased all practice in the field of CFS/ME, microscopy in whatever form, and also all forms of alternative and/or unusual treatment modalities including long term and "pulsed" antibiotic treatment for this condition.

Mr Fortune submitted that during your oral evidence you told the Panel how over time, having stopped your practice as a GP with a special interest in CFS/ME, and having read the reports of the GMC's Experts and finally having been confronted by Professor O (KAVC) in conference, your mind set had changed. He submitted that even if scorn was poured by the GMC on this late conversion, the Panel were entitled to give such conversion very significant weight. He reminded the Panel that you have said that your former patients at your NHS Bolton clinic are now looked after by a colleague and that you will not treat such patients in the future.

Mr Fortune submitted that even if the Panel accepts the conversion, albeit late as genuine, it must then consider whether a pattern of such single minded beliefs and behaviour, whether in the field of CFS/ME or in respect of any other conditions, is likely to happen again in the future.

Mr Fortune asked the Panel to consider your assertion that you will only practise evidence based medicine, consistent with mainstream medical opinion. He stated that you have said that you want to continue with your general practice and in your OOH work.

He submitted that although the GMC has asserted that you have embarked upon a 'damage limitation exercise', it is for the Panel to judge whether your evidence demonstrated genuine insight.

Mr Fortune reminded the Panel that it has heard evidence from Dr P and Dr Q, both colleagues from Royal Bolton Hospital NHS Foundation Trust, as to how well you perform in a clinical setting and how well regarded you are regarded professionally by medical and nursing staff alike.

Finally, Mr Fortune submitted that even if the Panel concludes that your acts and/or omissions amount to misconduct, it is open to the Panel to conclude that your fitness to practise is not impaired presently given your declaration that you have had a fundamental change of mind set and that you wish to return to evidence based medicine.

Decision

The issue of impairment is one for the Panel to determine, exercising its own judgment. In reaching its decision, the Panel has noted all the evidence adduced in this case and the submissions of both counsel. The Panel has considered the need to protect patients and the public, to maintain public confidence in the profession, and to declare and uphold proper standards of conduct and behaviour.

In approaching its task, the Panel followed the test outlined by Lady Justice Smith, as referred to above.

The Panel has taken account of the advice of the Legal Assessor that in the case of Cheatle v GMC [2009] EWHC 645 (Admin), Cranston J made clear that Panels considering the question of impairment should engage in a two step process: first, they should establish whether on the facts found proved, one of more of the routes provided for by Section 35C had been established [in this case misconduct]; only if they conclude that such a route had been established, should they go on to the second step and consider whether the doctor's fitness to practice **is** impaired by reason of that route.

Misconduct:

In deciding whether your actions amount to misconduct, the Panel had regard to the case of Roylance v GMC (no 2) [2000] 1 AC 311 in which the Privy Council stated:

> "misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances."

In this regard, the Panel considered the various aspects of the GMC's publication Good Medical Practice (2001 and 2006 editions) to which it was referred by Mr Donne. The introduction to the 2001 edition states:

> "Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care…"

Paragraph 2 states:

> "Good clinical care must include:
>
> - An adequate assessment of the patient's condition, based on the history, clinical signs and, if necessary, an appropriate examination;
> - Providing or arranging investigations or treatment where necessary…"

You treated some patients without even seeing them. Professor O, an expert called on your behalf, considered that '…it was inappropriate to submit specimens from your CFS/ME patients to other unaccredited individuals or laboratories…' You accepted this criticism during your evidence and described your practice as 'bad medicine'.

