PUBLIC RECORD

Dates: 07/11/2022-09/12/2023 & 23/01/2023 - 27/01/2023

Medical Practitioner's name:	Dr Sarah MYHILL
GMC reference number:	2734668
Primary medical qualification:	MB BS 1981 University of London

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Impaired

Summary of outcome

Suspension, 9 months.

Review hearing directed

Immediate order imposed

Tribunal:

Legally Qualified Chair	Mrs Julia Oakford
Medical Tribunal Member:	Professor Robert Mansel
Medical Tribunal Member:	Dr Ann Smalldridge

Tribunal Clerk:	Ms Jemine Pemu

Attendance and Representation:

Medical Practitioner:	Not present and not represented
GMC Representative:	Ms Rosalind Emsley-Smith, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 09/12/2022

Background

1. Dr Myhill obtained her MBBS medical qualification at the University of London in 1981. Prior to the events which are the subject of the hearing, Dr Myhill worked for 20 years within the NHS in General Practice. Dr Myhill then spent six months as an Associate Specialist at the Royal Shrewsbury Hospital working with patients with chronic fatigue syndrome. At the time of the events Dr Myhill specialised in ecological medicine and had done so for a number of years. She was also the Secretary of the British Society for Ecological Medicine. Ecological medicine is defined by the British Society for Ecological Medicine as the study and good practice of allergy, environmental and nutritional medicine for the benefit of the public.

2. The allegation that has led to Dr Myhill's hearing can be summarised as that, on a number of occasions, between approximately July 2015 and April 2018, Dr Myhill failed to provide good clinical care to Patient A.

3. It is further alleged that on one or more occasion between March and May 2020, Dr Myhill promoted and endorsed the use of agents to treat and protect against viral and bacterial infections, including Coronavirus. It is alleged that Dr Myhill failed to clearly articulate a number of factors in relation to "the Agents" namely, Vitamin C, Iodine, Vitamin D and Ivermectin, including that they were not universally safe when used in the way she recommended and were not licensed to be used as anti-viral agents. It is alleged that Dr Myhill's recommendations and actions risked patient safety and undermined public health.

4. It is also alleged that between 9 and 13 April 2020 Dr Myhill failed to provide good clinical care to Patient B.

5. The initial concerns in relation to Patient A were raised with the GMC on 18 May 2018 through an email sent to the GMC by Dr C, Patient A's General Practitioner ('GP') following a consultation with Patient A where the discussion focused on Dr Myhill's input into Patient A's care.

6. Further concerns were raised by Dr D, the Responsible Officer for the Independent Doctors Federation ('IDF') on 27 July 2020 in relation to Patient B. Dr D notified the GMC by completing a "Responding to fitness to practise concerns" form. Dr D explained that she had concerns that Dr Myhill had been acting as a GP, despite her appraisal statement confirming that she no longer offered GP services and had not attended GP mandatory training. Following a review of Dr Myhill's appraisal, Dr D was of the view that it was clear that Dr Myhill practised within Ecological Medicine and treated patients with chronic fatigue syndrome and thyroid problems many of whom were longstanding patients.

The Outcome of Applications Made during the Facts Stage

7. Dr Myhill was neither present nor represented at the hearing. The Tribunal granted the GMC's application to proceed in Dr Myhill's absence, made pursuant to Rule 31 of the

General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'). The Tribunal's full decision on the application is included at Annex A.

8. On day one of proceedings, the Tribunal granted in part the GMC's application, made pursuant to Rule 34(13) of the Rules, that, Patient B, Patient B's wife, Dr F, Dr E , Dr G, Dr H, Dr D, Dr J and Dr K give evidence remotely. The Tribunal accepted that Patient B, Patient B's wife, Dr F, Dr E, Dr G, Dr H and Dr D should give evidence remotely. The Tribunal took the view that it was in the interest of justice for Dr J and Dr K to give evidence in person. The Tribunal's full decision on the application is included at Annex B.

9. On day two of proceedings, the Tribunal granted a further application from the GMC, made pursuant to Rule 34(13) of the Rules, that Dr J give evidence remotely. The Tribunal's full decision on the application is included at Annex C.

10. On day two of proceedings, the Tribunal also granted a further application from the GMC, made pursuant to Rule 34(13) of the Rules, that Dr K give evidence remotely. The Tribunal's full decision on the application is included at Annex D.

11. On 14 November 2022, the Tribunal refused an application from the GMC, made pursuant to Rule 34(1) of the Rules, to admit an email received by the GMC from Dr K into evidence. The Tribunal's full decision on the application is included at Annex E.

12. On 21 November 2022, the Tribunal granted an application from the GMC, made pursuant to Rule 34(1) of the Rules, to admit further documents into evidence. The Tribunal's full decision on the application is included at Annex F.

13. On 07 December 2022, the Tribunal amended paragraph 7(d) of the Allegation pursuant to Rule 17(6) of the Rules. The Tribunal's full decision on the application is included at Annex G.

The Allegation and the Doctor's Response

14. The Allegation made against Dr Myhill is as follows:

That being registered under the Medical Act 1983 (as amended):

1. You consulted with Patient A and you:

a. failed to identify a specific hypothyroid-related symptom which required a change to Patient A's thyroid replacement preparation; To be determined

b. inappropriately recommended that Patient A switch from her GP prescribed, licensed and evidence-based drug, L-Thyroxine therapy, to an internet-sourced pig thyroid extract ('PTE') (Metavive); To be determined

c. prescribed PTE at a high dose which was inappropriate because:

i. your aim to achieve a fully suppressed level of TSH was contrary to national and international guidance; To be determined

ii. it exposed Patient A unnecessarily to the long-term risks of developing:

1. osteoporosis; To be determined
2. fracture; To be determined
3. atrial fibrillation; To be determined
4. cardiac impairment; To be determined
5. stroke; To be determined

d. suggested that a low-normal T3 level implied that Patient A was a poor-converter of T4 to T3 which was without any scientific foundation; To be determined

e. over-treated Patient A with PTE; To be determined

f. suggested that Patient A's raised T3 level was likely due to thyroid hormone receptor resistance when it was actually due to over-treatment with PTE; To be determined

g. failed to inform Patient A's GP of information relating to:

i. the prescribing regimen; To be determined

ii. your rationale and justification for deviating from Patient A's L-Thyroxine therapy. To be determined

2. On or before 8 December 2017 you consulted with Patient A and you:

a. failed to test Patient A for the presence of virus in the blood (i.e. epstein barr virus ('EBV') viral load by PCR (polymerase chain reaction)) to confirm evidence of significant re-activation; To be determined

b. incorrectly interpreted Patient A's virology results; To be determined

c. incorrectly diagnosed Patient A with myalgic encephalomyelitis (ME) driven by viral activity and immune activation; To be determined

d. used Patient A's EBNA IgG antibody reading and EBV VCA IgG reading as justification for recommending long-term treatment with Valaciclovir, which was inappropriate because:

i. the readings had no clinical significance other than indicating previous infection with EBV; To be determined

ii. high or elevated antibody levels can be present for years; To be determined

iii. the readings were not diagnostic of:

1. recent infection; To be determined
2. re-activation; To be determined

e. suggested that Patient A's cytomegalovirus ('CMV') result was indicative of previous CMV infection, but this had no clinical significance because:

i. it is a common finding in the UK; To be determined

ii. it only indicates previous infection with CMV at some time in Patient A's life; To be determined

f. prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because:

i. you failed to demonstrate any evidence of active EBV or CMV infection provoking Patient A's Chronic Fatigue Syndrome ('CFS'); To be determined

ii. there was no clinical indication for long term use of anti-viral therapy; To be determined

iii. Valaciclovir is not licensed for the treatment of EBV infection and CMV infection; To be determined

iv. your prescribing was outside the licensed indications for Valaciclovir; To be determined

v. it unnecessarily exposed Patient A to potential side effects of Valaciclovir; To be determined

vi. it unnecessarily exposed Patient A to long-term risks associated with Valaciclovir. To be determined

3. In your letter of 30 April 2018 to Patient A's GP, you stated that Valaciclovir was used to treat type 1, 2 and 3 herpes infections which was inappropriate because:

a. there was no evidence that Patient A had severe or frequent recurrences of genital herpes; To be determined

b. the dose of 1 gram four times daily was significantly higher than the licensed dose for preventing herpes simplex virus infections. To be determined

4. On or before April 2018 you consulted with Patient A and you advocated treatment with Vitamin B12 to manage CFS which was inappropriate because:

a. there was no evidence that Patient A:

i. was Vitamin B12 deficient; To be determined

ii. had a recognised indication of pernicious anaemia; To be determined

iii. had Vitamin B12: To be determined

1. deficiency associated anaemia; To be determined
2. tobacco amblyopia; To be determined
3. leber's optic atrophy; To be determined

iv. had any other recognised indication for B12 replacement therapy. To be determined

5. On or before April 2018 you consulted with Patient A and you failed to:

a. adequately consider the possibility that Patient A's symptoms were, at least in part, caused by anxiety and depression; To be determined

b. refer Patient A to an appropriate specialist who could treat her long-term history of anxiety and depression. To be determined

6. You prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because:

    a. adequate treatment for conditions of deficiency requires only maintenance injections once every two to three months; To be determined

    b. it is not recommended by NICE; To be determined

    c. Patient A was exposed to daily injections with associated potential short-term side effects; To be determined

    d. Patient A was exposed to potential long-term complications; To be determined

    e. there is a lack of biochemical, physiological and clinical evidence for rationale for the use of daily Vitamin B12 in the context used. To be determined

7. You consulted with Patient A and:

    a. prior to prescribing a parenteral magnesium supplement you failed to measure Patient A's:

        i. serum magnesium; To be determined

        ii. urine magnesium; To be determined

        iii. renal clearance to determine if any deficiency was due to:

            1. altered renal absorption; To be determined

            2. altered gut absorption; To be determined

    b. you failed to identify that Patient A was formally suffering from magnesium deficiency ('hypomagnesaemia'); To be determined

c. you prescribed Patient A 0.5ml daily of a 10mg/ml of magnesium sulphate (MgSO4) which was inappropriate because:

i. there was no clinical indication for magnesium supplements; To be determined

ii. the dose was wholly inadequate to:

1. treat primary hypomagnesaemia; To be determined
2. help maintain magnesium homeostatis assuming a baseline of normomagnesaemia; To be determined

iii. the prescription included 2% lignocaine, a local anaesthetic agent, which was inappropriate because it was not clinically indicated; To be determined

d. ~~your parenteral administration of the prescribed medication was inappropriate because~~: your advice on the parenteral administration of the prescribed medication was inappropriate because: Amended under rule 17(6)

i. there was no evidence that parenteral MgSO4 had any efficacy in treating CFS; To be determined

ii. Patient A was unnecessarily subjected to subcutaneous injections; To be determined

iii. the dose could have been supplied by a single chewable tablet; To be determined

iv. there was no urgent clinical situation; To be determined

v. administering magnesium subcutaneously is not the recommended route for the licensed parenteral MgSO4 solutions available; To be determined

vi. Patient A did not have any predisposing conditions such as Crohn's Disease with concomitant bowel cancer and radiation damage; To be determined

e. following your prescribing to Patient A you failed to check and monitor Patient A's blood magnesium level to confirm an ongoing clinical need to continue the magnesium injections; To be determined

f. in the alternative to paragraph 7.b, 7.c., and 7.e., you failed to notify Patient A's GP of:

i. your diagnosis of magnesium deficiency; To be determined

ii. your basis for your diagnosis of magnesium deficiency; To be determined

iii. any monitoring you carried out of Patient A following the diagnosis of magnesium deficiency. To be determined

Internet

8. On one or more occasion as set out in Schedule 1, you used the internet to promulgate your views and opinions on viral and/ or bacterial infections ('Your Media'). To be determined

9. In Your Media you promoted and endorsed the use of the agents, the details of which are set out in Schedule 2 ('the Agents'), to treat and protect against viral and bacterial infections, including 2019-nCoV pandemic ('Coronavirus') in that you:

a. made a series of recommendations as set out at Schedule 3; To be determined

b. published, or allowed your website to publish, the articles listed in Schedule 4, and these:

i. purport to provide guidance on how to treat Coronavirus infection; To be determined

ii. recommend use of the Agents; To be determined

c. sold 15% Lugol's iodine on the sales section of your website, and in doing so made recommendations about its use as set out at Schedule 5. To be determined

10. In relation to the recommendations in Your Media, you failed to clearly articulate that:

a. the Agents are not:

i. licensed to be used as anti-viral agents in vivo; To be determined

ii. universally safe for people when used in the way you recommended; To be determined

b. there is no published evidence to support the Agents being effective contact viricides when used in the manner you have stated; To be determined

c. there are health risks and/or side effects associated with using the Agents in the manner you have stated; To be determined

d. the use of Vitamin D in the manner you have stated is not supported by any UK guidelines or trial data; To be determined

e. the use of the Agents off-licence requires a robust knowledge of the evidence for the efficacy and safety of the Agents when used in the manner you recommended; To be determined

f. you did not have a specialist background in the following areas:

i. the use of virucides; To be determined

ii. clinical pharmacology; To be determined

iii. infectious diseases; To be determined

iv. clinical virology; To be determined

v. public health medicine. To be determined

11. Your recommendations/acts as outlined in paragraphs 9 and/or your omissions as outlined in paragraph 10:

a. risked patient safety in that they:

i. exposed patients to potential serious harm, including toxicity, and/or; To be determined

ii. were not peer reviewed, and/ or; To be determined

iii. failed to meet NICE guidance of vitamin D dosing, and/or; To be determined

iv. were unproven in terms of their benefits; To be determined

b. undermined public health in that they:

i. exposed patients to potential serious harm, including toxicity, and/or; To be determined

ii. were not peer reviewed, and/ or; To be determined

iii. failed to meet NICE guidance of vitamin D dosing, and/or; To be determined

iv. were not supported by any professional UK medical body or the NHS; To be determined

v. were unproven in terms of their benefits; To be determined

vi. had the potential to undermine public confidence in the medical profession. To be determined

Patient B

12. Between 9 April 2020 and 13 April 2020, you were involved in the care of Patient B after they experienced an unexpected fall, and you:

    a. acted outside the limits of your declared skills and experience by providing services normally provided by a GP; To be determined

    b. failed to:

        i. diagnose Patient B had a possible fractured hip that required immediate management; To be determined

        ii. indicate the need for:

            1. an ambulance; and/ or To be determined
            2. attendance at an Accident and Emergency department; To be determined
            3. explain clearly that the risk of catching Covid-19 was outweighed by the risk of an untreated hip fracture; To be determined

    c. administered without clinical justification:

        i. prednisolone 20mg; To be determined
        ii. diazepam 2mg; To be determined
        iii. ketogenic diet. To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

The Facts to be Determined

15. As Dr Myhill was neither present nor represented at the hearing, no admissions were made during the course of the hearing. Therefore, the Tribunal was required to determine the entirety of the allegation.

Witness Evidence

16. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Patient B, by video link;
- Patient B's wife, by video link;
- Dr E, Senior House Officer for the Wye Valley NHS Trust in the Accident and Emergency Department at Hereford Hospital at the time of the index events, by video link;
- Dr D, Responsible Officer (RO) for the Independent Doctors Federation (IDF), by video link.

17. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Dr H, Consultant in Emergency Medicine, dated 26 February 2021;
- Dr G, Trust's Serious Incident Panel, dated 9 March 2021;
- Mr N, Legal Adviser to the GMC, dated 21 November 2022.

Expert Witness Evidence

18. The Tribunal also received evidence from five expert witnesses, all of which gave oral evidence during the course of the hearing:

- Dr J produced expert reports dated 25 September 2019, 24 June 2020,

4 December 2020 and 21 April 2021 and an addenda report dated 24 February 2022. He gave oral evidence at the hearing by video link;

- Dr L produced an expert report dated 7 May 2019 and 29 March 2022. He also gave oral evidence at the hearing in person;
- Professor M produced an expert report dated 27 June 2019 and a supplementary expert report dated 15 March 2022. He also gave oral evidence at the hearing in person;
- Dr K produced an expert report dated 19 September 2019 and also gave oral evidence at the hearing by video link;
- Dr F produced an expert report dated 28 April 2021 and a supplementary expert report dated 19 March 2022. He also gave oral evidence at the hearing by video link and in person.

Documentary Evidence

19. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included but was not limited to:

- Dr Myhill's MPTS Determination on non-compliance dated 1 October 2020;
- Email between Dr D and Dr Myhill, dated 22 and 23 July 2020 respectively;
- Medical Practice Information Transfer Form dated 16 July 2020;
- Initial account of events by witness Patient B's wife, dated October 2020;
- Screenshots of WhatsApp messages sent between Patient B's wife and her family, dated 9 April – 12 April 2020;
- Referral from Dr C, Stamford Medical Centre, to the GMC dated 18 May 2018, including copies of Patient A's GP records;
- Medical records of Patient A provided to the GMC from Dr C, including copies of correspondence from Dr Myhill;

- E-mail from Dr Myhill to the GMC dated 5 November 2018, providing comments in response to the referral;
- Transcript of YouTube video uploaded by Dr Myhill on 12 March 2020;
- Transcript of YouTube video uploaded by Dr Myhill on 27 March 2020;
- Transcript of video hosted by website 'NHS Corona Doctors on the Frontline', titled Dr Sarah Myhill webinar AMN on 12 May 2020;
- Transcript of UK Health Radio interview of Dr Sarah Myhill on 16 March 2020;
- Dr K's CV, undated;
- Joint statement: Supporting doctors in the event of a COVID-19 epidemic in the UK, published 11 Mach 2020;
- Thyroid hormone replacement – a counterblast to guidelines Article, published December 2017;
- Good practice in prescribing and managing medicines and devices, dated February 2013.

The Tribunal's Approach

20. In reaching its decision on facts, the Tribunal has borne in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation. Dr Myhill does not need to prove anything. The standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred. The case of Byrne v GMC [2021] EWHC 2237 has reiterated this.

21. The Tribunal had to consider whether to draw an adverse inference by virtue of the fact that Dr Myhill was not present. Throughout its deliberations it bore this in mind and took into account the criteria set out in MPTS guidance (February 2021) and the case of *Kusmin v GMC [2019] EWHC 2129*.

22. The Tribunal received a good character direction from the Legally Qualified Chair ('LQC') and accepted that it should take this into account when considering the allegation.

23. The LQC referred the Tribunal to the cases of *R (on the application of Dutta) v GMC [2020] EWHC 1974 (Admin)* and *Khan v GMC [2021] EWHC 374 (Admin)* and it accepted it the following:

- Tribunals should not assess a witness's credibility exclusively on their demeanour when giving evidence;
- Tribunals should consider all the evidence before them before coming to a conclusion about a witness's credibility;
- It is open to Tribunals not to rule out the whole of a witness's evidence based on credibility as credibility can be divisible;
- Tribunals should base factual findings on inferences drawn from documentary evidence and known or probable facts and use oral evidence to subject the documentary records to critical scrutiny;
- Tribunals should assess the evidence in the round.

The Tribunal's Analysis of the Evidence and Findings

24. The Tribunal has considered each paragraph of the Allegation separately and has evaluated the evidence in order to make its findings on the facts.

Patient A

The evidence

25. The Tribunal received written and oral evidence in relation to these paragraphs from the following witnesses:

- Dr K produced an expert report dated 19 September 2019. He also gave oral evidence via video link;

- Professor M produced an expert report dated 27 June 2019. He also gave oral evidence at the hearing;
- Dr L produced an expert report dated 07 May 2019. He also gave oral evidence at the hearing;
- Dr J produced an expert report dated 25 September 2019. He also gave oral evidence via video link.

26. The Tribunal received written evidence that included but was not limited to:

- Referral from Dr C, Stamford Medical Centre, to the GMC dated 18 May 2018, including copies of Patient A's GP records;
- Medical records of Patient A provided to the GMC from Dr C including copies of correspondence from Dr Myhill;
- E-mail from Dr Myhill to the GMC dated 5 November 2018, providing comments in response to the referral.

27. The LQC considered it prudent to clarify her legal advice as paragraphs of the Allegation relating to Patient A involved four Expert witnesses instructed by the GMC. She reminded the Tribunal that an expert should have the necessary qualifications and experience to act as an expert and should be independent and give objective unbiased opinions. In addition, an expert should make it clear if a particular matter falls outside his expertise. The Expert has a duty to assist the Tribunal with matters within their expertise. The Expert is not there to act as advocate for the GMC.

28. The LQC reminded the Tribunal that the expert evidence is only part of the evidence before it and if it does not accept the expert evidence, then it should give cogent reasons. She reminded it that the medical members should not themselves act as experts in deciding issues in the case but should an issue arise which they believe is an important medical issue which affects their decision not covered in evidence they should state this openly and give the parties the opportunity to submit further evidence or make submissions.

29. The LQC clarified that Dr Myhill's evidence was in form of letters and emails only. She had not given any sworn evidence that had been subject to cross examination by the GMC or questioning by the Tribunal. Although, it was a matter for the Tribunal to give such weight as it considered appropriate to this evidence, it could not treat this evidence as expert evidence as it was not independent.

Allegation 1a

30. The Tribunal considered whether Dr Myhill consulted with Patient A and failed to identify a specific hypothyroid-related symptom which required a change to Patient A's thyroid replacement preparation.

31. The Tribunal considered Dr L's evidence in his expert report, that Dr Myhill did not identify a specific hypothyroid-related symptom which needed to be addressed through a change to Patient A's thyroid replacement preparation. However, in his oral evidence, he stated, that he would only make a change in medication based on the biochemistry and not on symptoms. Dr L stated that '*there were no symptoms that would override the biochemistry. The biochemistry was 'spot on'*.'

32. The Tribunal found that as Dr L had made it clear that there were no specific symptoms that would require a change to Patient A's treatment, it followed that Dr Myhill did not have a duty to identify any specific hypothyroid-related symptoms.

33. Therefore, the Tribunal found paragraph 1(a) not proved.

Allegation 1b

34. The Tribunal considered whether Dr Myhill consulted with Patient A and inappropriately recommended that Patient A switch from her GP prescribed, licensed and

evidence-based drug, L-Thyroxine therapy, to an internet-sourced pig thyroid extract ('PTE') (Metavive).

35. The Tribunal considered Dr L's opinion as stated in his expert report: '*Thyroid hormone replacement is of course indicated in hypothyroidism and PTE is, indeed, a form of thyroid hormone replacement. However, the question is whether changing her from her previous treatment with L-Thyroxine, whose dose looked to be spot-on, was indicated? On the basis of the only relevant source of data available to me, Patient A GP records and Dr Myhill's letter of 21-July-17 (sic), I cannot discern anything to justify the recommendation to switch her from a prescribed, licensed and evidence-based drug (L-Thyroxine) to an unlicensed and unregulated product (PTE)*'. He further stated, '*PTE is still a reasonably effective form of thyroid hormone replacement for a patient with hypothyroidism*.'

36. The Tribunal was mindful of the letter from Dr Myhill to Patient A's GP dated 21 July 2015 which stated '*We then have to look at the causes of sleep disturbances and the major one is nocturnal hypoglycaemia- again a manifestation of metabolic syndrome. We know alcohol can get one off to sleep, it actually disturbs sleep very much because it induces nocturnal hypoglycaemia. Furthermore, I suspect Patient A has been undertreated with thyroid hormones- see below- and it is thyroid and adrenal hormones that are responsible for determining our circadian rhythm*.'