Paragraph 3 of the 2001 version states:

> "In providing care you must:
>
> - Recognise and work within the limits of your professional competence;
> - Be competent when making diagnosis and when giving or arranging treatment…"

In his report, Professor O stated "You were ill-equipped technically and insufficiently trained to carry out high resolution microscopy on human specimens for diagnostic purposes…the structures you saw in whole blood preparations and that you interpreted as being spirochaetes were in fact artefacts, and that none of your CFE/ME patients in whom you diagnosed chronic Lyme borreliosis by this method had Lyme infection or spirochaetaemia or other bacterial infection…Your treatment regimens (both antibiotic and non-antibiotic) for both 'chronic Lyme disease' and for supposed Gram-positive blood infections were inappropriate, lacking in a valid base and potentially dangerous to patients…As a consequence you were placing your patients at risk and not acting in the patients' best interests."

The Panel is of the view that you failed to critically appraise where your thinking was taking you; such appraisal is particularly important when pursuing beliefs outside orthodox medical views.

Paragraph 10 states:

> "You must be honest and objective when assessing the performance of those you have supervised or trained. Patients may be put at risk if you confirm the competence of someone who has not reached or maintained a satisfactory standard of practice."

Professor O stated that the results produced by the unaccredited laboratories 'were entirely unreliable and should not have been used to diagnose active infections.'

Paragraph 12 states:

> "You must work with colleagues to monitor and maintain the quality of the care you provide and maintain a high awareness of patient safety. In particular, you must:
>
> - Take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training
> - Respond constructively to the outcome of reviews, assessments or appraisals of your performance…"

You did not work with your colleagues but chose to work in isolation in your private practice.

In relation to audit, you did not undertake any audits of your private practice.

Subsequent to a visit from Professor M on 1 December 2005 and hearing his concerns, you did not alter your practice. On receipt of his report relating to that visit, you took several weeks to read the report and persisted with your alternative course of conduct.

Paragraph 21 states:

> "Good communication between patients and doctors is essential to effective care and relationships of trust. Good communication involves:
>
> - Giving patients the information they ask for or need about their condition, its treatment and prognosis, in a way they can understand, including, for any drug you prescribe, information about any serious side effects and, where appropriate, dosage…"

You did not effectively communicate with your patients. Professor O described your letters as 'oblique' and was critical of what you now describe as 'pseudo science' in your generic explanations. The letters were described by the experts as lacking evidence and misleading.

The Panel is in no doubt that you breached each of these aspects of Good Medical Practice. This type of conduct is not in the public interest; it has put patients and the public at risk, it has damaged the public confidence in the profession, and it falls below the standard of conduct and behaviour expected of registered medical practitioners.

The Panel has determined that your actions and omissions constitute misconduct which is sufficiently serious that it can properly be described as misconduct going to fitness to practise.

Impairment:

The Panel next considered whether by reason of that misconduct your fitness to practise is impaired.

The Panel accepts that you were a good and caring doctor who, prior to the events in question, had an otherwise unblemished career. It also accepts that you were motivated by a wish to help your patients with CFS/ME. However, you chose to embark on an alternative way of practice and in doing so you closed your mind to the orthodox approach. You did not listen to mainstream medical opinion and instead chose to pursue your alternative views. These included the prescription of long term antibiotics and other unconventional treatments. The latter included the use of medilight therapy which involved the removal and reinsertion of patients' blood in a non-sterile environment; this was described as horrifying by an expert in the field of microbiology. Despite being challenged by the Inspector of Microbiology and Infection Control at the Department of Health and being told on more than one occasion of his concern about your practice in relation to CFS/ME, your diagnostic ability, your use of unlicensed laboratories and treatment regimens, you persisted with this conduct until stopped by the PCT in late 2010 as a consequence of giving undertakings.

In reaching its decision as to whether your fitness to practise is impaired by reason of your misconduct, the Panel asked itself the first three questions posed by Lady Justice Smith in her fifth Shipman report which deal with both past and future conduct. The Panel first considered those elements of the questions which deal with your **past** conduct, namely: had you in the past acted so as to put a patient or patients at unwarranted risk of harm; and/or had you in the past brought the medical profession into disrepute; and/or had you in the past breached one of the fundamental tenets of the medical profession?