37. Dr Myhill further stated '*Although these result are acceptably within population reference ranges that is not the same thing as ones individual normal range….The clinical input is as important as the biochemistry and there is clearly scope here to increase the dose.*'

38. The Tribunal had regard to Dr L's expert report in which he stated, '*Therefore, my conclusion is that Dr Myhill's interpretation and use of laboratory tests of thyroid function … and was principally driven by the need or desire to justify her preference for unlicensed and poorly evidence-based PTE over L-Thyroxine.*' He further stated, *'Her decision to recommend*

PTE instead of L-Thyroxine was based entirely upon misconceptions that "natural hormones are always better…".'

39. In his evidence, Dr L accepted that he was not an expert in treating patients with CFS and he had no experience of using pig thyroid extract himself. The Tribunal had regard to the fact that Dr Myhill was acknowledged to be an ecological doctor who had treated patients with CFS and thyroid disease over a number of years. In his report, Dr L stated that the majority of patients with primary hypothyroidism are treated in primary care. In response to Tribunal questions, he confirmed that as a secondary care consultant, he looked after approximately 50 patients with hypothyroidism, most of whom had the diagnosis following surgery. The Tribunal found that on the balance of probabilities, in the context of Patient A and taking into consideration all of the above, that the change of preparation was not inappropriate.

40. Therefore, the Tribunal found paragraph 1(b) not proved.

Allegation 1c (i)

41. The Tribunal considered whether Dr Myhill consulted with Patient A and prescribed PTE at a high dose which was inappropriate because her aim to achieve a fully suppressed level of TSH was contrary to national and international guidance. The key issue in this allegation is what the aim of Dr Myhill's treatment was.

42. In Dr Myhill's letter to Patient A's GP of July 2015, she stated, *'Although these results are acceptable within population reference ranges that is not the same thing as one's individual normal range…The clinical input is as important as the biochemistry and there is clearly scope here to increase the dose*.' This decision was queried in 2018 by Patient A's GP to which Dr Myhill responded '*At that time she was clinically euthyroid. Her present blood levels of thyroid hormones are similar to the above. It is important to recognise that the clinical picture is as important as the biochemistry…*'.

43. The Tribunal accepted that Dr L stated, '*Dr Myhill over-dosed Patient A with PTE, aiming to achieve a supressed level of TSH that is contrary to national and international guidance*.' The Tribunal was unable to discern why Dr L considered that this was Dr Myhill's aim as she indicated that her aim was to treat the patient clinically rather than through using biochemistry.

44. The Tribunal therefore found paragraph 1(c)(i) not proved.

Allegation 1c (ii)

45. The Tribunal considered whether Dr Myhill consulted with Patient A and prescribed PTE at a high dose which was inappropriate because it exposed Patient A unnecessarily to the long-term risks of developing osteoporosis, developing fracture, cardiac impairment and stroke.

46. The Tribunal had regard to Dr L's report in which he stated that *'The long-term risks of excessive thyroid hormone replacement include loss of bone density, potentially leading to osteoporosis and fracture, and an increased risk of atrial fibrillation (AF), potentially leading to cardiac impairment and stroke*.'

47. The Tribunal acknowledged that Dr Myhill monitored Patient A in relation to the high dose of PTE. It accepted there were long term risks of excessive thyroid hormone replacement as stated by Dr L. The Tribunal considered that it also had to consider whether PTE was 'necessary' in the particular circumstances of Patient A. The Tribunal is aware that Patient A had trust in Dr Myhill and indeed when discussing the issue with her GP she wished to continue with the treatment despite the issue of atrial fibrillation being raised with her, as evidenced in Patient A's consultation with her GP on 15 February 2016. The Tribunal therefore took the view that Patient A accepted that she was exposed to these long term risks. Under all the circumstances the Tribunal found that it was necessary to treat Patient A

with the high dose of PTE. Therefore, the Tribunal considered that despite there being long term risks, it was necessary to treat Patient A with PTE at a high dose.

48. The Tribunal therefore found paragraph 1(c)(ii) not proved.

Allegation 1d

49. The Tribunal considered whether Dr Myhill consulted with Patient A and suggested that a low-normal T3 level implied that Patient A was a poor-converter of T4 to T3 which was without any scientific foundation.

50. In her letter to Patient A's GP dated 21 July 2015, Dr Myhill stated, '*Furthermore she has rather low levels of T3 and that suggests she is a poor converter of T4 to T3.*'

51. The Tribunal considered the evidence of Dr L where he stated, '*Moreover, Dr Myhill's suggestion that a low-normal T3 level implied that Patient A was a poor converter of T2 to T3 was without any specific foundation based on current evidence*.'

52. The Tribunal took into account Dr L's report where he stated that '*It is interesting to note that depressive symptoms may be more common in those harbouring genetic variants of D2 that results in less efficient conversion of T4 to T3; indeed, the psychiatric literature reports some success using T3 for resistant depression even in euthyroid patients*.' In response to Tribunal questions, he conceded that there '*is interesting work looking at patients who may have difficulty converting T4 to T3, it is not fully understood.*' The Tribunal considered the wording of the allegation which states '*without any scientific foundation'*. It followed from Dr L's concession that there is some scientific foundation, albeit limited, for Dr Myhill's suggestion.

53. The Tribunal therefore found paragraph 1(d) not proved.

Allegation 1e

54. The Tribunal considered whether Dr Myhill consulted with Patient A and over-treated Patient A with PTE.

55. The Tribunal took into account Dr L's evidence that Dr Myhill overtreated Patient A with PTE according to the biochemistry. The Tribunal acknowledge that a supressed TSH level is evidence of overtreatment. It saw the relevant blood tests which showed clearly that the TSH level was almost completely supressed. The Tribunal therefore accepted the opinion of Dr L.

56. The Tribunal therefore found paragraph 1(e) proved.

Allegation 1f

57. The Tribunal considered whether Dr Myhill consulted with Patient A and suggested that Patient A's raised T3 level was likely due to thyroid hormone receptor resistance when it was actually due to over-treatment with PTE.

58. The Tribunal had regard to the response from Dr Myhill to the GMC on 5 November 2018 when she stated, '*In this case there was more than one reason for this patient to be hypothyroid. The patient suffered from primary hypothyroidism, in CFS there is often an element of secondary hypothyroidism (due to hypothalamic pituitary damage), we often see high levels of T4 and low T3 on blood suggesting poor T4 to T3 conversion and the fact that the patient was euthyroid despite a raised T3 tells us she probably also has thyroid hormone receptor resistance.*'

59. The Tribunal had further regard to Dr L's expert report in which he stated, '*Dr Myhill's response to the GMC that Patient A's raised T3 was probably due to thyroid hormone receptor*

resistance (a very rare condition affecting around 2-in-100,000), rather than from being over-treated with PTE is enormously improbable.'

60. The Tribunal considered that this allegation related to Patient A's blood test results of April 2018 undertaken by Patient A's GP.

61. The Tribunal took into account, Dr Myhill's letter of 30 April 2018 to Patient A's GP where she commented on the blood test results. In this letter she stated '*Patient A slightly high free T3 may be because she took her dose of NDT at 9am which is too close to the blood test at 11.30. at least a 4 hour gap is usual.*' The Tribunal had regard to Dr L's expert report in which he addresses Dr Myhill's comments. He stated '*Dr Myhill makes a valid point about ideally checking thyroid blood tests only after 4-6 hours from ingesting thyroid hormones. Nevertheless, with the 2-3x daily dosing regimen she recommended in 2015, peak-trough effect in T3 levels would be significantly mitigated and, at the high dose of PTE recommended, it's likely that T3 levels were raised most of the time, except perhaps in the immediate pre-dose period.*' Further, Dr L in oral evidence stated that there was no information as to when Patient A had taken the medication, or when the blood test was taken. The Tribunal considered that the response from Dr Myhill to the GMC on 5 November could not be considered to be consulting with Patient A. The Tribunal has taken into account all of the above but has considered that it is unlikely that Dr Myhill consulted with Patient A in the manner that is suggested by this paragraph of the allegation.

62. The Tribunal therefore found paragraph 1(f) not proved.

Allegation 1g (i)

63. The Tribunal considered whether Dr Myhill consulted with Patient A and failed to inform Patient A's GP of information relating to the prescribing regimen.

64. The Tribunal had regard to a letter from Dr Myhill to Patient A's GP in which she stated, '*I, therefore, suggest swapping initially to an equivalent dose of natural thyroid which is a physiological mix of T4 an T3- that would be 1 ½ grains daily and I would suggest taking 1 grain with breakfast and ½ grain with lunch. If all is well clinically then I recommend increasing the dose in ½ grain increments every two weeks until she gets up to possibly 2 ½ or 3 grains, including an evening dose of say ½ grain with supper- this is because for some a later dose of thyroid hormones improves sleep quality. If this is well tolerated then wait a month and re-check thyroid function tests to see where we stand biochemically.'* The Tribunal considered this letter and took the view that it did provide information related to the prescribing regime for PTE.

65. The Tribunal was aware that Dr L had described Dr Myhill's notes as '*anodyne'* and '*non-specific'*, the Tribunal did not accept this view as it was able to see the note (as above) and considered it had sufficient information relating to the prescribing regime.

66. The Tribunal therefore found paragraph 1(g)(i) not proved.

Allegation 1g (ii)

67. The Tribunal considered whether Dr Myhill consulted with Patient A and failed to inform Patient A's GP of information relating to her rationale and justification for deviating from Patient A's L-Thyroxine therapy.

68. The Tribunal had regard to Dr L's report in which he referred to '*a convincing rationale or justification'.* His opinion was that her rationale and explanation was not convincing. The Tribunal considered that Dr Myhill did inform Patient A's GP of her rationale and justification, albeit one that Dr L did not accept.

69. The Tribunal therefore found paragraph 1(g)(ii) not proved.

Allegation 2a

70. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and failed to test her for the presence of virus in the blood (i.e. epstein barr virus ('EBV') viral load by PCR (polymerase chain reaction)) to confirm evidence of significant re-activation.

71. The Tribunal had regard to the letter from Dr Myhill to Patient A's GP dictated 08 December 2017 in which she stated, '*Epstein Barr virus showed evidence of EBV infection with late primary infection or recent activation. However, her EBNA IgG antibody at 230 is a very high reading as is her EBV VCA IgG at >750 (<20 U/ml negative).'*

72. The Tribunal considered the expert report of Professor M in which he stated, '*Dr Myhill does not mention whether the IgM is positive, which would indicate a recent infection, I therefore assume that the IgM test was negative or not performed. She has also not tested for the Prescence of virus in the blood (ie EBV viral load by PCR). If the viral load was very high this would potentially be evidence of a significance of re-activation.*' It also noted the oral evidence of Professor M in which he confirmed that Dr Myhill would have had easy access to PCR testing for EBV and had a duty to test for EBV by PCR if she was going to prescribe anti-viral medication for EBV.

73. The Tribunal did not have Patient A's medical notes from Dr Myhill and therefore drew an adverse inference that she had not tested as suggested by Professor M. However, the Tribunal considered that she did not have a duty to perform the PCR test as she did not intend to use antiviral medication for EBV.

74. The Tribunal therefore found paragraph 2(a) not proved.

Allegation 2b

75. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and incorrectly interpreted their virology results.

76. The Tribunal considered Dr Myhill's letter of 8 December 2017 in which she stated, '*Patient A got back in touch with me again for further input into management of her health problems. Many chronic fatigue syndromes are triggered by viral infection and work done by Dr O has shown that many such patients do well on antivirals…. Patient A requested Human Herpes Virus antibodies which showed evidence of past (latent) infection. Epstein Barr virus showed evidence of EBV infection with late primary infection or recent activation. However, her EBNA IgG antibody at 230 is a very high reading as is her EBV VCA IgG at >750 (<20 U/ml negative). Her cytomegalovirus result was also suggestive of previous CMV infection.'*

77. The Tribunal did not have the actual laboratory records relating to any possible testing undertaken by Dr Myhill.

78. The Tribunal considered the expert report of Professor M in which he stated, '*My opinion is that these results merely indicate previous infection with EBV. EBV infection is extremely common and over 90% of the adult population of the UK will have similar antibody results as they have also been previously infected with EBV. The infection is often acquired in childhood or early adult life and remains as a latent infection for the rest of the lifetime of the individual. Reactivation of the virus can occur but is usually asymptomatic unless there is evidence of immune-deficiency. Dr Myhill does not mention whether the IgM is positive, which would indicate a recent infection, I therefore assume that the IgM test was negative or not performed. She has also not tested for the presence of virus in the blood (ie EBV viral load by PCR). If the viral load was very high this would potentially be evidence of a significance of re-activation. Therefore, I consider that the finding of EBNA IgG antibody and EBV VCA IgG antibodies is of no clinical relevance other than indicating previous infection with EBV. High or elevated antibody levels may be present for years and are not diagnostic of recent infection or reactivation... In my opinion, Dr Myhill has misinterpreted the results and these results, by themselves, are not diagnostic of either "late primary infection," or "recent activation".*'

79. The Tribunal took into account the Dr Myhill's letter as set out above. However, it accepted the opinion of Professor M.

80. The Tribunal therefore found paragraph 2(b) proved.

Allegation 2c

81. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and incorrectly diagnosed her with myalgic encephalomyelitis (ME) driven by viral activity and immune activation.

82. The Tribunal considered the expert report of Professor M in which he stated, '*In the GP letter dictated 08.12.2017 Dr Myhill states that "Patient A's ME is driven by viral activity, the idea here is that if the immune system is activated, then that as I call it kicks an immunological hole in the energy bucket. Furthermore, the immune activation could well explain her flu like symptoms, aching and sore muscles, sore throat and headaches." I assume that she was trying to explain her concept of CFS in layman's terms; however, this statement is unspecific, imprecise and unfounded as there is no evidence from the tests reported that there is any viral activity or immune activation*.'

83. The Tribunal noted that Dr Myhill actually said, '*This flags up the possibility that Patient A's ME…*'.

84. The Tribunal was aware from Dr Myhill's letter of 21 July 2015 that '*Patient A got back in touch with me again for further input into management of her chronic fatigue syndrome*'. The Tribunal therefore considered that Patient A had already been diagnosed with CFS in the past. On this occasion, all that Dr Myhill was doing was flagging up a possibility that Patient A's ME was driven by viral activity.

85. The Tribunal therefore found paragraph 2(c) not proved.

Allegation 2d (i), 2d(ii) and 2d(iii)

86. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and used their EBNA IgG antibody reading and EBV VCA IgG reading as justification for recommending long-term treatment with Valaciclovir, which was inappropriate because the readings had no clinical significance other than indicating previous infection with EBV; high or elevated antibody levels can be present for years; and the readings were not diagnostic of recent infection and/or re-activation.

87. The Tribunal had regard to the letter of 08 December 2017 from Dr Myhill to Patient A's GP in which she stated, '*Patient A got back in touch with me again for further input into management of her health problems. Many chronic fatigue syndromes are triggered by viral infection and work done by Dr O has shown that many such patients do well on antivirals…. My View is with this clinical and immunological picture, it is well worth trying her on antivirals'.*

88. The Tribunal considered the expert evidence of Professor M in which he stated, '*In my opinion, Dr Myhill has failed to demonstrate any evidence of active EBV (or CMV) infection provoking Patient A's chronic fatigue syndrome and there is no clinical indication for long-term use of anti-viral therapy*.' In addition, he stated '*The actual laboratory results are not included in the documents provided. However, Dr Myhill comments that Herpes virus antibodies showed evidence of past (latent) infection. She goes on to say that Epstein Barr virus showed evidence of EBV infection with late primary infection or recent activation. However, her EBNA IgG antibody at 230 is a high reading as is her EBV VCA IgG at greater than 750. She uses these results as justification for recommending long-term treatment with Valaciclovir*.'

89. The Tribunal was unable to find any evidence that Dr Myhill used these results as justification for recommending long-term treatment for Valaciclovir as stated by Professor M.

90. The Tribunal therefore found paragraph 2d (i), 2d(ii) and 2d(iii) not proved.

Allegation 2e(i) and 2e(ii)

91. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and suggested that Patient A's cytomegalovirus ('CMV') result was indicative of previous CMV infection, but this had no clinical significance because it is a common finding in the UK, and/ or it only indicates previous infection with CMV at some time in Patient A's life.

92. The Tribunal had regard to Dr Myhill's letter of the 08 December 2017, in which she said, '*Her cytomegalovirus result was also suggestive of previous CMV infection*.' It accepted that Dr Myhill had said this but could find no evidence in the letter that she considered this of clinical significance.

93. The Tribunal considered the evidence of Professor M in which he stated, *'Dr Myhill also states that "her cytomegalovirus result was also suggestive of previous CMV infection". The actual results are not stated. I assume she has positive IgG antibodies to CMV and negative IgM antibodies. This again would be a very common finding in the UK and merely indicates previous infection with CMV at some time in Patient A's life. In my opinion, this is of no clinical significance*.'

94. The Tribunal therefore found paragraph 2(e)(i) and 2(e)(ii) proved.

Allegation 2f (i)

95. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and prescribed long-term Valaciclovir treatment at a dose of 1 gram four times

daily which was inappropriate because Dr Myhill failed to demonstrate any evidence of active EBV or CMV infection provoking Patient A's Chronic Fatigue Syndrome ('CFS').

96. The Tribunal found this paragraph not proved on the same basis that it found paragraphs 2(a) and 2(d) not proved.

97. The Tribunal therefore found paragraph 2(f)(i) not proved.

Allegation 2f (ii)

98. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because there was no clinical indication for long term use of anti-viral therapy.

99. The Tribunal considered that the reasoning set out in paragraph 2(a) and 2(d) applied to this paragraph.

100. The Tribunal therefore found paragraph 2(f)(ii) not proved.

Allegation 2f (iii)

101. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because Valaciclovir is not licensed for the treatment of EBV infection and CMV infection.

102. The Tribunal had regard to Professor M's report in which he stated *'Dr Myhill's letter dictated 30.04.2018 acknowledges that Valaciclovir is not licensed for treating EBV Ans Dr Myhill now states that she uses it primarily to treat and prevent type 1 and type 2 and type 3 herpes infections (i.e. HSV , HSV2, VZV). "Patient A has genital Herpes and this is the primary*

reason for prescription". Dr Myhill appears to have changed her reason for prescribing Valaciclovir and the dose recommended (one gram four times a day) is far higher than the licensed dose foe preventing Herpes Simplex virus infections I.e. 500mg once daily. There is no evidence in the GP records that Patient A had severe or frequent recurrences of genital Herpes.'

103. The Tribunal accepted that it has not seen Dr Myhill's records of Patient A. However, Dr Myhill has stated in her letter of 30 April 2018 (Not in a letter before 08 December 2017) that Patient A had genital herpes. The Tribunal had regard to the "*Good practice in prescribing and managing medicines and devices*" Guidance published in 2013 regarding prescribing medication outside of licensed indications and accepted that there were situations where Patient A's treatment could be undertaken outside licensed requirements. It was clear that Patient A was a fully informed patient as shown by her GP records and her participation in treatment decisions with her GP and Dr Myhill.

104. The Tribunal therefore found paragraph 2(f)(iii) not proved.

Allegation 2f (iv)

105. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because her prescribing was outside the licensed indications for Valaciclovir.

106. The Tribunal took account of Professor M's opinion '*Therefore, the use of Valaciclovir as recommended by Dr Myhill in her letter dictated 08.12.17 i.e. one gram four times daily for some months, possibly years, is therefore outside the licenced indications for Valaciclovir i.e. she prescribed an incorrectly high dose given for a non-licenced indication over a prolonged period*.'

107. The Tribunal also had regard to Professor M's report in which he stated, '*daily doses of Valaciclovir over long-term is licenced for the suppression of recurrent symptoms of Herpes Simplex Virus when a dose of 500mg once daily is recommended (twice daily in immuno-compromised adult).*'

108. The Tribunal accepted that the license includes clinical indication and dosage and there was no explanation from Dr Myhill as to why the dose was higher than the licensed dose.

109. The Tribunal accepted the opinion of Professor M.

110. The Tribunal therefore found paragraph 2(f)(iv) proved.

Allegation 2f (v)

111. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because it unnecessarily exposed Patient A to potential side effects of Valaciclovir.

112. The Tribunal had regard to the fact that Dr Myhill was prescribing a higher dose of Valaciclovir than was licenced. The Tribunal accepted the evidence within Professor M's expert report in which he stated, '*Valaciclovir is generally safe and well tolerated, but side-effects reported have included headache, nausea, anaphylaxis, dizziness, dyspnoea, rashes, rise in liver function tests. The most important long-term risk is of renal impairment and renal stones. Dr Myhill rightly pointed out these potential risks and advised accordingly to have regular checks for renal function and increase fluid intake. Therefore, Valaciclovir does have long-term risks and adverse effects and, as with all medication should be prescribed with caution weighing up the advantages and disadvantages. The principle of "first do no harm" does not seem to have applied in this case.*'

113. The Tribunal interpreted this allegation as that Dr Myhill was prescribing a high dose of Valaciclovir and this had the potential for side effects which would not necessarily have occurred with the normal dose. The Tribunal accepted the opinion of Professor M.

114. The Tribunal therefore found paragraph 2(f)(v) proved.

Allegation 2f (vi)

115. The Tribunal considered whether on or before 8 December 2017 Dr Myhill consulted with Patient A and prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because it unnecessarily exposed Patient A to long-term risks associated with Valaciclovir.

116. The Tribunal once again accepted the expert evidence of Professor M in which he stated, '*The most important long-term risk is of renal impairment and renal stones. Dr Myhill rightly pointed out these potential risks and advised accordingly to have regular checks for renal function and increase fluid intake. Therefore, Valaciclovir does have long-term risks and adverse effects and, as with all medication should be prescribed with caution weighing up the advantages and disadvantages. The principle of "first do no harm" does not seem to have applied in this case*.'

117. The Tribunal therefore found paragraph 2(f)(vi) proved.

Allegation 3a

118. The Tribunal considered whether in her letter of 30 April 2018 to Patient A's GP, Dr Myhill stated that Valaciclovir was used to treat type 1, 2 and 3 herpes infections which was inappropriate because there was no evidence that Patient A had severe or frequent recurrences of genital herpes.

119. The Tribunal accepted the expert evidence of Professor M in which he stated, '*There is no evidence in the GP records that Patient A had severe or frequent recurrences of genital Herpes. Therefore, in my opinion, Dr Myhill's comments that "in this case we can use Valaciclovir within licence" is incorrect.*'

120. The Tribunal could find no reference in the GP records or in Dr Myhill's communications to indicate that Patient A had severe or frequent recurrences of genital herpes and therefore, as it did not have Dr Myhill's medical records of Patient A, it drew an adverse inference that there is no evidence that Patient A had severe or frequent recurrences of genital herpes.

121. The Tribunal therefore found paragraph 3(a) proved.

Allegation 3b

122. The Tribunal considered whether in her letter of 30 April 2018 to Patient A's GP, Dr Myhill stated that Valaciclovir was used to treat type 1, 2 and 3 herpes infections which was inappropriate because the dose of 1 gram four times daily was significantly higher than the licensed dose for preventing herpes simplex virus infections.

123. The Tribunal accepted the opinion of Professor M within his expert report in which he stated '*daily doses of Valaciclovir over long-term is licenced for the suppression of recurrent symptoms of Herpes Simplex Virus when a dose of 500mg once daily is recommended (twice daily in immuno-compromised adult).*'

124. The Tribunal therefore found paragraph 3(b) proved.

Allegation 4a(i), 4a(ii), 4a(iii) and 4a(iv)

125. The Tribunal considered whether on or before April 2018 Dr Myhill consulted with Patient A and advocated treatment with Vitamin B12 to manage CFS which was inappropriate because there was no evidence that Patient A was Vitamin B12 deficient. It also considered whether, at this time, there was no evidence that Patient A had a recognised indication of pernicious anaemia, and/or had Vitamin B12 deficiency associated anaemia; tobacco amblyopia; and/or leber's optic atrophy. The Tribunal also considered whether, at this time, there was no evidence that Patient A had any other recognised indication for B12 replacement therapy.

126. The Tribunal accepted that Dr Myhill advocated treatment of Patient A using Vitamin B12 for the purpose of treating CFS. It had regard to Dr Myhill's letter to Patient A's GP dictated on 30 April 2018 in which she stated '*This has been used for decades to treat CFS… However, the bottom line is that B12 is very safe and has no toxicity. Serum levels do not predict clinical response and indeed many patients do not see clinical benefit until serum levels are above 2000. Patient A has been improved for using Vitamin B12 injections.*' The Tribunal had no other evidence from Dr Myhill related to the use of B12.

127. The Tribunal took the view that Dr Myhill was using B12 to treat Patient A's CFS, not for Vitamin B12 deficiency.

128. The Tribunal acknowledges that Dr Myhill was prescribing Vitamin B12 to treat CFS. It noted the expert evidence of Dr K of the licenced indications of Vitamin B12. In his report, he stated, '*As regards vitamin B12, there is no suggestion Patient A was deficient and Dr Myhill does not provide evidence that patient A required replacement therapy or treatment of the recognised and licensed indications of pernicious anaemia, other vitamin B12 deficiency associated anaemia, tobacco amblyopia or Leber's optic atrophy. Dr Myhill's management of Patient A pertains to chronic fatigue syndrome in the correspondence included*.'

129. The Tribunal also noted Dr K's evidence '*Furthermore, while I do not have specific expertise in the management of chronic fatigue syndrome/myalgic encephalomyelitis*

(CFS/ME), regarding the potential use of vitamin B12 to treat CFS/ME I refer the reader to the existing National Institute for Health and Clinical Excellence (NICE) guidance. This advises there is insufficient evidence for the use of supplements such as vitamin B12 in CFS/ME and that these should not be prescribed for treating symptoms for the condition.'

130. The Tribunal accepted that Dr Myhill was prescribing Vitamin B12 outside of its licenced indications and NICE Guidelines. It then considered whether it was appropriate for Dr Myhill to do this. It accepted the oral evidence of Dr K where he stated that all doctors on occasion prescribe unlicensed medication which may be outside NICE Guidelines. He stated that they do this in consultation with the patient. The Tribunal therefore considered whether Dr Myhill had fully informed the patient of this. It took account of the consistent evidence that there was nothing to suggest that Patient A was not fully able to understand and consent to treatment. It took account of the evidence which was consistent that Patient A was fully engaged in the treatment provided by Dr Myhill to her as evidenced by her discussion with her GP. The Tribunal considered that Dr Myhill was of good character and in oral evidence Dr D confirmed that all Dr Myhill's appraisals were satisfactory to date. Taking these factors into account, the Tribunal determined that it is likely that Dr Myhill fully informed Patient A as required.

131. The Tribunal therefore found paragraphs 4a(i), 4a(ii), 4a(iii) and 4a(iv) not proved.

Allegation 5a

132. The Tribunal considered whether on or before April 2018 Dr Myhill consulted with Patient A and she failed to adequately consider the possibility that Patient A's symptoms were, at least in part, caused by anxiety and depression.

133. The Tribunal accepted that Dr Myhill had a duty to adequately consider the possibility that Patient A's symptoms were, at least in part, caused by anxiety and depression. The Tribunal had regard to the letter dated 31 July 2015 which states '*Fatigue is the symptom we*

experience when energy demand exceeds energy delivery and it is attention to both sides of this equation that gets a result. The way I think about chronic fatigue syndrome is that we all have a certain bucketful of energy available to us everyday. Fatigue is the symptom we all experience at the end of every day which prevents us from emptying that bucket of energy. Of course part of my job is to make that bucket of energy as large as possible through addressing mitochondrial function, sleep, thyroid function, diet and so on. However, we also have to look at how that energy is spent and essentially it can be spent mentally, physically, emotionally, or immunologically. Patients quickly work this out and the careful spending of mental and physical energy we call pacing. Psychotherapy may help the spending of emotional energy. However, the difficult one is the immunological hole in our energy bucket. We all know this exists- take a normal person and give them a dose of flu and they will develop a very acute fatigue.'

134. The Tribunal referred to Patient A's GP records which showed that she had a history of anxiety and depression since 1994 which had been treated by her GP on an ongoing basis including a referral to a mental health team in July 2016.

135. The Tribunal considered Dr K's comments that Dr Myhill should have considered the possibility that these conditions were not adequately managed. However, it considered that her anxiety and depression were being treated by her GP and it was not the role of Dr Myhill as a private practitioner to review the work of Patient A's GP.

136. The Tribunal therefore found paragraph 5(a) not proved.

Allegation 5b

137. The Tribunal considered whether on or before April 2018 Dr Myhill consulted with Patient A and she failed to refer Patient A to an appropriate specialist who could treat her long-term history of anxiety and depression.

138. The Tribunal noted Dr K's comments that Dr Myhill should have considered the possibility that these conditions were not adequately managed by her existing treatment. However, it did not consider that this was a duty of Dr Myhill as a private practitioner to review the work of Patient A's GP. It found that it was for Patient A's GP to refer (as she had in the past in July 2016) not Dr Myhill.

139. The Tribunal therefore found paragraph 5(b) not proved.

Allegation 6a

140. The Tribunal considered whether Dr Myhill prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because adequate treatment for conditions of deficiency requires only maintenance injections once every two to three months.

141. In determining this paragraph, the Tribunal used the dictionary definition of the word prescribed which when used in the context of the medical practitioner '*authorised the use of a medicinal treatment for someone'*. The Tribunal has already found that Dr Myhill was treating Patient A for CFS and not for Vitamin B12 deficiency.

142. The Tribunal therefore found paragraph 6(a) not proved.

Allegation 6b

143. The Tribunal considered whether Dr Myhill prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because it is not recommended by NICE.

144. The Tribunal accepted that this prescribing of Vitamin B12 injections was not recommended by NICE. However, this did not preclude it being prescribed by Dr Myhill

provided Patient A had been fully informed, and Patient A had agreed. The Tribunal considered that it appeared from Patient A's consultations with her GP that she was fully aware of the treatment provided by Dr Myhill.

145. The Tribunal has found that Dr Myhill informed Patient A of the fact that this treatment was outside relevant guidelines.

146. The Tribunal therefore found paragraph 6(b) not proved.

Allegation 6c

147. The Tribunal considered whether Dr Myhill prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because Patient A was exposed to daily injections with associated potential short-term side effects.

148. The Tribunal had regard to Dr K's opinion which states '*Also, while the documentation does not provide the specific route of injection or dose of vitamin B12; if injected, vitamin B12 is typically administered as hydroxycobalamin via intramuscular injection. In this regard, daily use of intramuscular injection has the short-term risks of frequent local pain and discomfort as well as the longer-term potential to induce chronic changes at recurrent injection sites such as scarring and fibrosis*.'

149. The Tribunal did not have Patient A's medical records kept by Dr Myhill. Therefore, it draws an adverse inference that the Vitamin B12 was being injected intramuscularly as opined by Dr K.

150. The Tribunal therefore found paragraph 6(c) proved.

Allegation 6d

151. The Tribunal considered whether Dr Myhill prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because Patient A was exposed to potential long-term complications.

152. The Tribunal considered that it was not inappropriate as Dr Myhill was treating Patient A for CFS and the Tribunal has found that Patient A had been fully informed concerning the uses of Vitamin B12.

153. The Tribunal therefore found paragraph 6(d) not proved.

Allegation 6e

154. The Tribunal considered whether Dr Myhill prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because there is a lack of biochemical, physiological and clinical evidence for rationale for the use of daily Vitamin B12 in the context used.

155. The Tribunal inferred from the absence of references to this in Dr Myhill's communication with Patient A's GP and the absence of this in her medical records that Dr Myhill had not identified biochemical, physiological and clinical evidence in her rationale for the use of daily Vitamin B12 in the context used.

156. The Tribunal therefore found paragraph 6(e) proved.

Allegation 7a(i)

157. The Tribunal considered whether Dr Myhill consulted with Patient A and prior to prescribing a parenteral magnesium supplement she failed to measure Patient A's serum magnesium.

158. The Tribunal first noted Dr Myhill's letter of 08 December 2017, in which she states, '*Magnesium is a particularly difficult element to correct because it is both a symptom and a cause of chronic fatigue syndrome - it is necessary for ATP to release its energy, it is necessary for oxidative phosphorylation and much of resting energy goes to maintain calcium magnesium ion pumps. So, where there is magnesium deficiency, oxidative phosphorylation goes slow and there is insufficient energy to ion pumps to function, so magnesium cannot be drawn into cell where it is needed for oxidative phosphorylation. This is one of the many vicious cycles in fatigue syndromes. By giving parenteral magnesium reduces the concentration gradient and makes the work of the ion pumps easier so intracellular levels can rise. The problem with magnesium is that for the above reasons it is very difficult to replete just by oral supplements and there is no doubt that some patients need magnesium by injection and I would suggest 0.5 ml magnesium sulphate daily. If [Patient A] starts to feel improvement, then she can begin to space the injections out further. I can confirm that I am also supplying [Patient A] with the wherewithal to carry out magnesium injections, i.e. 10mg/ml, magnesium sulphate, 0.5 ml insulin syringes; lignocaine 2%; and a Safe-Clip for their safe disposal*'.'

159. The Tribunal had regard to the expert opinion of Dr J in which he states, '*From this statement I presume the magnesium is being given as a prophylactic supplement. I say this because I can find no evidence that Dr Myhill previously established that she was formally suffering from magnesium deficiency (hypomagnesaemia). This would have required measurements of serum and urine magnesium, and if these were abnormal, further assessments of its renal clearance to establish if the deficiency was due to altered renal or gut absorption. Recent data also suggests poor dietary intake may be a common risk factor for hypomagnesaemia. For example, if you accept normal serum magnesium levels as >0.8mmol/l then mild magnesium deficiency through poor diet may affect up to one third of some populations (…). Nevertheless, I can see no evidence Dr Myhill measured Patient A's serum magnesium before prescribing a parenteral magnesium supplement*'.

160. The Tribunal accepted the oral evidence of Dr J in which he clarified that you would first measure the 'serum magnesium' via a blood test. There is no evidence in Dr Myhill's letters or emails that she carried out a blood test and the Tribunal did not receive the medical records. The Tribunal determined to draw an adverse inference from this that it is not likely that Dr Myhill carried out a blood test.

161. The Tribunal therefore found paragraph 7(a)(i) proved.

Allegation 7a(ii) and 7(a)(iii)

162. The Tribunal considered whether Dr Myhill consulted with Patient A and prior to prescribing a parenteral magnesium supplement she failed to measure Patient A's urine magnesium and renal clearance to determine if any deficiency was due to altered renal absorption, and/or altered gut absorption.

163. The Tribunal accepted Dr J's evidence that 'urine magnesium' and 'renal clearance' would only be undertaken following an abnormal blood test result. The Tribunal determined that as it had found that Dr Myhill had not carried out the blood test, it could not find that she had a duty to undertake a urine magnesium or renal clearance test.

164. The Tribunal therefore found paragraphs 7(a)(ii) and 7(a)(iii) not proved.

Allegation 7b

165. The Tribunal considered whether Dr Myhill consulted with Patient A and failed to identify that Patient A was formally suffering from magnesium deficiency ('hypomagnesaemia').

166. The Tribunal took account of the evidence it considered in relation to 7(a)(i) and determined that Dr Myhill had failed to identify that Patient A was formally suffering from magnesium deficiency as she had not undertaken a serum magnesium blood test.

167. The Tribunal therefore found paragraph 7(b) proved.

Allegation 7c(i)

168. The Tribunal considered whether Dr Myhill consulted with Patient A and prescribed Patient A 0.5ml daily of a 10mg/ml of magnesium sulphate (MgSO4) which was inappropriate because there was no clinical indication for magnesium supplements.

169. The Tribunal accepted Dr J's opinion, '*Since hypomagnesaemia was not established, the clinical need for magnesium supplements was absent*.' Therefore, the Tribunal considered it was inappropriate.

170. The Tribunal therefore found paragraph 7(c)(i) proved.

Allegation 7c(ii)(1) and 7c(ii)(2)

171. The Tribunal considered whether Dr Myhill consulted with Patient A and prescribed Patient A 0.5ml daily of a 10mg/ml of magnesium sulphate (MgSO4) which was inappropriate because the dose was wholly inadequate to treat primary hypomagnesaemia and help maintain magnesium homeostasis assuming a baseline of normomagnesaemia.

172. The Tribunal accepted the expert opinion of Dr J in which he stated, '*Hence Patient A should ideally be taking 320mg/day of elemental magnesium. The submission … shows that Dr Myhill prescribed 0.5ml daily of a solution containing 10mg/ml of magnesium sulphate (MgSO4). This solution is a very low strength and appears to be an unlicensed formulation… Nevertheless, 0.5ml of the solution prescribed by Dr Myhill would provide only 5mg, which is*

only 5/320 or 1.5% of the RDA. This dosing seems quite nonsensical. It is a dose that is wholly inadequate to treat primary hypomagnesaemia or help maintain magnesium homeostasis assuming a baseline of normomagnesaemia.'

173. The Tribunal therefore found paragraphs 7c(ii)(1) and 7c(ii)(2) proved.

Allegation 7c(iii)

174. The Tribunal considered whether Dr Myhill consulted with Patient A and prescribed Patient A 0.5ml daily of a 10mg/ml of magnesium sulphate (MgSO4) which was inappropriate because the prescription included 2% lignocaine, a local anaesthetic agent, which was inappropriate because it was not clinically indicated.

175. The Tribunal had regard to the expert opinion of Dr J in which he stated, '*The prescription also included 2% lignocaine a local anaesthetic agent. I presume this was provided because the subcutaneous injection of magnesium was uncomfortable or painful. I cannot confirm this as this route is not licensed and no mention is made of the need for lignocaine either in the summary or product characteristics (SPC) cited above or in the case reports where subcutaneous magnesium has been used….Therefore, the 10mg/ml solution Dr Myhill prescribed was hypotonic and subcutaneous solutions that deviate significantly from isotonic can be both painful and cause tissue damage*.'

176. The Tribunal therefore found paragraph 7c(iii) proved.

Allegation 7d(i)

177. The Tribunal considered whether Dr Myhill consulted with Patient A and her advice on parenteral administration of the prescribed medication was inappropriate because there was no evidence that parenteral MgSO4 had any efficacy in treating CFS.

178. The Tribunal had regard to Dr Myhill's evidence in her letter to Patient A's GP dictated on 08 December 2017 and considered that there was no evidence from her that magnesium had any efficacy in treating CFS. In addition, Dr J said there was no evidence that magnesium had any efficacy in treating CFS.

179. The Tribunal therefore found paragraph 7d(i) proved.

Allegation 7d(ii) and 7d(iii)

180. The Tribunal considered whether Dr Myhill consulted with Patient A and her advice on parenteral administration of the prescribed medication was inappropriate because Patient A was unnecessarily subjected to subcutaneous injections and/or the dose could have been supplied by a single chewable tablet.

181. The Tribunal accepted the expert opinion of Dr J in which he stated, '*Dr Myhill was also only apparently trying to give Patient A 5mg per day of elemental magnesium. This dose could have been easily supplied by, for example, a single chewable tablet of a licensed oral formulation of magnesium sulphate…'.* He further stated, *'Hence, it is unclear to me why Dr Myhill opted for parenteral administration of a magnesium supplement, that if necessary at all, could have been more reasonably and safely supplied by a tablet.'*

182. The Tribunal therefore found paragraph 7d(ii) and 7d(iii) proved.

Allegation 7d(iv)

183. The Tribunal considered whether Dr Myhill consulted with Patient A and her advice on parenteral administration of the prescribed medication was inappropriate because there was no urgent clinical situation.

184. The Tribunal noted the expert opinion of Dr J in which he stated '*Magnesium can be given parenterally (specifically intravenously) for hypomagnesaemia, but only in urgent clinical situations such as ventricular dysrhythmias or in pregnancy where severe pre-eclampsia presents with seizures (eclampsia).*'

185. The Tribunal accepted that there was no evidence that this was an urgent clinical situation.

186. The Tribunal therefore found paragraph 7d(iv) proved.

Allegation 7d(v)

187. The Tribunal considered whether Dr Myhill consulted with Patient A and her advice on parenteral administration of the prescribed medication was inappropriate because administering magnesium subcutaneously is not the recommended route for the licensed parenteral MgSO4 solutions available.

188. The Tribunal accepted the expert opinion of Dr J that administering magnesium subcutaneously is not the recommended route for the licensed parenteral MgSO4 solutions available. Dr J further stated, '*I have never encountered magnesium being given subcutaneously in this way and it is not a recommended route for the licensed parenteral MgSO4 solutions available.*'

189. The Tribunal therefore found paragraph 7d(v) proved.

Allegation 7d(vi)

190. The Tribunal considered whether Dr Myhill consulted with Patient A and her advice on parenteral administration of the prescribed medication was inappropriate because Patient

A did not have any predisposing conditions such as Crohn's Disease with concomitant bowel cancer and radiation damage.

191. The Tribunal accepted Dr J's expert opinion in which he stated, '*There are a handful of case reports documenting the use of this (subcutaneous) route to maintain normal magnesium levels in patients with very high magnesium requirements due to bowel pathology such as Crohn's with concomitant bowel cancer and radiation damage*'. He further stated, '*However, this extreme scenario does not apply to Patient A who had none of these predisposing disorders.*'

192. The Tribunal therefore found paragraph 7d(vi) proved.

Allegation 7e

193. The Tribunal considered whether Dr Myhill consulted with Patient A and following her prescribing to Patient A she failed to check and monitor Patient A's blood magnesium level to confirm an ongoing clinical need to continue the magnesium injections.

194. The Tribunal took into account Dr J's expert opinion given in his oral evidence in which he clarified that the low level of magnesium being administered would not require ongoing clinical monitoring. He stated that in principle Dr Myhill was required to monitor the Patient's magnesium's levels but in this particular instance, it was inconceivable that the dose given would have any impact on the serum magnesium level.

195. The Tribunal therefore found paragraph 7e not proved.

Allegation 7f

196. The Tribunal considered whether Dr Myhill consulted with Patient A and in the alternative to paragraph 7.b, 7.c., and 7.e., failed to notify Patient A's GP of her diagnosis of

magnesium deficiency; and/or her basis for the diagnosis of magnesium deficiency; and/or any monitoring she carried out of Patient A following the diagnosis of magnesium deficiency.

197. As the Tribunal has previously found 7b and 7c proved, it did not need to consider this paragraph with respect to them. It then considered this paragraph in relation to paragraph 7e of the allegation. The Tribunal took the view that 7e only related to paragraph 7f(iii).

198. The Tribunal had found that Dr Myhill did not have to monitor Patient A's blood magnesium level, and therefore, she did not have to inform Patient A's GP that monitoring was to be carried out.

199. The Tribunal therefore found paragraph 7f not proved in its entirety.

Internet

The evidence

200. The Tribunal received written and oral evidence in relation to these paragraphs from the following witnesses:

- Dr L produced an expert report dated 29 March 2022. He also gave oral evidence at the hearing;
- Professor M produced an expert report dated 15 March 2022. He also gave oral evidence at the hearing;
- Dr J produced expert reports dated 24 June 2020, 4 December 2020 and 21 April 2021 and an addenda report dated 24 February 2022. He gave oral evidence at the hearing by video link.
- Mr N, Legal Adviser to the GMC provided written evidence of the chronology of the web 'screen shots'.

201. The Tribunal received evidence as set out in Schedule 1 that included but was not limited to:

- YouTube video uploaded on 12 March 2020 and transcript thereof;
- YouTube video uploaded on 27 March 2020 and transcript thereof;
- Video of interview between Academy of Nutritional Medicine (ANM) and Dr Myhill on 12 May 2020. Uploaded (via YouTube) to website: NHS Corona Doctors on the Frontline and transcript thereof;
- Transcript of UK Health Radio interview of Dr Sarah Myhill on 16 March 2020;
- Screen shots of Dr Myhill's Website domain.

202. The Tribunal bore in mind that Dr Myhill was of good character throughout its consideration of the Internet paragraphs of the Allegation. It received no witness evidence other than from the experts. There was no evidence from Dr Myhill responding to the 'internet' matters.

Allegation 8

203. The Tribunal considered whether Dr Myhill used the internet to promulgate her views and opinions on viral and/or bacterial infections.

204. The Tribunal had regard to the Internet publications as set out in Schedule 1 to the Allegation.

'Schedule 1- Internet publications and media broadcasts

1. *YouTube videos uploaded on:*
   a. *12 March 2020;*
   b. *27 March 2020;*
   c. *21 May 2020.*

2. *Video of interview between Academy of Nutritional Medicine (ANM) and Dr Myhill on 12 May 2020. Uploaded (via YouTube) to website: NHS Corona Doctors on the Frontline.*

3. *MP3 audio file of UK Health Radio interview with Dr Myhill on 16 March 2020.*

4. *On 13 March 2020, an article written by you titled 'Coronavirus-what you need to know', was made publicly available at the following internet domain: … ('the Article').*

5. *Website domain name … ('Your Website') and articles hosted thereon*.'

205. The Tribunal has reviewed the three YouTube videos and has read all the other documentations put before it. In relation to paragraph 5 of Schedule 1 it read the four articles as follows:

'1. 'Coronavirus- it is not a death sentence! What do you need to do for viral survival'.
2. 'Vitamin C- learn to use this vital tool well- the key is getting the dose right'.
3. 'Iodine- another vital multitasking tool that should be a household word'.
4. 'Effective prevention and treatment for all respiratory viruses including Covid and Influenza'.

206. The Tribunal has seen Doctor Myhill in the You-Tube videos and is satisfied it is her because she is introduced as Dr Myhill. It has seen that Dr Myhill promoted and endorsed the use of high doses of Vitamin C and Vitamin D and the inhalation of iodine for the treatment of bacterial and viral infections including Covid. Taking all of the evidence into account it found that Dr Myhill promulgated her views and opinions on viral infections and or/bacterial infections.

207. The Tribunal therefore found paragraph 8 proved.

Allegation 9

208. The Tribunal considered whether in 'Her Media', Dr Myhill promoted and endorsed the use of 'the Agents' to treat and protect against viral and bacterial infections, including Coronavirus.

209. The Tribunal considered each of 'the Agents' listed in schedule 2:

- High dose Vitamin C ascorbic acid;
- Iodine in the form of an iodine solution inhaled from a salt pipe;
- Vitamin D;
- Ivermectin.