The Panel had particular regard to your breaches of Good Medical Practice as set out above. It is in no doubt that your conduct in the past put patients at unwarranted risk of harm, brought the medical profession into disrepute and breached fundamental tenets of the medical profession.

The Panel next considered those elements of the questions which deal with your **future** conduct, namely: are you in the future liable to act so as to put patients at

unwarranted risk of harm; and/or liable to bring the medical profession into disrepute; and/or liable to breach one of the fundamental tenets of the medical profession?

In addressing your future conduct, the Panel had well in mind the words of Silber J at paragraph 64 of his judgment in Cohen v GMC [2008] EWHC 581 (Admin):

> "There must always be situations in which a Panel can properly conclude that the act of misconduct was an isolated error on the part of the medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired."

In addition, the Panel took account of the words of Silber J at paragraph 65 of that judgment:

> "It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

The Panel also considered paragraph 116 of the judgment of Cox J in the case of Grant:

> "When considering whether or not fitness to practise is currently impaired, the level of insight shown by the practitioner is central to a proper determination of that issue."

The Panel had the benefit of your live testimony and exercised its own judgment when considering your insight and current mindset.

The Panel noted that your misconduct was sustained over a period of years and involved a significant number of patients. It did not consider that your misconduct fell into the category of 'isolated error'.

In relation to the issues of insight and remediation, the Panel has noted your assertion that you have, albeit it late in the day, accepted that your mindset had been wrong and that you had been persuaded by the alternative view of clinicians who thought there was a link between CFS/ME and Lyme borreliosis. The Panel found your evidence to be truthful. The Panel considered that in the course of your evidence you demonstrated remorse, regret, contrition and shame. It accepted your evidence that you have closed your private practice, will not treat patients with CFS/ME and will only practice in mainstream medicine. You told the Panel that you had been 'trying to satisfy your intellectual curiosity' and that you now needed to be 'knocked off your perch'. You also stated that you needed to take a break and reflect. It concluded that you have demonstrated insight into your misconduct and it is satisfied that you have learned from this experience.

In all the circumstances, the Panel has concluded that in the future you are not liable to act so as to put patients at unwarranted risk of harm, or to bring the medical profession into disrepute or to breach fundamental tenets of the medical profession.

In considering whether your fitness to practise is currently impaired, the Panel had well in mind paragraph 62 of the judgment of Silber J in the case of Cohen:

> "Any approach to the issue of whether a doctor's fitness to practise should be regarded as impaired must take account of the need to protect the individual patient, and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour."

The Panel also noted the judgment of Ouseley J in the case of R on the application of Sharma v GDC [2010] EHWC 3184 (Admin), in which he stated:

> "The context of impaired fitness to practise is broader than a risk to individual patients… it also includes impaired fitness, whereby practice without sanction would undermine public confidence in the profession, or undermine the maintenance of proper standards of professional conduct. Impaired fitness to practise is measured by the effect which continued practice, without correction or remedy, would have on those objectives which the GDC seeks to maintain. This is the thinking within paragraph 62 of Cohen…"

Further, the Panel took account of the judgment of Cox J in the case of Grant where she stated:

> "It is essential when deciding whether fitness to practise is impaired, not to lose sight of the fundamental considerations emphasised at the outset of Silber J's judgment at paragraph 62 [of Cohen], namely the need to protect the public and the need to declare and uphold proper standards of conduct and behaviour so as to maintain public confidence in the profession."

As previously stated the Panel's conclusion is that this was serious misconduct which had put patients at unwarranted risk of harm, brought the medical profession into disrepute and breached fundamental tenets of the medical profession. Despite its finding that you are not liable in the future to present a risk to patients, bring the medical profession into disrepute or breach one of the fundamental tenets of the medical profession, the Panel concluded that in the circumstances of this case a finding of impairment is needed in the public interest and must be made in order to declare and uphold proper standards of conduct and behaviour and to maintain public confidence in the profession.

Accordingly, the Panel has determined that your fitness to practise is impaired by reason of your misconduct.