Allegation 9(a)

210. The Tribunal considered whether Dr Myhill had made a series of recommendations as set out in Schedule 3 of the Allegation:

'Schedule 3- Recommendations

1. Recommendations from the Article referred to at Schedule 1, paragraph 4:
    1. Vitamin C at least 5 grams daily;
    2. *'Sniff and inhale Lugol's iodine 15% 2-3 times a day using a salt pipe. I suggest 2 drops in a salt pipe sniffed up into the nose and inhaled 15-20 times. Iodine is an effective topical disinfectant. It is also volatile so when inhaled kills or substantially reduces the numbers of all microbes threatening to enter the airways.*'
    3. '*And/or …possibly use a face mask, drizzle 2-4 drops of Lugol's iodine 15% on to the lining. for the same reasons as above. Re-apply Lugol's three times a day.*'

4. *'And/or …smear iodine oil (made as above) round the nose and upper lip three times a day. Yes, it does stain the skin yellow temporarily but it slowly evaporates from the skin to generate a disinfectant cloud of iodine. This is good for kids who may not be able to use a salt pipe or tolerate a mask.'*
5. at the first sign of any infection to:
    i. *'Take 10 grams of vitamin C (as ascorbic acid powder) in 500 ml of water every hour until you get diarrhoea – this is called 'bowel tolerance'*
    ii. *'You must take enough vitamin C – you can only fail by under-dosing. Vitamin C is completely safe and you can do no harm with it. As one of my comic patients put it 'Premature crapping is preferable to premature croaking.''*
    iii. *'Inhale Lugol's iodine every two hours. I suggest 2 drops in a salt pipe sniffed up into the nose and inhaled – this may slightly stain the inside of your nose – but then you know the iodine is present. You will know the iodine is in the right place because you can smell it.'*
    iv. *'Iodine is non-toxic to humans and all mammals (but if you are allergic to iodine then you should not use it)'*.

2. From an article hosted on Your Website titled '*Effective prevention and treatment for all respiratory viruses including Covid and Influenza'* as referred to in Schedule 1, paragraph 5:

'Introduction

These safe nutritional interventions are now so well established that vaccination has been rendered irrelevant.

DO NOW, and for life

- *Take vitamin D3 10,000iu daily (this is roughly equivalent to one hour of full body sunshine exposure). This gets blood levels up sufficiently high to reduce*

the risk of death from covid-19 to near-zero. The dose for children is proportionately less

- *Take vitamin C 5grams (5,000mgs) in water, consume this little and often through the day*
- *Eat a Paleo-Ketogenic (low carb) diet and apply* **Groundhog Basic**

…

AT THE FIRST HINT OF ANY RESPIRATORY SYMPTOMS

- *Apply* **Groundhog Basic**

Reduce the loading dose of virus by:

1. **Using a salt pipe with iodine.** *Drizzle Lugol's iodine 15% 1-2 drops (whatever is tolerated – if you can smell it then you have a therapeutic dose) into the mouthpiece– sniff this to saturate upper and lower airways. Iodine is volatile. Use Valsalva manoeuvre to blow the iodine into the middle ear and sinuses- see* **Clearing your ears by Go Flight Med**.*Keep going for 5-10 sniffs – iodine gets everywhere and tiny amounts (ie one part per million) kill all microbes! Do this at least three times daily but as often as convenient. Indeed any chronic infection, bacterial viral or fungal would be killed with this. See my YouTube* **Dr Myhill advises on treating viral infection**
2. **Take vitamin C to bowel tolerance.** *Speed is of the essence to flush out any virus before it has a chance to invade. Take 10 grams of vitamin C every hour until you get diarrhoea. This may be slightly inconvenient but far preferable to risking acute and chronic covid or influenza! Continue with bowel tolerance doses of vitamin C until you are completely recovered. Some need 50-100 grams daily. Once recovered go back to your normal 5 (possibly 10) grams daily – see my webpage –* **Vitamin C – learn to use this vital tool well – the key is getting the dose right** *- This is a reproduction of Chapter 31 of* **Our book 'Ecological Medicine'**

3. ***Use iodine oil*** *(10 parts coconut oil to 1 part 15% Lugol's iodine) on hands and face to reduce physical spread of virus – see my webpage* ***Iodine – another multitasking tool that should be a household word*** *This is a reproduction of Chapter 32 of* ***Our book 'Ecological Medicine'***

   If you have not been taking vitamin D3, take a one-off loading dose of 100,000iu at once, (if possible take the active vitamin D calcitriol 0.5mcgms daily for 14 days to instantly restore levels). Either way, follow this up with 10,000iu vitamin D daily for life.

If symptoms progress (and this is very unlikely with all the above in place) then use ivermectin 0.3mgs per kg of body weight for at least 5 days or until recovered. For a 60kgs (9 ½ stone) person this is a daily dose of 18mgs ivermectin. Perhaps get some in now for emergency use – see ***BIRD GROUP****. I am a belt and braces doctor!...'*

211. The Tribunal had regard to all the recommendations set out in Schedule 3 as seen in the Articles:

- 13 March 2020 Article written by Dr Myhill entitled *'Coronavirus- what you need to know*' which was made publicly available on the internet.
- Article hosted by Dr Myhill's Website entitled '*Effective prevention and treatment for all respiratory viruses including Covid and Influenza*'

212. The Tribunal considered that it was very clear from reading the articles that Dr Myhill was making recommendations regarding the use of 'the Agents' for the treatment of, and to protect against, viral and/or bacterial infections including Coronavirus.

213. The Tribunal therefore found paragraph 9(a) proved.

Allegation 9(b)(i) and 9(b)(ii)

214. The Tribunal then set out to determine whether Dr Myhill published or allowed her website to publish articles which purported to provide guidance on how to treat coronavirus infection and recommended the use of 'the Agents'.

215. The Tribunal had regard to Dr Myhill's website article entitled *'Coronavirus- it is not a death sentence! What do you need to do for viral survival'.*

216. The Tribunal considered that this article did provide guidance on the treatment of Coronavirus. For example, Dr Myhill recommends that before any signs or symptoms of Coronavirus that people '*should take at least 5000iu and ideally 10,000iu of vitamin D and at least 5 grams of vitamin C'*. She also recommends that in the event of exposure people should inhale 15 % Lugol's iodine 2/3 times a day, 15 -20 sniffs from a salt filled pipe.

217. In addition, it noted that Dr Myhill recommended that at the first sign of infection, a patient should ingest 10 grams of Vitamin C until there is diarrhoea and sniff iodine from a pipe two hourly.

218. The Tribunal also considered the article available on Dr Myhill's website entitled "*Effective prevention and treatment for all respiratory viruses including Covid and Influenza*". It considered this article clearly provided guidance as set out in its title.

219. The Tribunal also had regard to the advice on Dr Myhill's website articles which states, '*Vitamin C- learn to use this vital tool well- the key is getting the dose right*' and '*Iodine- another vital multitasking tool that should be a household word'.*

220. The Tribunal also found that Dr Myhill recommended the use of Ivermectin in the article '*Effective prevention and treatment for all respiratory viruses including Covid and Influenza'* also found on Dr Myhill's website.

221. The Tribunal found that the four articles purported to provide guidance on the treatment of Covid using 'the Agents', namely Vitamin C, Iodine, Vitamin D and Ivermectin.

222. The Tribunal therefore found both paragraphs 9(b)(i) and 9(b)(ii) proved.

Allegation 9(c)

223. The Tribunal considered whether Dr Myhill sold 15% Lugol's iodine on the sales section of her website, and in doing so, made recommendations about its use on her website.

224. The Tribunal saw the extract from Dr Myhill's website which showed that she was selling 15% Lugol's iodine. The Tribunal interpreted 'selling' to include 'offering to sell'. It also had regard to Schedule 5 which was information accompanying iodine for sale on her website;

'Schedule 5- Information accompanying iodine for sale on Your Website

Iodine is an essential element which is lacking in Western diets. We should all be taking iodine 1mg daily at least. Iodine can also be used in much higher doses therapeutically. Its contact kills all microbes and is the best disinfectant. It helps to strip out toxic metals from the body and one can safely take 20mgs daily. (Lugol's iodine 15% one drop contains approx. 8mgs). (One 30 ml bottle contains approx. 600 drops)'.

'Lugol's Iodine 15% - 30 ml (Potassium Iodide is 10% and Iodine is 5%)

Take 2 drops Lugol's iodine 15% minimum daily for life.'

'Derived from Mined Crystals.

Shake well before use

Store in a cool dark place

NOTE: The label is discoloured as Lugol's Iodine is drawn through the bottle.

The product is perfectly fine.'

225. The Tribunal found that this clearly set out the recommendations for its use.

226. The Tribunal therefore found paragraph found 9(c) proved.

Allegation 10(a)(i)

227. The Tribunal set out to determine whether, in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that 'the Agents' are not licensed to be used as anti-viral agents in vivo. It considered each agent separately. The Tribunal was aware that this paragraph contains the word 'failure'. The Tribunal had to consider whether Dr Myhill had a duty to clearly articulate whether 'the Agents' are not licensed to be used as anti-viral agents in vivo. The Tribunal considered that Dr Myhill had a duty to articulate relevant information to enable patients to make a fully informed choice. The Tribunal considered that it was important for medical practitioners when recommending the use of the medicines to the public, to make it clear when the recommendation is outside the license of the product. This allows a member of the public to make an informed decision about whether to use the product.

Allegation 10(a)(i)- Vitamin C

228. The Tribunal had regard to the expert report of Dr J in which he stated:

'The doses of vitamin C recommended by Dr Myhill (5g/day rising to 10g/hour at onset of coryzal symptoms) are well in excess of any published (or my) experience and well in excess of doses licensed for even severe vitamin C deficiency.'

229. The Tribunal therefore found paragraph 10(a)(i) proved in respect of Vitamin C.

Allegation 10(a)(i)- Iodine

230. The Tribunal went on to determine whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that iodine is not licensed to be used as an anti-viral agent in vivo.

231. The Tribunal once again had regard to the expert report of Dr J in which he stated, '*Iodine is not licensed or recommended to prevent viral infection in the way Dr Myhill suggests by inhalation*.'

232. The Tribunal therefore found paragraph 10(a)(i) proved in respect of iodine.

Allegation 10(a)(i)- Vitamin D

233. The Tribunal then considered whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that Vitamin D is not licensed to be used as an anti-viral agent in vivo.

234. The Tribunal was once again mindful of Dr J's report in response to Dr Myhill's claim during the interview with the Academy of Nutritional Medicine that Vitamin D is of proven benefit against Covid-19 and her advice that patients should be taking at least 5,000 and ideally 10,000 international units daily. Dr J, in his report, stated, '*This recommendation is again wrong and at odds with the SPC for licensed formulations of vitamin D. They all emphasise that even when treating patients with confirmed vitamin D deficiency oral doses above 800IU (of D3 or equivalent) should be given for a maximum of 12 weeks under medical supervision then adjusted based on blood levels of vitamin D'.*

235. The Tribunal therefore found paragraph 10(a)(i) proved in respect of Vitamin D.

Allegation 10(a)(i)- Ivermectin

236. The Tribunal then considered whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that Ivermectin is not licensed to be used as an anti-viral agent in vivo.

237. The Tribunal had regard to Dr J's report in which he stated that Ivermectin '*is not licensed to treat any human viral infection'*. In his report, Dr J went on to say that '*The doses of Ivermectin that Dr Myhill recommends are neither licensed nor taken from a trial showing robust efficacy in Covid 19 infections' 'in summary, ivermectin is neither licensed nor indicated for use in patients who have viral respiratory symptom'*.

238. The Tribunal therefore found paragraph 10(a)(i) proved in respect of Ivermectin.

Allegation 10(a)(ii)

239. The Tribunal then considered whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that 'the Agents' were not universally safe for people when used in the way she recommended. The Tribunal considered the meaning of 'universally safe' and gave it the dictionary definition. It defined 'universal' as '*done by or involving all the people in the world or in a particular group'* and 'safe' as '*free from hurt or damaged; unharmed'.* It then addressed what it considered to be the difference between what is not safe and what is side effects. It considered that just because something gave some people side effects, it did not necessarily make it unsafe. It also noted that it is logically impossible to say that anything is universally safe, so the Tribunal took a common-sense approach to this issue. In considering all the agents, the Tribunal took this reasoning into account. The Tribunal also had to consider whether Dr Myhill had a duty to articulate that 'the Agents' were not universally safe for people when used in the way she recommended.

Allegation 10(a)(ii)- Vitamin C

240. The Tribunal noted that Dr J made it clear that there are side effects from consuming large doses of Vitamin C as advised by Dr Myhill, namely diarrhoea and the possibility of kidney stones. However, he does not state that Vitamin C is unsafe, he merely stated that '*mega dosing with vitamin C is not entirely without side effects'*. The Tribunal also considered the expert evidence of Dr L in which he states, '*Because the body is so good at limiting absorption and excreting excess amounts, vitamin C has low toxicity and is not believed to cause serious adverse effects at high intakes, apart from diarrhoea, nausea, abdominal cramps and other disturbances arising from the osmotic effect of unabsorbed vitamin C in the gastrointestinal tract*.'

241. The Tribunal accepted the experts' opinions which did not conclude that taking Vitamin C as recommended by Dr Myhill was unsafe. It therefore followed that she did not have a duty to articulate that it was not universally safe.

242. The Tribunal therefore found paragraph 10(a)(ii) not proved with respect of Vitamin C.

Allegation 10(a)(ii)- Iodine

243. The Tribunal accepted that the expert, Dr J, was unable to assist with the precise dosage of iodine delivered from the salt pipe. Whilst the Tribunal accepted the expert's evidence that ingesting iodine, i.e. taking it by mouth, is not universally safe. Schedule 2 of the Allegation refers specifically to consuming '*iodine in the form of an iodine solution inhaled from a salt pipe'*. During his evidence, he was unable to confirm what dosage of iodine is delivered to the patient via a salt pipe. Therefore, the Tribunal could not be certain of the dose received by the patient based solely on the clay pipe method of consuming iodine. Therefore, the Tribunal was not persuaded by the GMC that inhaling iodine in the method described in the schedule was not universally safe for people when inhaled from a salt pipe.

244. The Tribunal considered that Dr Myhill did not have a duty to articulate that iodine was not universally safe.

245. The Tribunal therefore found paragraph 10(a)(ii) not proved with respect to iodine.

Allegation 10(a)(ii)- Vitamin D

246. The Tribunal accepted the expert evidence of Dr L and Dr J in which they informed the Tribunal that consuming Vitamin D in excess amounts places a patient at risk of developing hypercalcaemia which can be fatal if severe and left untreated. The Tribunal therefore considered that Dr Myhill had a duty to articulate that Vitamin D was not universally safe for people when used in the way she recommended.

247. The Tribunal therefore found paragraph 10(a)(ii) proved with respect to Vitamin D.

Allegation 10(a)(ii)- Ivermectin

248. The Tribunal accepted the evidence of Dr J in his report, in which he stated, '*Ivermectin has been widely used in tropical aid programmes to eradicate filarial disease where it has been found to be largely safe in the recommended doses*'.

249. The Tribunal found that the GMC had not proved that Ivermectin was universally unsafe when used as recommended by Dr Myhill because the expert had qualified his opinion as above.

250. The Tribunal considered that Dr Myhill did not have a duty to articulate that Ivermectin was not universally safe.

251. The Tribunal therefore found paragraph 10(a)(ii) not proved with respect to Ivermectin.

Allegation 10(b)

252. The Tribunal then set out to determine whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that there is no published evidence to support 'the Agents' being effective contact viricides when used in the manner she advised. The Tribunal had to consider whether Dr Myhill had a duty to do this.

Allegation 10(b)- Vitamin C

253. The Tribunal accepted the evidence of Dr J that '*There is in vitro (performed outside the body) data showing that ascorbic acid can kill viruses but typically it is in the presence of metal cations (such as iron and Copper) and at concentrations and pHs that are not physiologically relevant. Indeed, as one recent editorial states, it is very unlikely to be direct contact with the virus that explains the virucidal activity of ascorbic acid and it is most unlikely that it is virucidal in vivo (in the body).*'

254. The Tribunal considered carefully the opinion of Dr J but nevertheless, did not consider that Dr Myhill had a duty to explain to people that there was no published evidence to support 'the Agents' being effective contact viricides when used in the manner advised. The Tribunal considered that it was a common-sense approach that a doctor could not be expected to articulate details of all published evidence to members of the public when making recommendations. It would therefore not be reasonable to expect Dr Myhill to have a duty to articulate this.

255. The Tribunal therefore found paragraph 10(b) not proved with respect to Vitamin C.

Allegation 10(b)- Iodine

256. The Tribunal accepted the view of Professor M in which he stated '*I am not aware of any clinical studies of the use of Iodine pipes and their use is not recommended in the current*

NICE COVID-19 guidelines (NG191 2022). Therefore, Dr Myhill's advice and recommendations are not supported by any scientific literature in-vivo (i.e. randomised clinical trials) and not supported by current NICE guidance.' It was also mindful of the evidence of Dr L in which he stated that '*There are no data to support any clinically meaningful viricidal effect of sniffing Lugol's iodine via a salt pipe, nor any data to support prevention of Covid-19, or in mitigating disease severity, by reducing the level of exposure to infectious particles*.'

257. The Tribunal considered whether Dr Myhill had a duty to articulate that there were no trials or recommendations relating to the use of iodine by salt pipe. The Tribunal considered that it was a common-sense approach that a doctor could not be expected to articulate the details of all published evidence to members of the public when making recommendations. It would therefore not be reasonable to expect Dr Myhill to have a duty to articulate this.

258. The Tribunal therefore found paragraph 10(b) not proved with respect to iodine.

Allegation 10(b)- Vitamin D

259. The Tribunal was not aware that there was any evidence that Dr Myhill had claimed in her recommendations that Vitamin D was an effective contact viricide.

260. The Tribunal therefore found paragraph 10(b) not proved with respect to Vitamin D.

Allegation 10(b)- Ivermectin

261. The Tribunal was not aware that there was any evidence that Dr Myhill had claimed in her recommendations that Ivermectin was an effective contact viricide.

262. The Tribunal therefore found paragraph 10(b) not proved with respect to Ivermectin.

Allegation 10(c)

263. The Tribunal set out to determine whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that there are health risks and/or side effects associated with using 'the Agents' in the manner she had stated. The Tribunal also had to consider whether Dr Myhill had a duty to do so. The Tribunal considered that any doctor making a recommendation about a medication should be providing some details of health risks and/or side effects.

Allegation 10(c)- Vitamin C

264. The Tribunal accepts the opinion of Dr J that there can be health risks and or side effects associated with mega dosing Vitamin C which can include kidney stones and anaemia in susceptible people. The Tribunal also accepted that Dr Myhill failed to articulate any such advice. The Tribunal found that Dr Myhill had a duty to articulate such advice and failed to do so.

265. The Tribunal therefore found paragraph 10(c) proved with respect to Vitamin C.

Allegation 10(c)- Iodine

266. The Tribunal accepted the evidence of Dr J that continual use of iodine has the potential to cause iodine toxicity. He explained that chronic use of iodine risks chronic iodine poisoning and acute ingestion of significant volumes can be fatal.

267. The Tribunal bore in mind that in the document; "*Questions and Answers about Iodine",* the following question was asked to Dr Myhill: "*My husband's skin turned red and sore yesterday with an iodine drop test on his arm. It is still red but doesn't hurt any more (24 hours later). He did use the iodine/salt pipe (we think our son has had CoVid19 - he returned home 5 days ago with persistent cough and had had fever/flu fo 2 days 5 days earlier). My husband said he was uncomfortable with a burning sensation in his lungs for 3 hours after. What should we do*?"

268. Dr Myhill's response was that the individual was likely to be '*overdoing it'* with the iodine.

269. The Tribunal was aware that in a video hosted by the website 'NHS Corona Doctors on the Frontline', titled Dr Sarah Myhill webinar AMN of 12 May 2020, Dr Myhill made it clear that iodine taken in too high a dose can cause lung irritation. It therefore found that Dr Myhill had provided some guidance of risks in this particular video. However, there were a number of references to the use of iodine in 'Her Media' where no reference is made to health risks or side effects. The Tribunal considered that Dr Myhill had a duty to clearly articulate that there were health risks or side effects using iodine in the manner she stated. The Tribunal considered that Dr Myhill had a duty to inform the public of potential side effects and she failed to do so.

270. The Tribunal therefore found paragraph 10(c) proved with respect to iodine.

Allegation 10(c)- Vitamin D

271. The Tribunal bore in mind Dr J's report in which he detailed the risks of taking Vitamin D at the doses recommended by Dr Myhill. '*At the doses suggested by Dr Myhill (10,000 iU daily), there is a definite risk that susceptible individuals might develop hypercalcaemia and hypercalciuria, with a risk of forming renal stones or dehydrational kidney injury, and experiencing hypercalcaemic symptoms (thirst, polyuria, constipation, abdominal pains and confusion*).'

272. The Tribunal accepted the evidence of Dr L in which he stated, '*High doses of vitamin D can cause hypercalcaemia, which is associated with nausea, vomiting, weakness, bone pain and the development of kidney stones (calcium stones). Higher doses of vitamin D (such as 100,000 International Units) should only be given under medical supervision when the blood tests have shown vitamin D deficiency*.'

273. The Tribunal accepted the experts' opinions and considered that Dr Myhill had a duty to clearly articulate that there are health risks and/or side effects associated with using Vitamin D in the manner she stated, and she failed to do so.

274. The Tribunal therefore found paragraph 10(c) proved with respect to Vitamin D.

Allegation 10(c)- Ivermectin

275. The Tribunal was mindful of the evidence of Professor M in which he states, '*Ivermectin given as a short course is generally safe and it has been used for mass treatment campaigns in tropical regions to reduce the risk of helminth infections. The SPC (Summary of Product Characteristics 2022) lists undesirable effects, including liver dysfunction, including acute hepatitis, haematuria, toxic epidermal necrolysis and Stevens-Johnson syndrome*.'

276. The Tribunal accepted the expert's opinion and considered that Dr Myhill had a duty to clearly articulate health risks and/or side effects for the use of Ivermectin and she failed to do this.

277. The Tribunal therefore found paragraph 10(c) proved with respect to Ivermectin.

Allegation 10(d)

278. The Tribunal set out to determine whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that the use of Vitamin D in the manner she stated is not supported by any UK guidelines or trial data. The Tribunal had to decide whether she had a duty to do this.

279. In determining this paragraph, the Tribunal had regard to the expert evidence of Dr L who informed it that NICE had recently acknowledged that Vitamin D supplementation may

reduce the risk of winter respiratory infections. However, it also noted Dr L's evidence that the dose recommended by Dr Myhill was at the time, and remains now, unsupported by published evidence to support it being an effective viricide. It also bore in mind Professor M's evidence in which he referred to the NICE guidelines 2021 and December 2020, which concluded that evidence that Vitamin D is effective against viral infections including Covid is sparse, indirect and inconclusive. The Tribunal noted that these guidelines post-date one of Dr Myhill's articles titled "*Effective Prevention and treatment of all respiratory viruses including covid and influenza*" in respect of Vitamin D. It follows that at the time she made the recommendations, the use of Vitamin D in the manner she stated was not supported by UK guidelines or trial data.

280. The Tribunal had regard to the contents of Dr Myhill's website in relation to this- '*Benefits of Vitamin D: as of Sept 10, 2021, the Vitamin D wiki page had 34 trials, 6 trial results, 23 meta-analyses and reviews, 63 observations, 35 recommendations, 55 associations, 89 speculations, 6 videos'*. In stating this, Dr Myhill referenced '*Vitamin D Wiki Site- Covid-19 treated by Vitamin D-studies, reports, videos', 'Ortholmolecular.Org- Top 25 Vitamin D Publications in 2020'* and '*NHS Corona Doctors on the Frontline'*.

281. The Tribunal had regard to the article titled '*Benefits of Vitamin D'* which was modified on 25 January 2022. This post-dated the NICE guidelines of December 2020 which states, '*The NICE COVID-19 rapid guideline on vitamin D (NICE guidance NG187 Dec 2020) recommends that people encouraged to follow UK government advice on taking vitamin D supplements, "do not offer a vitamin D supplement to people solely to prevent COVID-19, except as part of a clinical trial" and "do not offer a vitamin D supplement to people solely to treat COVID-19, except as part of a clinical trial".*'

282. The Tribunal had regard to the latest website of Dr Myhill entitled "*Effective Prevention and treatment of all respiratory viruses including covid and influenza*" which was modified on 25 January 2022. It noted that in relation to Vitamin D, she gave a number of

references to studies but did not mention the 2020 NICE guidelines relating to the use of Vitamin D for Covid-19.

283. The Tribunal considered that it would have been preferable if Dr Myhill had updated her website include the NICE guidelines as well as the other reference materials she provided.

284. The Tribunal considered all of the above and found that Dr Myhill did not have a duty to articulate that the use of Vitamin D in the manner she stated is not supported by any UK Guidelines or trial data. The Tribunal considered that it would not be reasonable for a doctor to have to articulate all relevant reference material.

285. The Tribunal therefore found paragraph 10(d) not proved.

Allegation 10(e)

286. The Tribunal set out to determine whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that the off-licence use of 'the Agents' requires a robust knowledge of the evidence for the efficacy and safety of 'the Agents' when used in the manner she recommended. The Tribunal also had to consider whether Dr Myhill had a duty to do so.

287. The Tribunal bore in mind the expert evidence of Dr J who stated, '*To offer this specialist advice about use of virucides I would expect her to have a background in a specialty such as clinical pharmacology, infectious diseases, clinical virology or public health medicine. The agents she recommends (vitamin C and Lugol's iodine solution) are not licensed to be used as anti-viral agents in vivo and they are not entirely safe when used in the way suggested (as expanded in points 5 and 6). The use of agents off-licence also requires a robust*

knowledge of the evidence for the efficacy and safety of agents when used in this way. The practitioner also has a duty to explain to their patients/audience that what is being recommended if off-licence with all that that implies.'

288. The Tribunal considered firstly whether Dr Myhill had a duty to articulate that the off-licence use of 'the Agents' requires a robust knowledge of the evidence for the efficacy and safety of 'the Agent' when used in the manner she recommended on 'Her Media'. The Tribunal was provided with no evidence that Dr Myhill had a duty to articulate this. It had regard to the evidence of Dr J and considered that this related to Dr Myhill's own knowledge and background personally rather than the failure to articulate the off-license use of 'the Agents'.

289. The Tribunal therefore found paragraph 10(e) not proved.

Allegation 10(f)

290. The Tribunal set out to determine whether in Dr Myhill's recommendations in 'Her Media', she failed to clearly articulate that she did not have a specialist background in the areas of the use of virucides, clinical pharmacology, infectious diseases, clinical virology and public health medicine. The Tribunal also had to consider whether Dr Myhill had a duty to do so.

291. The Tribunal bore in mind the expert evidence of Dr J who states, '*To offer this specialist advice about use of virucides I would expect her to have a background in a specialty such as clinical pharmacology, infectious diseases, clinical virology or public health medicine. The agents she recommends (vitamin C and Lugol's iodine solution) are not licensed to be used as anti-viral agents in vivo and they are not entirely safe when used in the way suggested (as expanded in points 5 and 6). The use of agents off-licence also requires a robust*

knowledge of the evidence for the efficacy and safety of agents when used in this way. The practitioner also has a duty to explain to their patients/audience that what is being recommended if off-licence with all that that implies.'

292. The Tribunal considered firstly whether Dr Myhill had a duty to clearly articulate that she did not have a specialist background in the areas of the use of virucides, clinical pharmacology, infectious diseases, clinical virology and public health medicine in 'Her Media'. The Tribunal was provided with no evidence that Dr Myhill had a duty to articulate this. It had regard to the evidence of Dr J and considered that this related to Dr Myhill's own knowledge and background personally rather than the failure to clearly articulate that she did not have a specialist background in the aforementioned areas.

293. The Tribunal therefore found the entirety of paragraph 10(f) not proved.

Allegation 11(a)(i)

294. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation risked patient safety in that they exposed patients to potential serious harm, including toxicity. The Tribunal had particular regard to its findings in relation to paragraph 10(a)(ii) where it found only in relation to vitamin D and 10(c) where it found in relation to all 'the Agents'.

295. The Tribunal considered that in this allegation, the word patient was interchangeable with a member of the public. It recognised that not everybody that accessed the website was a patient of Dr Myhill.

296. The Tribunal took account of Dr J's report in which he stated '*The use of iodine and vitamin D are of more serious concern as both have the potential to cause serious and even potentially fatal toxicity…*'.

297. The Tribunal took into account the findings it had already made in relation to Vitamin D, Iodine, Vitamin C and Ivermectin and considered that these agents risked patient safety in that they exposed patients to potential serious harm, including toxicity.

298. The Tribunal therefore found paragraph 11(a)(i) proved.

Allegation 11(a)(ii)

299. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation risked patient safety in that they were not peer reviewed.

300. The Tribunal defined 'peer reviewed' by the dictionary definition which states '*a judgement on a piece of scientific or other professional work by others working in the same area*'.

301. The Tribunal considered the issue of Dr Myhill's peers and took into account her statements at the Academy of Nutritional Medicine International Awareness day Special on 12 May 2020. '*I run a mentoring group of doctors, many of whom are working within the NHS and are currently on the front line…*'.

302. The Tribunal considered that there was an element of peer review in relation to Dr Myhill's work. It also considered that Dr Myhill had provided references in relation to her work covering the effect of prevention and treatment of respiratory viruses including the effect of Covid and Influenza.

303. The Tribunal therefore found paragraph 11(a)(ii) not proved.

Allegation 11(a)(iii)

304. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation risked patient safety in that they failed to meet NICE guidance of Vitamin D dosing.

305. The Tribunal was aware that Dr Myhill's website article titled '*Effective prevention and treatment for all respiratory viruses including Covid and Influenza*' was last modified on 25 January 2022. This indicates that the article was still available on Dr Myhill's website after the NICE guidelines were issued in December 2020. The guidelines state, '*do not offer a vitamin D supplement to people solely to prevent Covid-19 except as part of a clinical trial'*. The Tribunal considered that this risked patient safety as Dr Myhill recommended vitamin D as a treatment which reduces the risk of death from Covid 19 to near zero. The Tribunal took the view that a member of the public who followed this advice could potentially ignore other risk mitigating strategies, for example, mask wearing or vaccination.

306. The Tribunal was also mindful of Professor M's expert evidence in which he stated '*The promotion … vitamin D supplements... None of these interventions are currently recommended for coronavirus infections in NICE guidance*.'

307. The Tribunal therefore found paragraph 11(a)(iii) proved.

Allegation 11(a)(iv)

308. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation risked patient safety in that they were unproven in terms of their benefit.

309. The Tribunal had regard to Professor M's report in which he states, '*Dr Myhill has a pseudo-scientific approach to her practice and makes unbased claims for the effectiveness of her regime. She does not practice evidence-based medicine and may encourage false*

reassurance in her patients who may believe that they will not catch COVID-19 or other infections if they follow her advice.'

310. The Tribunal therefore considered that Dr Myhill's actions in this sense did risk patient safety in that they were unproven in terms of their benefit.

311. The Tribunal therefore found paragraph 11(a)(iv) proved.

Allegation 11(b)(i)

312. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation undermined public health in that they exposed patients to potential serious harm, including toxicity.

313. The Tribunal interpreted public health to mean the public's health in general rather than a specific patient.

314. The Tribunal considered this allegation in relation to all 'the Agents'.

315. The Tribunal took account of Dr J's report in which he stated, '*The use of iodine and vitamin D are of more serious concern as both have the potential to cause serious and even potentially fatal toxicity…'*.

316. The Tribunal found that exposing patients to potential serious harm undermines public health. The Tribunal considered that Dr Myhill exposed people to potential serious harm, particularly from Vitamin D toxicity.

317. The Tribunal therefore found paragraph 11(b)(i) proved.

Allegation 11(b)(ii)

318. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation undermined public health in that they were not peer reviewed.

319. The Tribunal determined that as it did not find paragraph 11(a)(ii) proved, it therefore follows that paragraph 11(b)(ii) cannot be found proved.

320. The Tribunal therefore found the entirety of paragraph 11(b)(ii) not proved.

Allegation 11(b)(iii)

321. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation undermined public health in that they failed to meet NICE guidance of Vitamin D dosing.

322. The Tribunal was aware that Dr Myhill's website article titled '*Effective prevention and treatment for all respiratory viruses including Covid and Influenza*' was last modified on 25 January 2022. This indicates that the article was still available on Dr Myhill's website after the NICE guidelines were issued on December 2020. The guidelines state, '*do not offer a vitamin D supplement to people solely to prevent Covid-19 except as part of a clinical trial'*. This risked patient safety as Dr Myhill recommended vitamin D as a treatment which reduces the risk of death from Covid 19 to near zero.

323. The Tribunal was also mindful of Professor M's expert evidence in which he stated '*The promotion … vitamin D supplements... None of these interventions are currently recommended for coronavirus infections in NICE guidance*.'

324. The Tribunal therefore found paragraph 11(b)(iii) proved.

Allegation 11(b)(iv)

325. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation undermined public health in that they were not supported by any professional UK medical body or the NHS.

326. The Tribunal accepted that there was no evidence that all 'the Agents' were supported by professional UK medical bodies or the NHS. The Tribunal considered that if the public followed the recommendations of Dr Myhill in relation to 'the Agents', this could undermine public health because they may have confidence in 'the Agents' which could be misplaced. This could lead them to ignore other public health messages.

327. The Tribunal therefore found the entirety of paragraph 11(b)(iv) proved.

Allegation 11(b)(v)

328. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation undermined public health in that they were unproven in terms of their benefit.

329. The Tribunal had regard to Professor M's report in which he stated, '*Dr Myhill has a pseudo-scientific approach to her practice and makes unbased claims for the effectiveness of her regime. She does not practice evidence-based medicine and may encourage false reassurance in her patients who may believe that they will not catch COVID-19 or other infections if they follow her advice*.' The Tribunal accepted Professor M's expert opinion.

330. The Tribunal therefore found paragraph 11(b)(v) proved.

Allegation 11(b)(vi)

331. The Tribunal set out to determine whether Dr Myhill's recommendations as set out in Paragraph 9 and/or her omissions as outlined in Paragraph 10 of the Allegation undermined public health in that they had the potential to undermine public confidence in the medical profession.

332. The Tribunal had particular regard to the claims Dr Myhill had made with regard to the use of high dose Vitamin D, Vitamin C and iodine in the prevention and treatment of Covid-19. In particular, the Tribunal had regard Dr Myhill's claim that consuming high doses of Vitamin D, would prevent an individual from dying of Covid-19. The Tribunal considered that this would have the potential to undermine public health and public confidence in the medical profession.

333. The Tribunal therefore found paragraph 11(b)(vi) proved.

Patient B

The evidence

334. The Tribunal received written and oral evidence from the following witnesses:

- Patient B, by video link;
- Patient B's wife, by video link;
- Dr E, Senior House Officer for the Wye Valley NHS Trust in the Accident and Emergency Department at Hereford Hospital at the time of the index events, by video link;
- Dr D, Responsible Officer (RO) for the Independent Doctors Federation (IDF), by video link.

335. The Tribunal received expert evidence from Dr F which included two written expert reports and oral evidence both in person and via video link.

336. The Tribunal received written evidence that included but was not limited to:

- The hospital medical records for Patient B;
- Appraisal form for Dr Myhill, dated 1 August 2019;
- Medical Practice information transfer form;
- Email from Dr Myhill to IDF revalidation, dated 23 July 2020;
- Screenshots of WhatsApp messages sent between Patient B's wife and her family, dated 9 April – 12 April 2020;
- A letter from Dr Moran dated 15 January 2021.

337. The evidence of Patient B and Patient B's wife were consistent in that Patient B had had a fall in his bedroom on the 9 April 2020 (Good Friday) and that he had been admitted into hospital on 13 April 2020. Dr Myhill accepted this in her email dated 23 July 2020. The Hospital records confirmed that Patient B was admitted to hospital on 13 April 2020. A CT scan on Patient B was undertaken and it was found that he had a bleed around the brain. Also, X-rays confirmed that he had a fracture to the neck of the right femur. Also, during his stay in hospital, he developed Covid but recovered.

338. The medical records show the cranial bleed was treated conservatively and Patient B underwent surgery for his fractured hip.

339. The Tribunal bore in mind that Dr Myhill was of good character throughout its consideration of the matters relating to Patient B. The Tribunal acknowledged that the information from her in the email to her Responsible Officer of 23 July 2020 had not been evidence on oath, nor had she been cross examined. The contemporaneous evidence the Tribunal had were the hospital medical notes and the 'WhatsApp' messages between Patient B's wife and the children. Patient B's wife made reference to diary entries and notes she had made at the time, but the Tribunal were not provided with these. However, it did receive a typed document prepared by Patient B's wife, dated October 2020, which detailed the events

from 9 April 2020 to 13 April 2020, compiled from these notes and her memory of the events.

Allegation 12(a)

340. The Tribunal first considered whether Dr Myhill acted outside the limits of her declared skills and experience by providing services normally provided by a GP to Patient B between 9 April 2020 and 13 April 2020 after they experienced an unexpected fall.

341. The Tribunal took the view that there was no dispute that Patient B was under the care of Dr Myhill. It also accepted that Dr Myhill was no longer acting or practicing as a GP but was practicing ecological medicine as an ecological doctor at the time of the events.

342. It bore in mind the particular circumstances of this case. Namely, it was during the height of covid and also a bank holiday. The Tribunal also noted that Patient B did not have a GP where he was located at that time but instead he used Dr Myhill as his private medical practitioner. It took the view that it was likely that Dr Myhill was acting as a good Samaritan rather than in the capacity of GP. Whilst it is likely that an out of hours GP would arrive at a Patient's home and administer treatment on site, it is equally likely that a friend, who is also a doctor, would respond to such an emergency as a good Samaritan.

343. The Tribunal considered that Dr Myhill acted beyond her scope as a 'Good Samaritan' by assessing the patient, arranging treatment and providing ongoing care to Patient B. The Tribunal noted the expert evidence of Dr F that Dr Myhill should have advised Patient B to contact 111 and arrange for an ambulance. Dr F maintained that Dr Myhill adopted the role of a GP by assessing Patient B, diagnosing him with a sprain, and treating him. The Tribunal took the view that it is accepted that Dr Myhill did not have the necessary, mandatory training to act as a GP, and had not kept up to date with her appraisals in order to act as a GP. It noted that, in her appraisal, Dr Myhill stated that her patients are aware that she does not offer emergency services but she often carries out 'Good Samaritan' work for her patients.

The Tribunal took the view that any doctor acting as a Samaritan to treat a patient in an emergency situation is likely to act in a similar way.

344. The Tribunal determined that Dr Myhill acted in a 'Good Samaritan' role. It accepts that Dr Myhill was an ecological doctor but that she acted as any medical practitioner would in the circumstances of the situation. It took the view that any medical practitioner could continue to monitor and treat patients in such circumstances.

345. The Tribunal therefore found paragraph 12(a) to be not proved.

Allegation 12(b)(i)

346. The Tribunal then went on to consider whether, between 9 April 2020 and 13 April 2020 Dr Myhill failed to diagnose a possible fractured hip that required immediate management after Patient B experienced an unexpected fall.

347. The Tribunal noted that it is a fact that she did not diagnose a possible fractured hip that required immediate management. The Tribunal accepted the evidence of Patient B's wife that Patient B's leg kept falling out of the bed in a lateral position and that he was in a great deal of pain. The Tribunal also accepts Dr F's view that this was a sign of a fractured neck of femur.

348. The Tribunal therefore found paragraph 12(b)(i) proved.

Allegation 12(b)(ii)(1) and 12(b)(ii)(2)

349. The Tribunal went on to determine whether Dr Myhill failed to indicate the need for an ambulance at the time of the events.

350. The Tribunal took the view that, despite the initial errors in Dr Myhill's diagnosis, she should have noted that Patient B was on the floor in pain. It accepted the expert opinion of Dr F that Dr Myhill should have recognised that due to the great deal of pain that Patient B was in, he should have only been moved by professionals using stabilising splints and should have attended an Accident and Emergency department.

351. The Tribunal therefore found paragraph 12(b)(ii)(1) and 12(b)(ii)(2) proved.

Allegation 12(b)(ii)(3)

352. The Tribunal then considered whether Dr Myhill failed to explain clearly to Patient B that the risk of catching Covid-19 was outweighed by the risk of an untreated hip fracture.

353. The Tribunal noted the expert view of Dr F that the risk of an untreated hip fracture outweighed the risk of catching Covid-19. The Tribunal noted that Dr Myhill had a duty to explain to Patient B the risks of going into hospital against the risk of not going into the hospital. The Tribunal took the view that Dr Myhill did not discuss with Patient B, the risks and benefits of going into hospital and allow Patient B to make his own informed decision regarding whether he wished to attend an Accident and Emergency department ('A&E') despite the risk of covid.

354. The Tribunal noted the expert opinion of Dr F that it would have been better to advise Patient B to visit A&E. The Tribunal bore in mind the opinion of Dr F that the risks involved with a delayed diagnosis of a hip fracture which include general deterioration of the patient, chest problems due to immobility, ongoing pain and more difficult surgery. However, the Tribunal did not consider that Dr F had given sufficient justification to show that this risk outweighed the risk of covid as there was a high risk of death at the time, particularly amongst elderly people. The Tribunal accepts that, at that time, covid was a serious risk for elderly people. It also bore in mind that there was no clear evidence to show that receiving

treatment at home for a possible hip fracture as opposed to visiting A&E would have been significantly worse.

355. The Tribunal therefore found paragraph 12(b)(ii)(3) not proved.

Allegation 12(c)(i)

356. The Tribunal considered whether Dr Myhill administered 20mg of prednisolone to Patient B without clinical justification.

357. The Tribunal noted that Dr Myhill accepts that she administered prednisolone because she was of the view that Patient B may have Addison's disease. However, it also noted Dr F's expert opinion that if Patient B did have Addison's disease, this is a condition that should have been managed in hospital along with the more urgent matter of Patient B's fractured hip.

358. The Tribunal therefore found paragraph 12(c)(i) proved.

Allegation 12(c)(ii)

359. The Tribunal considered whether Dr Myhill administered 2mg of diazepam to Patient B without clinical justification.

360. The Tribunal took the view that whilst diazepam may have helped with the muscle spasms that Patient B had experienced, it is not a pain killer. It therefore noted that it was not suitable for Dr Myhill to administer diazepam to Patient B at this time he was in need of pain relief due to his fractured hip.

361. The Tribunal therefore found paragraph 12(c)(ii) proved.

Allegation 12(c)(iii)

362. The Tribunal considered whether Dr Myhill administered the ketogenic diet to Patient B without clinical justification.

363. The Tribunal accepted Dr F's opinion that the ketogenic diet could be a long-term possible treatment. However, it also accepted Dr F's view that there was no clinical justification for Dr Myhill to administer this diet to Patient B at this time.

364. The Tribunal therefore found paragraph 12(c)(iii) proved.

The Tribunal's Overall Determination on the Facts

365.The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. You consulted with Patient A and you:

    a. failed to identify a specific hypothyroid-related symptom which required a change to Patient A's thyroid replacement preparation; **Not Proved**

    b. inappropriately recommended that Patient A switch from her GP prescribed, licensed and evidence-based drug, L-Thyroxine therapy, to an internet-sourced pig thyroid extract ('PTE') (Metavive); **Not Proved**

    c. prescribed PTE at a high dose which was inappropriate because:

        i. your aim to achieve a fully suppressed level of TSH was contrary to national and international guidance; **Not Proved**

        ii. it exposed Patient A unnecessarily to the long-term risks of developing:

1. osteoporosis; **Not Proved**
2. fracture; **Not Proved**
3. atrial fibrillation; **Not Proved**
4. cardiac impairment; **Not Proved**
5. stroke; **Not Proved**

d. suggested that a low-normal T3 level implied that Patient A was a poor-converter of T4 to T3 which was without any scientific foundation; **Not Proved**

e. over-treated Patient A with PTE; **Determined and Found Proved**

f. suggested that Patient A's raised T3 level was likely due to thyroid hormone receptor resistance when it was actually due to over-treatment with PTE; **Not Proved**

g. failed to inform Patient A's GP of information relating to:

i. the prescribing regimen; **Not Proved**

ii. your rationale and justification for deviating from Patient A's L-Thyroxine therapy. **Not Proved**

2. On or before 8 December 2017 you consulted with Patient A and you:

a. failed to test Patient A for the presence of virus in the blood (i.e. epstein barr virus ('EBV') viral load by PCR (polymerase chain reaction)) to confirm evidence of significant re-activation; **Not Proved**

b. incorrectly interpreted Patient A's virology results; **Determined and Found Proved**

c. incorrectly diagnosed Patient A with myalgic encephalomyelitis (ME) driven by viral activity and immune activation; **Not Proved**

d. used Patient A's EBNA IgG antibody reading and EBV VCA IgG reading as justification for recommending long-term treatment with Valaciclovir, which was inappropriate because:

   i. the readings had no clinical significance other than indicating previous infection with EBV; **Not Proved**

   ii. high or elevated antibody levels can be present for years; **Not Proved**

   iii. the readings were not diagnostic of:

      1. recent infection; **Not Proved**
      2. re-activation; **Not Proved**

e. suggested that Patient A's cytomegalovirus ('CMV') result was indicative of previous CMV infection, but this had no clinical significance because:

   i. it is a common finding in the UK; **Determined and Found Proved**

   ii. it only indicates previous infection with CMV at some time in Patient A's life; **Determined and Found Proved**

f. prescribed long-term Valaciclovir treatment at a dose of 1 gram four times daily which was inappropriate because:

   i. you failed to demonstrate any evidence of active EBV or CMV infection provoking Patient A's Chronic Fatigue Syndrome ('CFS'); **Not Proved**

   ii. there was no clinical indication for long term use of anti-viral therapy; **Not Proved**

   iii. Valaciclovir is not licensed for the treatment of EBV infection and CMV infection; **Not Proved**

iv. your prescribing was outside the licensed indications for Valaciclovir; **Determined and Found Proved**

v. it unnecessarily exposed Patient A to potential side effects of Valaciclovir; **Determined and Found Proved**

vi. it unnecessarily exposed Patient A to long-term risks associated with Valaciclovir. **Determined and Found Proved**

3. In your letter of 30 April 2018 to Patient A's GP, you stated that Valaciclovir was used to treat type 1, 2 and 3 herpes infections which was inappropriate because:

   a. there was no evidence that Patient A had severe or frequent recurrences of genital herpes; **Determined and Found Proved**

   b. the dose of 1 gram four times daily was significantly higher than the licensed dose for preventing herpes simplex virus infections. **Determined and Found Proved**

4. On or before April 2018 you consulted with Patient A and you advocated treatment with Vitamin B12 to manage CFS which was inappropriate because:

   a. there was no evidence that Patient A:

      i. was Vitamin B12 deficient; **Not Proved**

      ii. had a recognised indication of pernicious anaemia; **Not Proved**

      iii. had Vitamin B12:

         1. deficiency associated anaemia; **Not Proved**
         2. tobacco amblyopia; **Not Proved**
         3. leber's optic atrophy; **Not Proved**

iv. had any other recognised indication for B12 replacement therapy. Not Proved

5. On or before April 2018 you consulted with Patient A and you failed to:

   a. adequately consider the possibility that Patient A's symptoms were, at least in part, caused by anxiety and depression; Not Proved

   b. refer Patient A to an appropriate specialist who could treat her long-term history of anxiety and depression. Not Proved