The Panel will now invite submissions as to the appropriate sanction, if any, to be imposed on your registration. Submissions on sanction should include reference to the Indicative Sanctions Guidance (revised August 2009), using the criteria as set out in the guidance to draw attention to the issues which appear relevant to this case."

xxx

Determination on sanction:

"Dr Wright:

Having found your fitness to practise impaired by reason of your misconduct, the Panel has considered what sanction, if any, to impose upon your registration. In doing so, the Panel has given careful consideration to all the evidence, oral and documentary, adduced in your case, together with Mr Evans' submissions on behalf of the General Medical Council (GMC) and those of Mr Fortune on your behalf.

Submissions by Counsel

Mr Evans submitted that your conduct warranted at least suspension based on Paragraphs 69-76 of Indicative Sanctions Guidance (April 2009, revised August 2009 and March 2012) (ISG). He also submitted that erasure may be appropriate given the seriousness of your misconduct. He submitted that the behaviour you have exhibited amounted to a serious departure from the principles set out in Good Medical Practice (GMP) and that you persisted with your unorthodox and harmful practice despite clear warnings and opportunities to stop. Your behaviour was sufficiently serious to result in concern within the Department of Health and the Health Protection Agency. Your conduct was subject to review by a panel of experts. While Mr Evans accepted that your views were also held by other practitioners in this country, he submitted that it was important the public and profession understood that practice based on the views you held fell below acceptable standards and placed patients at risk. Mr Evans also submitted that there are cases where a sanction reflecting the gravity of the misconduct should be imposed regardless of any personal mitigation in order to maintain public confidence in the profession and to uphold proper standards of conduct and behaviour. He referred to the judgment of Sir Thomas Bingham MR in Bolton v The Law Society [1993] EWCA Civ 32 who held that:

> *"Because orders made by the tribunal are not primarily punitive, it follows that considerations which would ordinarily weigh in mitigation of punishment have less effect on the exercise of this jurisdiction … All of these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence … The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is a part of the price."*

Mr Evans further submitted that the Panel would undoubtedly wish to consider the personal mitigation advanced on your behalf. He also went on to say that in the event that the Panel considers suspension to be the appropriate sanction, then issues of mitigation could be reflected in the length of the suspension which would have to be proportionate to the degree of misconduct.

Mr Fortune asked the Panel to consider the fact that you willingly admitted all the charges and also that you have accepted that you are solely responsible and are truly sorry for what has happened. He reminded the Panel of its finding that you were *"a good and caring doctor who, prior to the events in question, had an otherwise unblemished career"* and that your motivation was a wish to help patients with ME/CFS. Mr Fortune submitted that no action was appropriate in your case, relying upon Paragraph 48 of the ISG that:

> *"no action might be appropriate in cases where the doctor has demonstrated considerable insight into his/her behaviour* ***and*** *has already embarked on, and completed, any remedial action the panel would otherwise require him/her to undertake."*

Mr Fortune also submitted that the circumstances of your case were exceptional and this is one of the very rare cases where no action would be appropriate.

Mr Fortune further submitted that if the Panel decided the option of taking no action was inappropriate, then conditions should be imposed on your registration in accordance with Paragraphs 58-68 of the ISG. He submitted that given your change of attitude and your stated intention to practise only evidence-based medicine, along with the evidence that this is how you are currently practising under an order of the Interim Orders Panel, then a period of conditions would be appropriate.

Mr Fortune also submitted that a sanction of suspension or erasure would be wholly disproportionate in this case.

The Panel's deliberations

The appropriate sanction is a matter for the judgment of the Panel. The Panel has had regard to the ISG. The purpose of a sanction is not to be punitive but to protect patients and the public interest. The public interest includes the protection of patients, the maintenance of public confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour. The Panel has also considered the principle of proportionality, weighing the interests of the public with your interests.