6. You prescribed Patient A with long-term daily Vitamin B12 injections for CFS which was inappropriate because:

   a. adequate treatment for conditions of deficiency requires only maintenance injections once every two to three months; Not Proved

   b. it is not recommended by NICE; Not Proved

   c. Patient A was exposed to daily injections with associated potential short-term side effects; Determined and Found Proved

   d. Patient A was exposed to potential long-term complications; Not Proved

   e. there is a lack of biochemical, physiological and clinical evidence for rationale for the use of daily Vitamin B12 in the context used. Determined and Found Proved

7. You consulted with Patient A and:

   a. prior to prescribing a parenteral magnesium supplement you failed to measure Patient A's:

      i. serum magnesium; Determined and Found Proved

ii. urine magnesium; **Not Proved**

iii. renal clearance to determine if any deficiency was due to:

1. altered renal absorption; **Not Proved**
2. altered gut absorption; **Not Proved**

b. you failed to identify that Patient A was formally suffering from magnesium deficiency ('hypomagnesaemia'); **Determined and Found Proved**

c. you prescribed Patient A 0.5ml daily of a 10mg/ml of magnesium sulphate (MgSO4) which was inappropriate because:

i. there was no clinical indication for magnesium supplements; **Determined and Found Proved**

ii. the dose was wholly inadequate to:

1. treat primary hypomagnesaemia; **Determined and Found Proved**
2. help maintain magnesium homeostatis assuming a baseline of normomagnesaemia; **Determined and Found Proved**

iii. the prescription included 2% lignocaine, a local anaesthetic agent, which was inappropriate because it was not clinically indicated; **Determined and Found Proved**

d. ~~your parenteral administration of the prescribed medication was inappropriate because~~: <u>your advice on the parenteral administration of the prescribed medication was inappropriate because:</u> **Amended under rule 17(6)**

i. there was no evidence that parenteral MgSO4 had any efficacy in treating CFS; **Determined and Found Proved**

ii. Patient A was unnecessarily subjected to subcutaneous injections; **Determined and Found Proved**

iii. the dose could have been supplied by a single chewable tablet; **Determined and Found Proved**

iv. there was no urgent clinical situation; **Determined and Found Proved**

v. administering magnesium subcutaneously is not the recommended route for the licensed parenteral MgSO4 solutions available; **Determined and Found Proved**

vi. Patient A did not have any predisposing conditions such as Crohn's Disease with concomitant bowel cancer and radiation damage; **Determined and Found Proved**

e. following your prescribing to Patient A you failed to check and monitor Patient A's blood magnesium level to confirm an ongoing clinical need to continue the magnesium injections; **Not Proved**

f. in the alternative to paragraph 7.b, 7.c., and 7.e., you failed to notify Patient A's GP of:

i. your diagnosis of magnesium deficiency; **Not Proved**

ii. your basis for your diagnosis of magnesium deficiency; **Not Proved**

iii. any monitoring you carried out of Patient A following the diagnosis of magnesium deficiency. **Not Proved**

Internet

8. On one or more occasion as set out in Schedule 1, you used the internet to promulgate your views and opinions on viral and/ or bacterial infections ('Your Media'). **Determined and Found Proved**

9. In Your Media you promoted and endorsed the use of the agents, the details of which are set out in Schedule 2 ('the Agents'), to treat and protect against viral and bacterial infections, including 2019-nCoV pandemic ('Coronavirus') in that you:

   a. made a series of recommendations as set out at Schedule 3; **Determined and Found Proved**

   b. published, or allowed your website to publish, the articles listed in Schedule 4, and these:

      i. purport to provide guidance on how to treat Coronavirus infection; **Determined and Found Proved**

      ii. recommend use of the Agents; **Determined and Found Proved**

   c. sold 15% Lugol's iodine on the sales section of your website, and in doing so made recommendations about its use as set out at Schedule 5. **Determined and Found Proved**

10. In relation to the recommendations in Your Media, you failed to clearly articulate that:

   a. the Agents are not:

      i. licensed to be used as anti-viral agents in vivo; **Determined and Found Proved**

      ii. universally safe for people when used in the way you recommended; **Determined and Found Proved only in relation to Vitamin D**

   b. there is no published evidence to support the Agents being effective contact viricides when used in the manner you have stated; **Not Proved**

c. there are health risks and/or side effects associated with using the Agents in the manner you have stated; **Determined and Found Proved**

d. the use of Vitamin D in the manner you have stated is not supported by any UK guidelines or trial data; **Not Proved**

e. the use of the Agents off-licence requires a robust knowledge of the evidence for the efficacy and safety of the Agents when used in the manner you recommended; **Not Proved**

f. you did not have a specialist background in the following areas:

i. the use of virucides; **Not Proved**

ii. clinical pharmacology; **Not Proved**

iii. infectious diseases; **Not Proved**

iv. clinical virology; **Not Proved**

v. public health medicine. **Not Proved**

11. Your recommendations/acts as outlined in paragraphs 9 and/or your omissions as outlined in paragraph 10:

a. risked patient safety in that they:

i. exposed patients to potential serious harm, including toxicity, and/or; **Determined and Found Proved**

ii. were not peer reviewed, and/ or; **Not Proved**

iii. failed to meet NICE guidance of vitamin D dosing, and/or; **Determined and Found Proved**

iv. were unproven in terms of their benefits; **Determined and Found Proved**

b. undermined public health in that they:

i. exposed patients to potential serious harm, including toxicity, and/or; **Determined and Found Proved**

ii. were not peer reviewed, and/ or; **Not Proved**

iii. failed to meet NICE guidance of vitamin D dosing, and/or; **Determined and Found Proved**

iv. were not supported by any professional UK medical body or the NHS; **Determined and Found Proved**

v. were unproven in terms of their benefits; **Determined and Found Proved**

vi. had the potential to undermine public confidence in the medical profession. **Determined and Found Proved**

Patient B

12. Between 9 April 2020 and 13 April 2020, you were involved in the care of Patient B after they experienced an unexpected fall, and you:

a. acted outside the limits of your declared skills and experience by providing services normally provided by a GP; **Not Proved**

b. failed to:

i. diagnose Patient B had a possible fractured hip that required immediate management; **Determined and Found Proved**

ii. indicate the need for:

1. an ambulance; and/ or **Determined and Found Proved**

2. attendance at an Accident and Emergency department; **Determined and Found Proved**

3. explain clearly that the risk of catching Covid-19 was outweighed by the risk of an untreated hip fracture; **Not Proved**

c. administered without clinical justification:

i. prednisolone 20mg; **Determined and Found Proved**

ii. diazepam 2mg; **Determined and Found Proved**

iii. ketogenic diet. **Determined and Found Proved**

Determination on Impairment - 25/01/2023

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Myhill's fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary.

Submissions

3. On behalf of the GMC, Ms Emsley-Smith, counsel, first reminded the Tribunal of the two-stage process and that it must first determine whether the facts admitted and found proved amount to misconduct before going on to consider the question of impairment.

4. Ms Emsley-Smith submitted that the Tribunal will first have regard to the test of serious misconduct, which is described as conduct which would be regarded as deplorable by fellow medical practitioners or properly informed members of the public. Ms Emsley-Smith reminded the Tribunal that it must judge whether the misconduct amounts to "serious misconduct" as

only serious misconduct will call into question a doctor's fitness to practice. She referred the Tribunal to the principles in the cases of *Roylance v General Medical Council [1999] UKPC 16*, where it was observed that misconduct involves acts or omissions which fall short of what was proper in the circumstances; and *Meadow v General Medical Council [2006] EWCA Civ 1390,* which states that the Tribunal must look forwards not backwards, but in order to form a view of the fitness of a person to practise today, the Tribunal should take account of the way in which the person concerned has acted or failed to act in the past.

Patient A

5. Ms Emsley-Smith submitted that the Tribunal's findings at the fact stage demonstrate a catalogue of errors on the part of Dr Myhill in her treatment of Patient A with Valaciclovir. She submitted that Dr Myhill exhibited a lack of understanding regarding virology results, an apparent lack of understanding for the licensed indications and appropriate dosing, or she ignored the guidance. Ms Emsley-Smith submitted that most significantly and concerningly, Dr Myhill exposed Patient A to unnecessary harm. She submitted that rather than appropriately reflect on her prescribing decisions when asked by Patient A's GP, Dr Myhill shifted her justification for use of the drug and chose not to reconsider or reflect.

6. Ms Emsley-Smith reminded the Tribunal of the expert opinion of Professor M in which he informed it that Dr Myhill's overall treatment of Patient A fell seriously below the standard expected of a reasonably competent Private Medical Practitioner. She submitted that by exposing Patient A to unnecessary potential short term and long-term harm and by not applying the principle of first do no harm, Dr Myhill's conduct in relation to prescribing Valaciclovir should properly be regarded as serious misconduct.

7. Ms Emsley-Smith submitted that Dr Myhill's prescription for long-term daily vitamin B12 injections was inappropriate because there was a lack of biochemical, physiological and clinical evidence for the rationale for daily Vitamin B12 injections in the context used. She reminded the Tribunal of its previous finding that Dr Myhill prescribing intramuscular injections

for Patient A was inappropriate. She submitted that Dr Myhill did not apply the principle of "first do no harm" and reminded the Tribunal of the expert evidence of Dr K in which he concluded that Dr Myhill fell seriously below the standard of a reasonably competent Private Medical Practitioner because she exposed Patient A to harm with a lack of evidence for her rationale for the treatment. She submitted that causing potential harm to a patient in the absence of identified evidence for treatment with vitamin B12 must constitute serious misconduct.

8. Ms Emsley-Smith submitted with regard to Patient A that the Tribunal found that there was no evidence that magnesium had any efficacy for treating CFS and there was no other basis for the prescription. Ms Emsley-Smith reminded the Tribunal of the expert opinion of Dr J in which he stated that Dr Myhill fell seriously below acceptable practice in prescribing magnesium in the absence of any clinical justification and unnecessarily subjected Patient A to subcutaneous injections as a consequence. She submitted that the Tribunal are entitled to find that Dr Myhill's treatment of Patient A with Valaciclovir, B12 and magnesium when looked at individually, each constitute serious misconduct. Ms Emsley-Smith further submitted that Dr Myhill's treatment of Patient A overall is a basis for a finding of serious misconduct. She reminded the Tribunal that Dr Myhill prescribed three treatments, in the absence of a solid evidential basis, each of which unnecessarily subjected Patient A to the potential for harm.

Internet

9. Ms Emsley-Smith submitted that by not informing members of the public that the Agents she recommended on her website were not licensed for use in the way she recommended and were not all universally safe, Dr Myhill failed in her duty to allow people to make a fully informed decision. Ms Emsley-Smith submitted that this is fundamental and pivotal to the relationship of trust which should exist between a doctor and their patient, or in this context, members of the public. She further submitted that such a failure constitutes serious misconduct because it undermines the relationship of trust which should exist between the public and the profession.

10. Ms Emsley-Smith submitted that misrepresenting by omission the safety of a treatment that Dr Myhill was widely recommending constitutes serious misconduct. She further submitted that failing in her duty to fully inform patients regarding risks and side effects is irresponsible and constitutes serious misconduct. Ms Emsley-Smith submitted that Dr Myhill exposed any member of the public whom accessed her media to harm, potentially extends to thousands of people. She reminded the Tribunal that it has previously accepted the expert evidence of Dr L that the harm not only exists in the form of risks and side effects but also to members of the public who followed the advice and consequently potentially ignored other risk mitigating strategies, for example, mask wearing or vaccination. She submitted that risking patient safety on such a large scale is serious misconduct.

11. Ms Emsley-Smith submitted that the Tribunal found that Dr Myhill had undermined public health in that she: exposed patients to potential serious harm, including toxicity; failed to meet NICE guidance on vitamin D dosing; her recommendations were not supported by any professional UK medical body or the NHS; her recommendations were unproven in terms of their benefits; her recommendations had the potential to undermine public confidence in the medical profession.

12. Ms Emsley-Smith submitted that Dr Myhill undermined the public's health in general. She submitted that Dr Myhill exposed people to potential serious harm, particularly from vitamin D toxicity, she risked patient safety by asserting that vitamin D reduced the risk of death from Covid 19 to near zero which was contrary to evidence and NICE guidance, her recommendations created a risk that the public would ignore other UK medical bodies or NHS health messages and consequently had the potential to undermine public confidence in the medical profession. Ms Emsley-Smith submitted that Dr Myhill's recommendations were dangerous in the way in which they undermined public health and this constitutes serious misconduct.

Patient B

13. Ms Emsley-Smith submitted that Dr Myhill should have recognised that Patient B had a possible fractured hip which required assessment and treatment in hospital. She submitted that it was as a direct consequence of Dr Myhill's input that Patient B's treatment was delayed and during the three days that he remained at home he was in pain, unable to move and at times he was delirious. Ms Emsley-Smith submitted that Dr Myhill accepts in her communication to Dr D that a fractured hip was part of her differential diagnosis and she was aware that Patient B was at risk of intracerebral haemorrhage. Ms Emsley-Smith submitted that at the point that she reached these conclusions she should have recognised that Patient B required transfer to hospital. She submitted that Dr Myhill's duty was to recognise that Patient B's condition indicated the need for an ambulance and attendance at A&E. She failed to recognise the reality of Patient B's condition. She submitted that the failure is without justification or mitigation.

14. Ms Emsley-Smith submitted that in failing in her duty to respond to the reality of Patient B's condition and provide the appropriate advice, Dr Myhill fell seriously below the standard of a reasonably competent private practitioner. She submitted that this failure constitutes serious misconduct.

15. Ms Emsley-Smith submitted that Dr Myhill expressed her justifications for administering prednisolone, diazepam and a ketogenic diet in her communication to Dr D. She reminded the Tribunal that Dr F stated that the treatments given by Dr Myhill were seriously below the standard of a reasonably competent doctor because they were not clinically indicated and by using them Dr Myhill missed the opportunity to offer, what would have been appropriate treatment; attendance at Accident and Emergency where an x-ray could have been arranged. She submitted that this constitutes serious misconduct.

Impairment

16. Ms Emsley-Smith referred the Tribunal to the test of Dame Janet Smith in relation to impairment in the Fifth Shipman Report, cited in the case of *CHRE v NMC & Grant (2011) EWHC 927*. She submitted that Dr Myhill has unquestionably brought the profession into disrepute. Ms Emsley-Smith submitted that Dr Myhill treated Patient A without regard to the fundamental principle of first do no harm. She stated that her management of Patient B was dangerous and delayed him accessing the treatment he required and via her media she risked harm to thousands of members of the public and generally undermined public health.

17. Ms Emsley-Smith submitted that Dr Myhill breached paragraph 1 of *Good Medical Practice (2013)* ('GMP') In her treatment of Patient A and B as she favoured pseudo-scientific medicine over evidence based medicine. She submitted that in her media, Dr Myhill made recommendations which risked patient health and undermined public health. Ms Emsley-Smith submitted that Dr Myhill breached paragraph 16a and 16b of GMP by prescribing treatment which risked harm without establishing a proper evidential basis for the treatment and so she failed to serve the patients needs. She submitted that in her treatment of Patient B, Dr Myhill failed to serve the patient's needs in her treatment decisions and she ignored the clear evidence of a fractured femur which required hospital admission. Ms Emsley-Smith submitted that Dr Myhill breached paragraph 16b of GMP with Patient A as she failed to have regard to the best evidence available in respect of risks as against efficacy.

18. Ms Emsley-Smith submitted that in her media recommendations, Dr Myhill breached paragraph 49 of GMP in that she failed to give patients/members of the public the information they needed to make informed decisions about their care. She submitted that Dr Myhill also breached paragraph 68 in that she failed to make reasonable checks to make sure the information she gave was accurate. Ms Emsley-Smith also submitted that Dr Myhill breached paragraph 70 and 71 of GMP in her media as she failed to make sure the information she published was factual and did not exploit patients' vulnerability or lack of medical knowledge.

19. Ms Emsley-Smith submitted that Dr Myhill put an unquantifiable number of patients at risk of harm. She submitted that Dr Myhill's disregard for evidence-based medicine and patient

safety is conduct so serious that a finding of current impairment is necessary for upholding proper professional standards in the profession and maintaining public confidence in the profession. Ms Emsley-Smith submitted that Dr Myhill has provided no evidence of insight or reflection. She submitted that Dr Myhill has refused to respond in any meaningful way to the GMC throughout the investigation, she has voluntarily absented herself from the hearing. She submitted that the Tribunal have no assurance whatsoever that Dr Myhill will not continue to make unfounded and potentially dangerous treatment decisions. Furthermore, the Tribunal have no assurance that Dr Myhill will not continue to publish recommendations which put the public at risk and undermine public health.

20. Ms Emsley-Smith submitted that Dr Myhill is currently impaired.

The Relevant Legal Principles

21. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

22. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: whether the facts as found proved amounted to misconduct; whether that misconduct was serious and then whether that finding could lead to a finding of impairment.

23. The Tribunal was aware that it would need to find serious misconduct rather than mere misconduct. It bore in mind the case of *Nandi v GMC (2004) EWHC 3417* as referred to by Ms Emsley-Smith. The Legally Qualified Chair referred the Tribunal to the case of *Mallon v GMC (2007) CSIH 17* which clarified that there are infinite varieties of misconduct and it should be for the Tribunal to decide having regard to the facts and circumstances of the case rather than using a specific term such as deplorable. She referred to the case of *R (Remedy UK Limited) v GMC (2010) EWHC 1245* where it was held that misconduct needs to be sufficiently serious so that it can properly be described as misconduct going to fitness to practise.

24. The Tribunal must determine whether Dr Myhill's fitness to practise is impaired today, taking into account Dr Myhill's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

25. The Tribunal reminded itself of the statutory overarching objective which is to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

26. With regard to impairment, the Tribunal had regard to the case of *CHRE v NMC and Grant [2011] EWHC 927* where Dame Janet Smith's observations in the Fifth Report of the Shipman Inquiry were endorsed. Dame Janet Smith suggested that questions of impairment could be considered in the light of the following considerations:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination 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*

The Tribunal's Determination on Impairment

Misconduct

27. The Tribunal considered that the following paragraphs of GMP are engaged in this case:

'1 Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

15 You must provide a good standard of practice and care. If you assess, diagnose or treat patients, you must:

a adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient

b promptly provide or arrange suitable advice, investigations or treatment where necessary

c refer a patient to another practitioner when this serves the patient's needs

16 In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs.

b provide effective treatments based on the best available evidence.

22 You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

a taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary

b regularly reflecting on your standards of practice and the care you provide

c reviewing patient feedback where it is available.

49 You must work in partnership with patients, sharing with them the information they will need to make decisions about their care…

65 You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.

68 You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.

70 When advertising your services, you must make sure the information you publish is factual and can be checked, and does not exploit patients' vulnerability or lack of medical knowledge.

71 You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information.

73 You must cooperate with formal inquiries and complaints procedures and must offer all relevant information while following the guidance in Confidentiality.'

28. The Tribunal received no further documentation from Dr Myhill at this stage relating to remediation, reflection or continued professional development. The Tribunal is aware and has seen parts of her appraisal in 2019 which demonstrated that she was, at that time, a competent doctor specialising in Chronic fatigue and related conditions. Further, Dr D, in her oral evidence

to the Tribunal, stated that there are no issues in her Appraisals relating to her competence. The Tribunal is aware that the appraisal system for doctors includes reflection, continuing professional development and discussion of incidents in clinical practice. However, the Tribunal does not know whether this allegation was discussed at the appraisals.

Patient A

Paragraph 1e, 2e(ii) and 2e(iii)

29. The Tribunal agreed with the submissions of Ms Emsley-Smith that Dr Myhill consulting with Patient A and over-treating her with PTE did not amount to serious misconduct as it was not clinically significant.

Paragraph 2f(iv), 2f(v), 2f(vi), 3a and 3b

30. The Tribunal found that paragraph 16a of GMP was engaged in relation to these paragraphs because it related to prescribing issues.

31. The Tribunal noted the expert opinion of Professor M that Dr Myhill prescribing long-term Valaciclovir treatment at too high a dose for a non-licensed indication was seriously below the standard expected of a reasonably competent private medical practitioner. It noted that there were risks involved by the high dose and long term treatment recommended and noted the comments made by Professor M that Dr Myhill had appropriately addressed the risks by informing the patient and arranging regular monitoring.

32. The Tribunal noted Professor M's comments:

'In potential mitigation of Dr Myhill's management I would make the following comments:

i. chronic fatigue is a common, but poorly understood condition

ii. conventional medicine has little to offer in terms of treatment

iii. *NICE recommended treatments i.e. CBT (cognitive behavioural therapy) and GET (graded exercise therapy) are of very limited benefit to most patients*

iv. *Many patients with CFS find that medical practitioners are often disinterested and unhelpful or do not take their problems seriously*

v. *Patients are therefore often desperate to seek a cure and find a medical practitioner who will listen to their concerns*

vi. *Dr Myhill has corresponded with the patient and her GP Practice explaining her rationale for the treatments offered.*

vii. *Dr Myhill does quote an evidence base for her use of valaciclovir, quoting Dr M L's work which consists of case series of patients and a small, randomised trial of Valaciclovir. These studies have not influenced the NICE guidance or product licence for Valaciclovir.*

viii. *There are very occasional patients who are unable to clear EBV or CMV infection and have persistence of viral IgM and high viral load associated with persisting symptoms after acute glandular fever. These patients may benefit from anti-viral treatment and I have treated a very small number of such patients in the past with a short course of Valaciclovir, monitoring symptoms and response (IgM and viral load). Patient A does not fall into this category of patient. '*

33. The Tribunal noted that, on the balance, Professor M offered the opinion that the prescription of Valaciclovir was seriously below the standards expected of a doctor.

34. The Tribunal considered that Dr Myhill had prescribed outside the licensed indications. It took into account the responses of all four experts (Dr K, Dr L, Dr J and Professor M) in the case of Patient A in response to oral questions by the Tribunal. Dr K said, '*I prescribe off label, we have to acknowledge that early trial evidence is not always translated into NICE Guidance, it doesn't mean its not safe. As a doctor we speak to the patient, talk about the risks/benefits.*' Dr L informed the Tribunal that "*there are lots of diseases for which they have no trial data, the GMC provides guidance on prescribing outside of licence."*

35. The Tribunal considered that paragraph 2 of GMP applied in Patient A's case:

> *'2 Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability.'*

36. The Tribunal has already considered in its determination on facts that Patient A, who had suffered from long term CFS, was a fully engaged patient in respect to all treatment provided by Dr Myhill.

37. Whilst the Tribunal took the view that the finding of facts in relation to Valaciclovir was misconduct, it determined that for the reasons above, this was not serious misconduct.

Paragraphs 6c and 6e

38. The Tribunal found that paragraphs 16a and 16b of GMP were engaged in relation to these paragraphs as it relates to prescribing of B12 injections.

39. The Tribunal determined that Dr Myhill's prescription for long-term daily vitamin B12 injections was inappropriate because there was a lack of biochemical, physiological and clinical evidence for the rationale for daily Vitamin B12 injections in the context used. It noted that whilst these injections were intramuscular and involved the potential for short-term side effects of pain and discomfort at the injection site, it could not find that these injections exposed Patient A to the potential for harm.

40. The Tribunal took the view that whilst there may not have been clear rationale for prescribing this treatment, Patient A was fully informed of the potential side effects, agreed to the treatment and then injected herself with B12. The Tribunal determined that this did not amount to serious misconduct as the patient had consented to the treatment and had the

capacity to cease treatment at any time but opted to continue with the treatment. The Tribunal was aware that Patient A suffered from CFS and as a result had chosen to receive treatment recommended by Dr Myhill who was an ecological practitioner.