The Panel began its deliberations by reflecting on four elements:

1. The features of your misconduct

- diagnoses based on inadequate evidence including non-validated laboratory tests and inappropriate methods such as direct microscopy, for which you were, in any event, inadequately trained;

- a lack of knowledge of microbiology and infectious diseases and practising well beyond your level of competence in the field of borrelia infection;

- advising or prescribing inappropriate and potentially hazardous (and possibly even dangerous) treatments, such as the use of Medilight;

- inappropriate diagnoses potentially causing further risk to patients through lost opportunities for correct diagnosis and treatment;

- providing patients, their carers and medical practitioners with inaccurate and misleading information about many aspects of Lyme disease and other borrelia infections;

- causing patients expense in the use of inappropriate and ineffective tests;

- the indiscriminate use of prolonged courses of broad spectrum antibiotics having potentially adverse public health effects by contributing to the development of antibiotic resistant bacteria in the community;

- the creation of false hope in some of your patients;

- creating tension and, in some cases, distrust between patients and orthodox medical practitioners.

2. Breaches of GMP

Paragraphs 2, 3, 10, 12, and 21 have been previously set out in the Panel's determination on impairment.

3. Aggravating factors

- the lengthy period when you practised what you now accept was "bad medicine" extended from 2003 to 2010;

- the number of patients affected: 100 per annum of whom approximately 50% were new patients;

- persisting with your unorthodox and harmful practice despite clear warnings and opportunities to stop;

- you only stopped when forced to do so by the PCT;

- you failed to take any remedial steps in respect of your patients.

4. Mitigating factors

- your admission of all the charges;
- your insight and expression of regret;
- your decision to cease treating ME/CFS patients;
- the fact that you are otherwise a "good and caring" doctor;
- your otherwise unblemished career;
- the fact that some aspects of the "alternative" treatment you were advocating were accepted by some practitioners.

No action

The Panel first considered whether to take no action in respect of your registration. The Panel considered that to take no action would insufficiently reflect the seriousness of your misconduct and the period of time over which your misconduct continued and would not be in the public interest.

Conditional registration

The Panel next considered whether it would be sufficient to impose a period of conditional registration. The Panel has already stated in its determination on impairment that it has concluded that in the future you are not liable to act so as to put patients at unwarranted risk of harm, or to bring the medical profession into disrepute or to breach fundamental tenets of the medical profession. However, given again the seriousness of your misconduct, the Panel did not consider conditions to be sufficient to reflect the public interest. The Panel concluded that conditions would not adequately address or reflect the serious nature of your misconduct, nor be sufficient to protect the reputation of the profession or to declare and uphold proper standards of conduct and behaviour.

Suspension

The Panel then considered whether to impose a period of suspension. In doing so the Panel has borne in mind paragraph 69 of the ISG:

> *"Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered medical practitioner. Suspension from the register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the period of suspension. Suspension will be an appropriate response to misconduct which is sufficiently*

serious that action is required in order to protect patients and maintain public confidence in the profession. However, a period of suspension will be appropriate for conduct that falls short of being fundamentally incompatible with continued registration and for which erasure is more likely to be the appropriate response (namely conduct so serious that the panel considers that the doctor should not practise again either for public safety reasons or in order to protect the reputation of the profession). This may be the case, for example, where there may have been acknowledgement of fault and where the panel is satisfied that the behaviour or incident is unlikely to be repeated. The panel may wish to see evidence that the doctor has taken steps to mitigate his/her actions."

Doctors occupy a position of privilege and trust in society and are expected to uphold proper standards of conduct in relation to the practice of medicine. It is clear that you neglected to do this by rejecting the advice given to you about your practice by Professor M, who was then employed by the Department of Health as Inspector of Microbiology, and you rejected the concerns of Dr N, Consultant Medical Microbiologist and head of the Lyme Borresliosis Unit at the Health Protection Agency, Public Health Laboratory, in Southampton. Your misconduct was of a very serious nature and has variously been described as you having lost all sense of proportion and scientific reasoning (Dr R) and, in relation to Medilight, as really worrying and having no science behind it (Dr N), and even as horrifying (Dr S).