Paragraphs 7a(i), 7b, 7c(i), 7c(ii) and 7c(iii)

41. The Tribunal found that paragraphs 1, 16a, 16b and 49 of GMP were engaged in relation to these paragraphs.

42. The Tribunal determined that in failing in her duty to carry out a blood test prior to prescribing a parenteral magnesium supplement, Dr Myhill's actions amounted to serious misconduct as there was no clinical indication for the prescription. Furthermore, it recognised that Dr Myhill subjected Patient A to undue pain by prescribing injections to Patient A when tablets could have been a viable option.

Internet

Paragraphs 10a(i), 10a(ii), 10(c) 11a(i), 11a(iii), 11a(iv), 11b(i), 11b(iii), 11b(iv), 11b(v) and 11b(vi)

43. The Tribunal found that paragraphs 16b, 49, 68, 70 and 71 of GMP were engaged in relation to these paragraphs.

44. The Tribunal took the view that Dr Myhill should have taken measures to ensure the people who accessed her media knew that there was no evidence, by way of studies and guidance, that the treatment she recommended would be effective. It also determined that Dr Myhill should have notified the public and her patients that the treatment was also not licensed, not universally safe and that there were potential health risks associated with using the treatment in the manner she recommended.

45. The Tribunal took the view that Dr Myhill's actions put patients at risk and undermined public health, for example the Tribunal had concerns that the advice on Dr Myhill's website could have discouraged people from following advice on wearing masks and vaccinations which in turn could put them at risk of harm. The Tribunal took the view that Dr Myhill put members of the public at risk.

46. The Tribunal was satisfied that Dr Myhill's conduct fell seriously below the standards expected of a doctor and represented serious breaches of the principles of GMP referred to above. It determined that Dr Myhill's actions in this amounted to serious misconduct.

Patient B

47. The Tribunal found that paragraphs 1, 15, 16a, 16b, 22 and 73 of GMP were engaged in relation to these paragraphs.

48. The Tribunal had regard to the circumstances around Dr Myhill failing to diagnose a fractured hip, indicate the need for an ambulance and/or attendance at A&E and administering prednisolone, diazepam and the ketogenic diet for Patient B. The Tribunal accepted the opinion of Dr F that this was a clear failure by Dr Myhill. The Tribunal took the view that although the initial error in diagnosis and management plan may have been understandable, in the subsequent four days from the 9th to 13th April when Patient B was not improving, Dr Myhill should have reconsidered her initial proposed treatment plan for Patient B and recognised that Patient B needed admission to hospital. It noted that this failure was compounded by the fact that Dr Myhill administered medications to Patient B without clinical justification.

49. The Tribunal also considered that these treatments were not relevant to the issues faced by Patient B at that time and would have done little to ease his pain and discomfort. The Tribunal reminded itself that Dr Myhill had several opportunities over this period of time to

review her management and it was Patient B's family, and not Dr Myhill, that eventually arranged for Patient B to attend the hospital.

50. The Tribunal therefore determined that Dr Myhill's actions in this amounted to serious misconduct.

Impairment

51. The Tribunal having found that some of the facts found proved amounted to serious misconduct went on to consider whether, because of that misconduct Dr Myhill's fitness to practise is currently impaired.

52. In determining whether a finding of current impairment of fitness to practise is necessary, the Tribunal looked for evidence of insight, remediation, and the likelihood of repetition and balanced these against the three elements of the overarching statutory objective.

53. The Tribunal had before it evidence that Dr Myhill had an appraisal meeting with her Responsible Officer, Dr D, dated 1 August 2019. Dr D gave evidence to the Tribunal that there were no concerns in relation to Dr Myhill's appraisal history.

54. In relation to Patient B, the Tribunal noted in Dr Myhill's response to Dr D in July 2020, 3 months after the events giving rise to these findings, she did not show any acknowledgement of the error, insight, learning or reflection from this event.

55. However, the Tribunal was mindful of the fact that Dr Myhill had not engaged in this hearing and therefore it had received no evidence of remediation or insight on her behalf in relation to the allegations before it. The Tribunal therefore determined that there was a risk of repetition in this case.

Patient A

Paragraphs 7a(i), 7b, 7c(i), 7c(ii) and 7c(iii)

56. The Tribunal carefully considered the criteria set out in the case of *Grant*.

> *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;*

57. The Tribunal considered that the dose of magnesium in this case was very small and the risk of harm from the injections is very low. It noted that the injections were self-administered, the patient was very involved in their own care and could have stopped these at any time. The Tribunal do not consider that this action put this patient at unwarranted risk of harm. However, the Tribunal accepted that Dr Myhill is likely to repeat this misconduct as she believes that this may assist a patient with CFS. Nevertheless, the Tribunal considered that the risk of harm is so low that there is a minimal patient safety issue.

> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute;*

58. Although Dr Myhill is prescribing outside of licence and NICE guidelines she has developed special expertise in managing CFS, a very difficult condition, for which Professor M has told the Tribunal there is very little that conventional medicine can offer. The Tribunal recognise the difficult balancing act of the need to protect the public who may be desperate and vulnerable from registered doctors prescribing medicines that can harm patients, against the need for doctors who develop experience treating conditions to try treatments, that for many reasons may not have an evidence base or licence. Dr L explained in his oral evidence the many reasons why drugs are not licensed and clinical trials are not carried out. All the

experts in the case agreed that it is appropriate for doctors to try and help their patients by using such products with appropriate adherence to the relevant GMC guidance. Therefore, the Tribunal found that Dr Myhill's misconduct had not brought the medical profession into disrepute and was not likely to do so in the future.

> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;*

59. The Tribunal found, having regard to the circumstances of the misconduct as set out above, that Dr Myhill had not breached a fundamental tenet of the medical profession and was not liable to do so in the future.

60. The Tribunal considered that none of the limbs in the overarching objective were engaged because of the reasons set out above.

61. The Tribunal therefore found that Dr Myhill's fitness to practice was not impaired in relation to Patient A.

Internet

Paragraphs 10a(i), 10a(ii), 10(c) 11a(i), 11a(iii), 11a(iv), 11b(i), 11b(iii), 11b(iv), 11b(v), 11b(vi)

62. The Tribunal carefully considered the criteria set out in the case of *Grant*.

> *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;*

63. The Tribunal has found this to be serious misconduct and it has received no evidence of remediation or insight from Dr Myhill and therefore considered that there is a high risk of her repeating the misconduct. This misconduct has the potential to put members of the public at risk of harm if they act in the manner suggested by Dr Myhill.

b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute;

64. The Tribunal considered that Dr Myhill's misconduct would bring the medical profession into disrepute by her continuing to advocate her own views on actions to be taken, for example, in relation to Covid19 and she has and is likely in the future to put public health at risk.

c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession;

65. The Tribunal has found that Dr Myhill has breached a number of the paragraphs of GMP and has put patients at risk of harm and is likely to do so in the future and these breach the fundamental tenets of the medical profession.

66. The Tribunal found for the reasons above that all three limbs of the overarching objective were also engaged.

67. The Tribunal therefore found that in relation the internet matters which it had found proved, Dr Myhill's fitness to practice is impaired.

Patient B

68. The Tribunal considered that there was no evidence of remediation, insight and reflection in relation to Patient B. The Tribunal noted that in response to Dr D raising a

complaint in July 2020, three months after the event, Dr Myhill showed no evidence of learning after the events. Furthermore, the Tribunal has had no evidence from Dr Myhill showing that insight or remediation has taken place during this time. The Tribunal took into account the following paragraphs of GMP: 22(a), 22(b) and 73.

69. The Tribunal took the view that it is not the error that Dr Myhill made in the original consultation that amounts to serious misconduct. The Tribunal determined that it was the failure to acknowledge this error and the lack of efforts made to correct the error made in the original consultation that amounts to serious misconduct and her fitness to practice being impaired as a result.

70. The Tribunal considered that the first three criteria of *Grant* applied in this case. It took the view that Dr Myhill has put Patient B at risk of harm in the past and therefore is likely to put other patients at risk of harm in the future and this would bring the medical profession into disrepute. Dr Myhill had clearly breached a fundamental tenet of the profession by her management of Patient B. The Tribunal determined that all three limbs of the overarching objectives are engaged for the reasons above.

71. The Tribunal therefore found that Dr Myhill's fitness to practise is impaired in relation to the findings relating to Patient B.

Overall finding

72. The Tribunal considered that a reasonable and well-informed member of the public would expect a finding of impairment to be made in this case, both to mark the seriousness of the misconduct, and to uphold proper standards across the medical profession. It considered that Dr Myhill's misconduct has brought the medical profession into disrepute. The Tribunal considered that public confidence in the profession would be undermined if a finding of impairment was not made in this case.

73. The Tribunal has therefore determined that Dr Myhill's fitness to practise is impaired by reason of misconduct in relation to the findings of the 'Internet' paragraphs and Patient B.

Determination on Sanction - 27/01/2023

1. Having determined that Dr Myhill's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

2. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction.

3. The Tribunal received further evidence on behalf of the GMC including email correspondence from Dr Myhill to the GMC dated 04 September 2021.

Submissions

4. On behalf of the GMC, Ms Emsley-Smith, counsel, submitted that the reputation of the profession as a whole is more important than the impact upon any particular doctor. She stated that Dr Myhill's misconduct as found proved has put patient safety at risk and undermined public confidence in the profession and so the Tribunal's decision on sanction must be consistent with upholding the overarching objective having taken account of the seriousness of the doctor's misconduct.

5. Ms Emsley-Smith reminded the Tribunal that it found paragraphs 16b, 49, 68, 70 and 71 of GMP to be engaged in relation to Dr Myhill's Internet recommendations. She also reminded the Tribunal that it found paragraphs 1, 15, 16a, 16b, 22 and 73 of GMP to be engaged in relation to Patient B.

6. Ms Emsley-Smith submitted that the absence of previous adverse findings against Dr Myhill should be considered a factor in her favour.

7. Ms Emsley-Smith submitted that Dr Myhill's position is aggravated by the fact that impairment has been found in respect of two distinct aspects of her practice. She submitted that Dr Myhill's conduct has undermined each of the three limbs of the overarching objective. Ms Emsley-Smith submitted that Dr Myhill has demonstrated no insight into her misconduct and the impact of her treatment decisions on the well-being and health of Patient B.

8. Ms Emsley-Smith submitted that Dr Myhill has demonstrated no insight into the risks she posed to the health and wellbeing of any member of the public who accessed her media and followed her advice. In relation to this, she submitted that potential for harm caused by Dr Myhill extended to countless individual people. Ms Emsley-Smith submitted that Dr Myhill has demonstrated no insight into the impact of her media recommendations on public health particularly during a period when public health messaging was of global importance.

9. Ms Emsley-Smith submitted that no action is not an appropriate response given the adverse findings of fact made against Dr Myhill. She submitted that there are no exceptional circumstances in this case which could justify no action being taken. Ms Emsley-Smith submitted that conditions are not appropriate in this case. She submitted that the primary issue with the imposition of conditions is that the nature of the impairment found in this case is not likely to be addressed by a period of retraining and/or supervision. Ms Emsley-Smith submitted that Dr Myhill has not communicated any willingness to engage in a period of retaining and/supervision. Conditions are therefore unworkable and would not reflect the seriousness of the findings of fact.

10. Ms Emsley-Smith submitted that paragraph 92 of the *Sanctions Guidance* ('SG') states that suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the

profession. She submitted that a period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration. Ms Emsley-Smith submitted that the factors listed in paragraph 97 indicate that Dr Myhill's conduct is both serious and incompatible with continued registration. She submitted that the absence of any insight or reflection leads inevitably to the conclusion that there is a continuing risk to patient safety as a consequence of Dr Myhill's pseudo-scientific approach to the practice of medicine.

11. Ms Emsley-Smith referred the Tribunal to paragraph 63 of the determination on impairment where it found that there is a high risk of Dr Myhill repeating the misconduct which arose out of her internet recommendations. She submitted that the Tribunal have found that this misconduct has the potential to put members of the public at risk of harm if they act in the manner suggested by Dr Myhill. Ms Emsley-Smith reminded the Tribunal that some of the harm risked is particularly serious. She submitted that, in the findings of fact, the Tribunal referred to the evidence of Dr J that the use of iodide and vitamin D are of serious concern as both have the potential to cause serious and even potentially fatal toxicity and this opinion was shared by Dr L.

12. Ms Emsley-Smith also referred the Tribunal to paragraph 64 of the determination on impairment where it found that Dr Myhill's misconduct which arose out of her internet recommendations would bring the medical profession into disrepute by her continuing to advocate her own views on actions to be taken, for example, in relation to Covid19 and she has and is likely in the future to put public health at risk.

13. Ms Emsley-Smith also referred the Tribunal to paragraph 65 of the determination on impairment where it found that Dr Myhill's misconduct which arose out of her internet recommendations breached a number of paragraphs of GMP and put patients at risk of harm and is likely to do so in the future and this breaches the fundamental tenets of the medical profession.

14. Ms Emsley-Smith referred the Tribunal to paragraph 70 of the determination on impairment where it found that Dr Myhill's misconduct in relation to Patient B put him at risk of harm and is likely to put other patients at risk of harm in the future. She reminded the Tribunal that it found that this would bring the medical profession into disrepute. Ms Emsley-Smith submitted that the Tribunal have found that Dr Myhill's conduct breached a number of paragraphs of Good Medical Practice and that her treatment of Patient B breached a fundamental tenet of the profession and was likely to in the future.

15. Ms Emsley-Smith directed the Tribunal to paragraph 109 of the SG which provides a list of factors which indicate that erasure is appropriate. She submitted that the quantity and nature of the breaches of GMP constitute a serious and persistent departure from its principles. Ms Emsley-Smith submitted that Dr Myhill's repeated and determined campaign articulated through her media should be seen as a deliberate disregard for GMP. She submitted that Dr Myhill demonstrated a reckless disregard for the safety of Patient B and the principles of GMP.

16. Ms Emsley-Smith submitted that the Tribunal has previously found that there is a high risk of repetition. She submitted that given that Dr Myhill repeatedly advocated potentially fatal treatments to any member of the public accessing her media, it is submitted that this feature is of particular significance.

17. Ms Emsley-Smith submitted that there is no evidence of insight from Dr Myhill. She submitted that Dr Myhill has had the opportunity to demonstrate some refection relating to her approach to medicine but has not done so. Ms Emsley-Smith submitted that in her communications with Dr D, Dr Myhill communicated no capacity to reflect and in her communications with the GMC and she has on occasions demonstrated contempt for the investigation and therefore her regulator and the public generally.

18. Ms Emsley-Smith submitted that erasure is the only sanction which could give effect to the overarching objective.

The Relevant Legal Principles

19. This stage of the proceedings is governed by Rule 17(2)m of the Rules and the Tribunal's task now is to decide what sanction, if any, should be imposed upon the registration of the Doctor.

20. When considering sanction, the Tribunal must have particular regard to the statutory overarching objective:

> *a. To protect, promote and maintain the health, safety and wellbeing of the public;*
> *b. To promote and maintain public confidence in the medical profession; and*
> *c. To promote and maintain proper professional standards and conduct for members of that profession.*

21. The purpose of a sanction is not to be punitive, but to protect patients and the wider public interest, although it may have a punitive effect. If the Tribunal departs from the SG, the relevant paragraph should be referenced and reasons for departing from the SG given.

22. The decision as to the appropriate sanction, if any, to impose is a matter for the Tribunal exercising its own judgment by reference to the SG. It must consider the least restrictive sanction first and then, if necessary, consider the other sanctions, having considered Ms Emsley-Smith's submissions on behalf of the GMC. The Tribunal must consider its determination on impairment and take those matters into account during its deliberations on sanction.

23. The Tribunal was aware that the reputation of the profession is more important than the interests of any individual member.

24. The public interest, which should be at the forefront of the Tribunal's mind, includes the public interest in enabling a suitable doctor to return to safe practice, but also the wider public interest of the protection of patients, the maintenance of confidence in the profession and the declaring and upholding of proper standards of conduct and behaviour.

The Tribunal's Determination on Sanction

25. In reaching its decision, the Tribunal has taken the SG into account and paid careful regard to the overarching objective. The Tribunal reminded itself that the main reason for imposing any sanction is to protect the public and that sanctions are not imposed to punish or discipline doctors, even though they may have a punitive effect. Throughout its deliberations, the Tribunal has applied the principle of proportionality, balancing Dr Myhill's interests with the public interest.

Aggravating and Mitigating Factors

26. The Tribunal has already set out its decision on the facts and impairment which it took into account during its deliberations on sanction. Before considering what action, if any, to take in respect of Dr Myhill's registration, the Tribunal considered and balanced the aggravating and mitigating factors in this case.

27. The Tribunal identified the following aggravating factors:

- The serious nature of the misconduct, which included creating serious risk of harm to patients and the public;
- Dr Myhill has shown a lack of insight and no evidence of reflection or remediation;
- Dr Myhill has refused to cooperate with the GMC;
- Impairment has been found in respect of two distinct aspects of Dr Myhill's practice;

- Dr Myhill has demonstrated no insight into her conduct and the impact of her treatment decisions on the well-being and health of Patient B;
- Dr Myhill has demonstrated no insight into the risks she posed to the health and wellbeing of any member of the public who accessed her media and followed her advice;
- The potential for harm extended to countless individual people;
- Dr Myhill has demonstrated no insight into the impact of her media recommendations on public health.

28. Having identified aggravating factors in this case, the Tribunal identified the mitigating factors to be:

- Dr Myhill has had no previous findings of misconduct made against her;
- Dr Myhill's responsible officer confirmed to the Tribunal that there are no concerns based on her appraisals;
- Dr Myhill continued to care for Patient B during the incident despite the Covid19 pandemic;
- Dr Myhill has been subject to over 30 GMC investigations in the past which has affected her attitude towards the GMC;
- There were no specific patient complaints.

29. The Tribunal accepted that the aggravating factors outweighed the mitigating factors due to the serious nature of the misconduct and the lack of insight and remediation.

30. The Tribunal carefully considered these features throughout its deliberations in considering the appropriate and proportionate sanction to impose. The Tribunal considered each sanction in ascending order of severity, starting with the least restrictive.

No action

31. The Tribunal first considered whether to conclude the case by taking no action. It noted that taking no action following a finding of impaired fitness to practise is only appropriate in exceptional circumstances. The Tribunal determined that there were no exceptional circumstances in this case and that, given the seriousness of its findings, it would not be sufficient, proportionate, or in the public interest to conclude this case by taking no action.

Conditions

32. The Tribunal next considered whether to impose conditions on Dr Myhill's registration. The Tribunal noted that conditions are appropriate and workable in certain circumstances and where the doctor has shown insight. It also noted that conditions may also be appropriate where a Tribunal is satisfied that the doctor will comply with them and has the potential to respond positively to their work being supervised.

33. The Tribunal noted that the SG provides that in cases such as this, it is difficult to identify any conditions that could be appropriate, proportionate, workable, and measurable. In light of Dr Myhill's misconduct, the Tribunal determined that it would be difficult to formulate appropriate and workable conditions. Further, given the nature of Dr Myhill's misconduct, along with the lack of remediation and insight, it was not satisfied that she would comply with any conditions imposed.

34. The Tribunal, in any event, was of the view that imposing conditions on Dr Myhill's registration would not sufficiently mark the seriousness of her misconduct.

Suspension

35. The Tribunal considered paragraph 92 and 97a and 97e of the SG to be particularly relevant to its consideration of suspension:

'91 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 doctor. Suspension from the medical 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 suspension, although this is not its intention.

92 *Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*

97 Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a A serious breach of Good medical practice, but where the doctor's misconduct is not fundamentally incompatible with their continued registration, therefore complete removal from the medical register would not be in the public interest. However, the breach is serious enough that any sanction lower than a suspension would not be sufficient to protect the public or maintain confidence in doctors.

e No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f No evidence of repetition of similar behaviour since incident.

g *The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour.*

36. The Tribunal accepted that in relation to paragraphs 97f and 97g Dr Myhill may repeat her misconduct and are not satisfied that she has insight. Nevertheless, the Tribunal took into account that Dr Myhill has been investigated a number of times and has recently indicated to the GMC that she will not engage with the process and indeed will '*shred'* anything that she receives. The Tribunal was aware that this was the first time that any findings had been made against Dr Myhill rather than an investigation which had not led to a Tribunal hearing.

37. Although the Tribunal accepts that there is a risk of similar behaviour from Dr Myhill, particularly in relation to the internet allegations, the Tribunal applied the principle of proportionality. It considered that time should be given to Dr Myhill to consider her position and initiate remediation and develop insight having read the Tribunal's determination. The Tribunal did not consider that the misconduct could not be remediated, for example, her media could be moderated to address the concerns found by the Tribunal and training might resolve the concerns relating to Patient B.

38. The Tribunal was of the view that while it had found that Dr Myhill's actions did amount to a number of breaches of GMP and there was a lack of remediation or insight, these individual breaches were not sufficiently serious as to constitute any fundamental incompatibilities with continued registration. The Tribunal concluded, considering the facts and context of the case, that Dr Myhill's actions in her misconduct were not fundamentally incompatible with continued registration.

39. Taking all of the evidence, submissions and its own deliberations into account, the Tribunal was satisfied that a period of suspension would mark the seriousness of Dr Myhill's misconduct. The Tribunal was of the view that during a period of suspension, Dr Myhill would have the time and opportunity to develop her insight and remediate her misconduct.

40. The Tribunal went on to consider whether the sanction of erasure was appropriate and proportionate in this case. The Tribunal reminded itself of the aggravating factors it had identified in this case and considered the following paragraphs of the SG as part of its deliberations:

> *'109 Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).*
>
> *a A particularly serious departure from the principles set out in Good medical practice where the behaviour is fundamentally incompatible with being a doctor.*
>
> *b A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety*
>
> *c Doing serious harm to others (patients or otherwise), either deliberately or through incompetence and particularly where there is a continuing risk to patients'*

41. The Tribunal did not consider Dr Myhill's behaviour to be fundamentally incompatible with continued registration as it was not of itself so serious as to warrant erasure. It did not fall into the categories of serious offending such as sexual, dishonest or violent misconduct. There have been no patient complaints nor has there been serious harm as far as the Tribunal is aware, albeit there is a risk of harm to the public.

42. The Tribunal carefully considered Ms Emsley-Smith's submission that erasure was the only appropriate sanction in this case. Having balanced all the factors in this case, including the aggravating and mitigating factors, the Tribunal considered that erasure would be disproportionate in the circumstances. The Tribunal considered that a member of the public in possession of all the facts would not consider Dr Myhill's conduct to be fundamentally incompatible with continued registration.

43. The Tribunal also considered that to erase Dr Myhill's name from the medical register would deprive the public of an otherwise good doctor with over 30 years' experience.

44. The Tribunal considered the mitigating factors it had identified, alongside the guidance and concluded that imposing a sanction of erasure would be disproportionate given the facts of this case.

45. Having considered the sanctions in ascending order of restrictiveness and having determined to suspend Dr Myhill's registration, the Tribunal went to on to consider the length of the period of suspension for her. The Tribunal determined to suspend Dr Myhill's registration from the medical register for a period of nine months. It was satisfied that such a period marked the seriousness of Dr Myhill's misconduct and upheld the over-arching objective to protect the public, maintain public confidence in the profession and uphold proper professional standards. The Tribunal concluded that a suspension of this length would provide Dr Myhill with an opportunity to reflect on her misconduct, develop insight and remediate appropriately.