The Panel has considered the aggravating and mitigating factors of your case with particular care. The Panel has noted your shame and remorse. In all of the circumstances of this case, the Panel considers that a period of suspension would be sufficient to mark the gravity of your misconduct.

The gravity of your misconduct is such that the Panel is in no doubt that there are elements of this case that are so serious that erasure could be considered as an appropriate and proportionate sanction. The Panel has not imposed the ultimate sanction because of your mitigating circumstances, in particular what the Panel regarded as compelling evidence of genuine insight and remorse. The Panel is, however, in no doubt that your rejection of considered and reputable expert advice was wholly unacceptable.

In determining the length of the suspension the Panel has taken account of its observation that without the mitigation this could well have been a case where erasure was appropriate. The Panel accepts that you were regarded as having a particular interest and experience in treating patients with ME/CFS to the extent that you were part of a group established by the Chief Medical Officer. The Panel considers that this may have given you some understandable reason for feeling that your competence was greater than it was in reality. But for this, the Panel considered that the seriousness of your misconduct would otherwise have justified suspension for 12 months. The primary purpose of the Panel is to protect the public and the public interest and the Panel is of the view that, balancing all of the factors,

to impose a period of suspension on your registration for **nine months** is appropriate in your case.

Having taken account of the fact that, at the conclusion of your suspension, you will have been out of clinical practice for a considerable length of time, the Panel determined that it was appropriate to direct that your case be reviewed. The review Panel may be assisted by the following:

- evidence that you have kept your medical knowledge sufficiently and appropriately up to date;
- evidence of any intention and plans for your future practice;
- up-to-date references or testimonials;
- any other information which you think may assist the review Panel including, for example, XXX.

Having concluded that your registration should be suspended for a period of nine months, the Panel will now determine, in accordance with Section 38(1) of the Medical Act, as to whether your registration should be suspended with immediate effect. The Panel will invite submissions from Mr Evans on behalf of the GMC on this matter and Mr Fortune on your behalf."

Determination on immediate sanction:

"Dr Wright:

Having determined that you should be suspended from the Medical Register for a period of nine months, the Panel has considered, in accordance with Section 38 (1) of the Medical Act 1983 as amended, whether it is necessary to impose an immediate suspension. It has taken account of the Indicative Sanctions Guidance (April 2009, revised August 2009 and March 2012) (ISG) in relation to immediate suspension.

The Panel has had regard to the submissions made by Mr Evans on behalf of the General Medical Council (GMC) who submitted that, given the Panel's determination on impairment and sanction, it is necessary for the protection of members of the public and in the public interest or in your interests for you not to remain in practise, pending the appeal period. Mr Evans referred the Panel to paragraph 121 of the ISG, which states:

> *"The doctor is entitled to appeal against any substantive direction affecting his/her registration. The direction does not take effect during the appeal period (28 days) or, if an appeal is lodged, until that appeal has been disposed of. During this time, the doctor's registration remains fully effective unless the panel also imposes an immediate order."*

Mr Evans also requested that the Interim Order currently imposed on your registration be revoked.

The Panel has also had regard to the submissions made on your behalf by Mr Fortune who did not oppose the application for an immediate order of suspension or for the revocation of the current Interim Order.

In view of the serious nature and extent of the findings made against you, together with the reasons the Panel has already articulated for suspending you from the Register, the Panel has determined that it is necessary in the public interest to make an order suspending your registration with immediate effect.

The effect of this direction is that your registration will be suspended from the date upon which written notice of this determination is deemed to have been served upon you. Unless you exercise your right of appeal, the earlier direction for suspension will take effect 28 days after notice of the outcome of this hearing is deemed to have been served upon you. The immediate order for suspension will remain in place until the substantive order takes effect.

The Panel hereby revokes the Interim Order currently imposed on your registration.

That concludes the case."

Confirmed

8 August 2012 **Chairman**