46. The Tribunal determined to direct a review of Dr Myhill's case. A review hearing will convene shortly before the end of the period of suspension, unless an early review is sought. The Tribunal wishes to clarify that at the review hearing, it will be Dr Myhill's responsibility to demonstrate how she has addressed this Tribunal's concerns. It therefore may assist the reviewing Tribunal if Dr Myhill provides:

- Evidence of insight;
- Evidence of CPD and measures taken to keep her knowledge up to date;
- Targeted training to address the issues relating to her misconduct;
- A reflective statement;
- Evidence of satisfactory appraisals since 2020;
- Evidence of remediation and steps taken to remediate issues identified;

- Report from her Responsible Officer showing that she has maintained her competence.

47. The Tribunal therefore determined to impose an order of suspension for 9 months with a review.

Determination on Immediate Order - 27/01/2023

1. Having determined that Dr Myhill's registration should be subject to an order of suspension for a period of nine months, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Myhill's registration should be subject to an immediate order.

Submissions

2. On behalf of the GMC, Ms Emsley-Smith submitted that that it follows from the Tribunal's findings that an immediate order of suspension is entirely appropriate, necessary and in the public interest due to the seriousness of the substantive findings and the potential risk to patient safety and public confidence in the medical profession.

The Tribunal's Determination

4. In reaching its decision, the Tribunal considered the relevant paragraphs of the SG and exercised its own independent judgement. In particular, it took account of paragraphs 172, 173 and 178, which state:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under*

pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.

173 *An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*

…

178 *Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'*

5. The Tribunal determined that given the circumstances of this case, it is necessary to protect members of the public and in the public interest to make an order suspending Dr Myhill's registration with immediate effect, to uphold and maintain professional standards and maintain public confidence in the profession.

6. This means that Dr Myhill's registration will be suspended from the date on which notification of this decision is deemed to have been served upon her. The substantive direction, as already announced, will take effect 28 days from that date, unless an appeal is made in the interim. If an appeal is made, the immediate order will remain in force until the appeal has concluded.

7. There is no interim order to revoke.

8. That concludes the case.

ANNEX A - 07/11/2022

Application on Service and Proceeding in absence

1. Dr Myhill was neither present nor legally represented at the hearing. The Tribunal had to consider firstly whether service had been properly effected as required by the General Medical Council (Fitness to Practise) Rules 2004 as amended ('The Rules') and the Medical Act 1983 ('The Act'). If it found service had been effected in accordance with the Rules, it would need to consider whether to proceed in Dr Myhill's absence. In reaching its decision it has taken into account all the information before it, including a 'Service Bundle' and the submissions by Ms Rosalind Emsley-Smith, Counsel, on behalf of the General Medical Council ('GMC'). It accepted the advice of the LQC who referred to the relevant Rules and caselaw.

Service

2. The Tribunal considered Rule 40 of the Rules which provides:

> *'(1) Any notice of hearing required to be served upon the Practitioner under these rules shall be served in accordance with paragraph 8 of Schedule 4 to the Act.*
>
> *(2) Subject to paragraph (1), any notice or document required to be served upon the practitioner under these rules can be served –*
>
> > *(a) by ordinary post; or*
> > *(b) by electronic mail to an electronic address that the practitioner has notified to the Registrar as an address for communications.'*

3. The Tribunal was aware that in this case email was used as a means of service as provided by Rule 40(4)(b) rather than other methods of service. This Rule provides in this regard:

'The service of any notice or document under these rules may be proved by…

***(b)** a confirmation of receipt of the notice or document sent by electronic mail.'*

4. In order for service by electronic mail it was necessary for Dr Myhill to have agreed to the use of electronic mail as provided by Rule 40(2)(b) above. The Tribunal was provided with an email notification form dated 24 October 2018, signed by Dr Myhill which provided:

' I SARAH MYHILL agree to be contacted by the General Medical Council and the MPTS via email at the above address, for the purposes of fitness to practice proceedings, including the sending of:

1. *Correspondence and updates on the investigation, supporting documentation.*

2. *Correspondence and documentation in relation to any MPTS hearing arising from the investigation.*

I understand that the correspondence and documents referred to above may contain confidential information and it is my responsibility to ensure that this email address is secure.

I understand that it is my responsibility to keep this email address up to date and to inform the General Medical Council if this changes.'

The Tribunal was therefore satisfied that email could be used for service.

5. The Tribunal was provided with a screen shot of Dr Myhill's registration details which contained her email address. This email was the same as she had agreed to be used.

6. The Tribunal was provided with a copy an email sent by the GMC to Dr Myhill's email address on 30 September 2022 which contained details of the Allegation and informing her that the MPTS will send her a Notice of Hearing separately. It received evidence that this email had been sent to Dr Myhill's email address, but no delivery notification was received and Dr Myhill did not respond to this email. On 10 October 2022 the GMC sent a further email to Dr Myhill requesting that she confirm safe receipt of the email. The GMC received an automated response which stated that she was out of office until 14 October 2022. The GMC received no further correspondence from Dr Myhill.

7. The Tribunal received evidence that the MPTS had sent Notice of Hearing to Dr Myhill using her agreed email on 3 October 2022. The Tribunal was satisfied the Notice contained all the information required by Rule 15 of the Rules. Doctor Myhill responded by email on 4 October 2022 stating, '*I shall not be attending the hearing*.'

8. The Tribunal determined that the Notice had been served in accordance with the Rules as set out above as the Notice of Hearing had been sent by email to Dr Myhill's email address which she had agreed could be used and further she had responded stating she would not be attending the hearing.

Proceeding in Absence

9. Having been satisfied in relation to service the Tribunal went on to consider whether to proceed in absence in accordance with Rule 31 which provides:

> *'31. Where the practitioner is neither present nor represented at a hearing, the Committee or Tribunal may nevertheless proceed to consider and determine the allegation if they are satisfied that all reasonable efforts have been made to serve the practitioner with notice of the hearing in accordance with these Rules.'*

10. Ms Emsley-Smith submitted that, firstly, the absence of Dr Myhill was voluntary and deliberate and secondly, any adjournment of this hearing is likely to be 'fruitless'. She stated that there was no evidence that Dr Myhill would change her mind and attend the hearing. The Tribunal accepted this submission as Dr Myhill had indicated by email on 4 October 2022 that she would not attend the hearing and there had been no further correspondence from her.

11. The Tribunal was aware from the advice provided by the Legally Qualified Chair that it had a discretion whether to proceed in Dr Myhill's absence. However, it should exercise that discretion with the utmost care and caution.

12. The Tribunal considered that the following factors were particularly relevant in this case:

- Dr Myhill had voluntarily absented herself as shown by the email of 4 October 2022.
- The requirement to be fair to the parties. The Tribunal was aware that there was a potential disadvantage to Dr Myhill in not being present but was aware it would need to be as fair as it could be to Dr Myhill during the hearing and to ask appropriate questions of the witnesses.
- Delay in the hearing would affect witnesses as well as the efficient and expeditious disposal of the case.
- The overarching objective needed to be considered and having regard to all the circumstances of this case it was necessary for the hearing to continue. It was in the public interest to proceed.
- There was a burden on the doctor to engage with their Regulator and the hearing process.
- An adjournment and the length of time before the case could be listed again was of concern because the Tribunal could not be satisfied Dr Myhill would attend.

13. The Tribunal considered all the above factors and the circumstances of the case. It decided that it should proceed in Dr Myhill's absence in accordance with Rule 31.

ANNEX B – 07/11/2022

Application to allow witnesses to give evidence remotely

1. On 7 November 2022 Ms Rosalind Emsley-Smith, Counsel on behalf of the GMC, made an application pursuant to Rule 34(13) of the General Medical Council (Fitness to Practise) Rules 2004 as amended 'The Rules' that the following witnesses should give evidence by video link:

- Patient B
- Patient B's wife
- Dr J, Expert
- Dr K, Expert
- Dr F, Expert
- Dr E, Doctor in Emergency Medicine
- Dr H, Consultant in Emergency Medicine
- Dr G, Consultant in Emergency Medicine
- Dr D, Responsible Officer

2. Ms Emsley-Smith contended that Patient B and Patient B's wife were elderly and it would be difficult for them to travel to Manchester. In relation to the other witnesses she said it could be difficult for them to travel to Manchester and also, they were all medical practitioners and could have clinical responsibilities. She stated that video link evidence would be effective for all these witnesses and it was in the interests of justice that her application be granted.

Tribunal's Decision

3. The Tribunal accepted the advice of the Legally qualified Chair who referred to the current GMC Guidance relating to the '*Use of video link, telephone evidence and special measures at Medical Practitioners Tribunal Hearings*.' She also referred to the case of *Polanski v Condé Nast Publication Ltd (2005) UKHL*, which found:

> *'It seems to me …that as a starting point it is important to recall that although evidence given in court is still often the best as well as the normal way of giving oral evidence, in view of technological developments, evidence by video link is both an efficient and effective way of providing oral evidence both in chief and in cross-examination.'*

4. The Tribunal took into account Rule 34(13) and Rule 34(14)(c) which state:

> ***'Rule 34 (13):*** *A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.*
>
> ***Rule 34(14)(c):*** *Only grant the application of it is in the interests of justice.'*

5. The Tribunal firstly considered the application in relation to Patient B and Patient B's wife. It accepted that it was difficult for them to a travel a long distance to Manchester. It therefore determined that it was in the interests of justice for them to give their evidence by video link.

6. The Tribunal secondly considered the application relating to the medical practitioners, other than the experts in the case. The Tribunal acknowledged that these witnesses were likely to have clinical responsibilities and duties which would make it difficult for them to attend in Manchester and could possibly impact on patient care. Further, these witnesses are witnesses of fact. It therefore decided that it was in the interests of justice for the following witnesses to give evidence by video link:

1. Dr E
2. Dr H
3. Dr G
4. Dr D

7. The Tribunal finally considered the application in relation to the expert witnesses in the case who had been instructed by the GMC and would normally be expected to attend the hearing in person. The Tribunal was of the opinion, despite the fact that they may have clinical duties and it was time consuming to travel to Manchester, that the nature of their evidence as experts was such that they should appear in person to give their evidence. Indeed, the Tribunal was aware that two other experts were already scheduled to attend in Manchester to give oral evidence. The Tribunal had not been provided with enough evidence to allow it to differentiate these experts from the ones already scheduled to appear in person to give oral evidence. The Tribunal found that it was not in the interests of justice for the following witnesses to give evidence by video link:

- Dr J
- Dr K
- Dr F

8. The Tribunal therefore granted the application in relation to Patient B and Patient B's wife, and the medical practitioners who were not to be called as Expert witnesses. The Tribunal refused the application in relation to the three expert witnesses.

ANNEX C - 07/11/2022

Application to allow witnesses to give evidence remotely

1. On 7 November 2022 Ms Rosalind Emsley-Smith, Counsel on behalf of the GMC, made a further application pursuant to Rule 34(13) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that, Dr J give evidence remotely.

2. Ms Emsley-Smith made reference to Rule 34(9) which states:

> *'Rule 34(9): In relation to proceedings before the Committee or a Medical Practitioners Tribunal, unless otherwise agreed between the parties or directed by a Case Manager, each party shall not less than 28 days before the date of a hearing-*
>
> *a. provide to the other party a list of every document which he proposes to introduce as evidence; and*
> *b. provide to the other party a copy of every document listed in paragraph (a) which the other party has not previously received.'*

3. Ms Emsley-Smith submitted that the GMC complied with Rule 34(9) on the 26 September 2022. She submitted that, in their letter, the GMC stated that they:

> *'a. did not intend to apply for any witness to give oral evidence in chief;*
> *b. did intend to apply for witnesses to give testimony via video link;*
> *c. in the absence of a response, would not arrange for witness(es) to give evidence orally at the hearing and would tell witness(es) they do not need to be available at any time during the hearing.'*

4. Ms Emsley-Smith then directed the Tribunal to Rule 39(9A) which states:

'Rule 39(9A): *Within 14 days of a list or document being provided under paragraph (9), the party to whom it is provided ("the receiving party") must notify the other party if the receiving party requires any relevant person to attend to give oral evidence or to be available for cross examination in relation to the subject matter of or making of any document. In the event that no such notification is received the Tribunal can determine allegation on the basis of the signed witness statements and exhibits. Witnesses do not need to attend to confirm the contents of their witness statements. The statements themselves contain a statement of truth.'*

5. Ms Emsley-Smith submitted that Dr Myhill did not notify the GMC that any of the witnesses were required to be cross-examined. She submitted that a registered doctor has a duty to cooperate with their regulator. She further submitted that the GMC have made the witness available in the event that the Tribunal had any questions of any witness for the purpose of determining the allegations.

6. Ms Emsley-Smith reminded the Tribunal of Rule 34(13) and Rule 34(14)(c) which state:

'Rule 34 (13): *A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.*

Rule 34(14)(c): *Only grant the application of it is in the interests of justice.'*

7. Ms Emsley-Smith submitted that If Dr J is required to attend Manchester to give evidence this will involve an 8/9 hour round trip for him. She submitted that the alternative would be for him to travel the day before and stay in Manchester over night with consequent cost to the GMC. Ms Emsley-Smith submitted that Dr J was unable to travel on the evening of the 7 November 2022 due to disruption to train services and the resulting overall length of the journey. She submitted that he is unable to undertake the round-trip journey on the

8 November 2022 due to the overall length of the journey and professional teaching commitments he has on Wednesday morning in Cambridge. Ms Emsley-Smith informed the Tribunal that Dr J is the only Clinical Fellow teaching medical students Clinical Pharmacology at Cambridge and has classes scheduled

8. Ms Emsley-Smith reminded the Tribunal that Dr J has provided 5 comprehensive reports. She submitted that there is nothing about his evidence and the presentation of it which would be undermined if his evidence was given by video link. She stated that Dr J will have all the material he may need available to him and can deal with any questions the Tribunal may have of him. Ms Emsley-Smith submitted that, if Dr J is required to give his evidence in person, this would require him to undertake a significant journey to get to Manchester. She submitted that the fatigue caused by the journey, coupled with the concern about the journey back may negatively impact the quality of J's evidence.

9. Ms Emsley-Smith submitted that the use of video link is both an effective and efficient way to deal with Dr J's evidence. She said that requiring him to travel to Manchester is inefficient, disproportionate and will cause delay to the progress of the hearing.

10. Ms Emsley-Smith submitted that there is no basis for saying that the interests of justice are undermined or compromised by granting the application for Dr J to give evidence by video link. She submitted that all parties have experienced how effective the large screen is for receiving evidence during a hearing.

11. Ms Emsley-Smith referred to the GMC's guidance on '*Use of video link, telephone evidence and special measures at Medical Practitioners Tribunal Hearings.*' She also referred to the case of *Polanski v Condé Nast Publication Ltd (2005) UKHL*, which stated that video link could be an effective way of giving evidence.

Tribunal's Decision

12. Tribunal accepted the advice of the Legally Qualified Chair who referred the Tribunal to the current GMC Guidance relating to the '*Use of video link, telephone evidence and special measures at Medical Practitioners Tribunal Hearings.*' She also referred to the case of *Polanski v Condé Nast Publication Ltd (2005) UKHL*, which found:

> *'It seems to me …that as a starting point it is important to recall that although evidence given in court is still often the best as well as the normal way of giving oral evidence, in view of technological developments, evidence by video link is both an efficient and effective way of providing oral evidence both in chief and in cross-examination.'*

13. The Tribunal considered that as an expert, Dr J should be prepared to physically give evidence and should have factored their GMC duties into their workload commitments. The Tribunal considered that although Dr J should be present, it accepted that he had workload commitments and difficulties in traveling to Manchester.

14. Therefore, the Tribunal decided that it was in the interest of justice for Dr J to give evidence by video link and granted the application.

ANNEX D - 08/11/2022

Application to allow witnesses to give evidence remotely

1. On 8 November 2022 Ms Rosalind Emsley-Smith, Counsel on behalf of the GMC, made an application made pursuant to Rule 34(13) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), that, Dr K give evidence remotely. Dr K was previously scheduled to give expert witness evidence in person later in the hearing.

2. Ms Emsley-Smith made reference to Rule 34(9) which states:

> *'Rule 34(9): In relation to proceedings before the Committee or a Medical Practitioners Tribunal, unless otherwise agreed between the parties or directed by a Case Manager, each party shall not less than 28 days before the date of a hearing-*
>
> *a. provide to the other party a list of every document which he proposes to introduce as evidence; and*
> *b. provide to the other party a copy of every document listed in paragraph (a) which the other party has not previously received.'*

3. Ms Emsley-Smith submitted that the GMC complied with Rule 34(9) on the 26 September 2022. She submitted that, in their letter, the GMC stated that they:

> *'a. did not intend to apply for any witness to give oral evidence in chief;*
> *b. did intend to apply for witnesses to give testimony via video link;*
> *c. in the absence of a response, would not arrange for witness(es) to give evidence orally at the hearing and would tell witness(es) they do not need to be available at any time during the hearing.'*

4. Ms Emsley-Smith then directed the Tribunal to Rule 39(9A) which states:

'Rule 39(9A): *Within 14 days of a list or document being provided under paragraph (9), the party to whom it is provided ("the receiving party") must notify the other party if the receiving party requires any relevant person to attend to give oral evidence or to be available for cross examination in relation to the subject matter of or making of any document. In the event that no such notification is received the Tribunal can determine allegation on the basis of the signed witness statements and exhibits. Witnesses do not need to attend to confirm the contents of their witness statements. The statements themselves contain a statement of truth.'*

5. Ms Emsley-Smith submitted that Dr Myhill did not notify the GMC that any of the witnesses were required to be cross-examined. She submitted that a registered doctor has a duty to cooperate with their regulator. She further submitted that the GMC have made the witness available in the event that the Tribunal had any questions of any witness for the purpose of determining the allegations.

6. Ms Emsley-Smith reminded the Tribunal of Rule 34(13) and Rule 34(14)(c) which state:

'Rule 34 (13): *A party may, at any time during a hearing, make an application to the Committee or Tribunal for the oral evidence of a witness to be given by means of a video link or a telephone link.*

Rule 34(14)(c): *Only grant the application of it is in the interests of justice.'*

7. Ms Emsley-Smith submitted that Dr K was unable to give evidence in person at such short notice as he had already taken on childcare duties on the day that he was scheduled to give evidence. She submitted that Dr K had advised that he may not be able to give evidence in person at a later date as his wife, who is also a doctor, is on duty throughout November. She submitted that Dr K had informed her that this, coupled with his own work schedule meant that he was unable to give evidence in person due to clinical and personal commitments alongside with the lack of time available to make alternative arrangements.

Tribunal's Decision

8. Tribunal accepted the advice of the Legally Qualified Chair who referred the Tribunal to the current GMC Guidance relating to the '*Use of video link, telephone evidence and special measures at Medical Practitioners Tribunal Hearings*.' She also referred to the case of *Polanski v Condé Nast Publication Ltd (2005) UKHL*, which found:

> *'It seems to me …that as a starting point it is important to recall that although evidence given in court is still often the best as well as the normal way of giving oral evidence, in view of technological developments, evidence by video link is both an efficient and effective way of providing oral evidence both in chief and in cross-examination.'*

9. The Tribunal considered that as an expert, Dr K should be prepared to physically give evidence and should have factored their GMC duties into their workload commitments. It considered that it was normally in the interests of justice for expert witnesses in particular to attend to give evidence, but due to the issues with Dr K's childcare and clinical duties, it determined to allow Dr K to give his evidence by video link and therefore granted the application.

ANNEX E - 14/11/2022

Determination on Admissibility of Evidence

1. On 14 November 2022 Ms Rosalind Emsley-Smith, Counsel on behalf of the GMC, made an application to admit further evidence, pursuant to Rule 34(1) of the General Medical Council ('GMC') ('Fitness to Practise') Rules 2004 (as amended)('the Rules').

Evidence

2. Ms Emsley-Smith told the Tribunal that a document in the form of an email had been received from Dr K, an Expert, on 12 November 2022. The Tribunal had been provided with a copy of this document. She reminded the Tribunal that Dr K had given evidence to the Tribunal on 11 November 2022. She confirmed that further research had been undertaken by Dr K because he considered he had not been able to answer fully a question from the Tribunal relating to Doctor Myhill's expertise in relation to "CFS /ME" and in particular in relation to a book Dr Myhill had written and the mitochondrial energy score that she herself had developed. She therefore contended the document was relevant and fair as it related to Tribunal questioning.

The Tribunal's Approach

3. The Tribunal bore in mind Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), which reads as follows:

> ***34(1)*** *The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.*

The Tribunal's Determination

4. The Tribunal carefully considered the content of the document sent by Dr K. It was concerned that he referred to articles published in 2019 and NICE guidelines published in 2021 to support his opinion. Further, the document also contained an opinion from the ME association who supported the 2021 NICE guidelines. The Tribunal is considering the Allegation which relates to matters arising before 2019. Dr Myhill would not have known about these articles or guidelines at the time of the Allegation. Further, the Tribunal must consider the Allegation in the light of whatever research or guidelines were available at the relevant time. Therefore, the Tribunal found that it was neither fair or relevant to admit the document.

5. The Tribunal therefore refused the application.

ANNEX F - 21/11/2022

Determination on Admissibility of Evidence

1. On 21 November 2022 Ms Rosalind Emsley-Smith, Counsel on behalf of the GMC, made an application to admit further evidence, pursuant to Rule 34(1) of the General Medical Council ('GMC') ('Fitness to Practise') Rules 2004 (as amended)('the Rules').

Evidence

2. Ms Emsley-Smith placed before the Tribunal, various documents that consisted of a signed witness statement prepared by the GMC Legal Adviser, Mr N. He exhibited a screenshot of a webpage from Dr Myhill's website taken in June 2021. The webpage contained information about how to take iodine, where it stated, '*one can take 20mg daily'.* Another screenshot was taken in November 2022 where the webpage now states, '*one can take 50mg daily'.*

3. Mr N also exhibited an email from Dr J dated 18 November 2022 in which he stated that this new information did not cause him to add, alter or amend the opinion he has expressed in his reports before the Tribunal.

4. Ms Emsley-Smith therefore contended the document was relevant and fair as it related to the charges to be determined by the Tribunal.

The Tribunal's Approach

5. The Tribunal bore in mind Rule 34(1) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), which reads as follows:

34(1) *The Committee or a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law.*

The Tribunal's Determination

6. The Tribunal carefully considered the contents of the document put before them. It accepted that the new evidence clarified the issue of when the website was accessed. The Tribunal noted that this issue would have arisen whilst determining the outcome of the charges. The Tribunal also found it helpful that both screenshots were put to Dr J and that they were able to gather his comments and expert opinion given this new information. The Tribunal found that the witness statement of Mr N provided sufficient context and chronology to both screenshots and the email of Dr J. Therefore, the Tribunal found that it was both fair and relevant to admit the statement and accompanying documents at this stage.

7. The Tribunal therefore granted the application.

ANNEX G - 07/12/2022

Application to amend the Allegation

1. On 07 December 2022 the Tribunal requested that Ms Rosalind Emsley-Smith, Counsel on behalf of the GMC, made representations on an application to amend the Allegation, pursuant to Rule 17(6) of the General Medical Council (Fitness to Practise) Rules 2004 ('the Rules').

2. Ms Rosalind Emsley-Smith, on behalf of the GMC, submitted that there was a typographical error within the Allegation. She invited the Tribunal to amend the stem of paragraph 7d of the Allegation from:

> 7. You consulted with Patient A and:
>
> d. your parenteral administration of the prescribed medication was inappropriate because:

To:

> 7. You consulted with Patient A and:
>
> d. your advice on the parenteral administration of the prescribed medication was inappropriate because:

3. The Tribunal was satisfied that the amendment could be made without injustice to either party. It therefore granted the application and paragraph 7d of the Allegation was amended as above.