Neutral Citation Number: [2025] EWHC 474 (Admin)

Case No: AC-2023 –LON-003846

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 03/03/2025

Before :
Mr Justice Dexter Dias

- -

Between :

Dr Sarah Barbara Myhill — **Appellant**

- and –

General Medical Council — **Respondent**

- -
- -

Louisa Bagley (instructed by **Public Access**) for the **Appellant**
Peter Mant (instructed by **GMC Legal**) for the **Respondent**

Hearing dates: 16 and 17 October 2024
Further written submissions: 31 October 2024
Draft circulated: 23 December 2024
Counsel suggestions: 10 January 2025
Perfected judgment circulated: 20 January 2025

Approved Judgment

This judgment was handed down remotely at 10.30 am on 3 March 2025 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

.....

JUDGMENT

Mr Justice Dexter Dias :

B123: Appeal bundle p.123; AS/RS: Appellant/Respondent skeleton argument.

§I. INTRODUCTION

1. In this statutory appeal brought under section 40 of the Medical Act 1983 ("**the Act**"), the appellant Dr Myhill makes a fresh evidence application. This is the court's ruling.

2. Dr Sarah Myhill is represented by Ms Bagley of counsel. The respondent is the General Medical Council ("**GMC**"). The respondent is represented by Mr Mant of counsel. The court is grateful to both counsel for their submissions in writing and orally.

3. I emphasise that this ruling does not dispose of the appeal, and in due course must be considered alongside the appeal's final judgment. However, full reasons are provided to assist parties at this stage. There is much to go through. The application raises several important issues of principle about the correct approach to fresh evidence when there is a previously undisturbed finding of misconduct. However, it is important to be clearsighted about what is being appealed and why, and how proper challenge can be made. Therefore, it will assist to set out the pertinent elements of the factual and procedural history to the case. This is not an exhaustive account, but what is relevant to the ruling on fresh evidence.

4. I divide the ruling into the 16 sections and an annex as set out in the table above.

5. The appellant is a very experienced doctor. She obtained her MBBS medical qualification at the University of London in 1981 and then worked for 20 years within the NHS in General Practice. She spent six months as an Associate Specialist at the Royal Shrewsbury Hospital working with patients with chronic fatigue syndrome. By the time of the complained of conduct, the appellant had been specialising in ecological medicine and had done so for a number of years, and was Secretary of the British Society for Ecological Medicine. The GMC brought charges against her for the online promotion, endorsement and/or sale of certain agents to treat and protect against viral and bacterial infections, including COVID-19, which the GMC alleged risked patient safety and undermined public health, including by exposing patients to potential serious harm. There was a separate allegation about a patient called Patient B, involving allegedly defective treatment.

6. On 7 November 2022, a hearing began before the Medical Practitioners Tribunal and ran for approximately six weeks (sitting days: 7 November – 9 December 2002, 23-27 January 2023). It delivered its decision, running to 149 pages, on 27 January 2023. To avoid confusion, this will be called the **Original Hearing** and the **Original Tribunal**. Misconduct was found and Dr Myhill's fitness to practise was found to be impaired. The Original Tribunal imposed a suspension of 9 months.

7. There was then a review hearing in November 2023 just before the expiry of the suspension. This will be called the **Review Hearing** and the tribunal the **Review Tribunal**. It is this tribunal's decision that is appealed (also called "impugned decision"). The decision letter is dated 20 November 2023, and Dr Myhill states she was notified about it on 24 November. Nothing turns on those four days. The grounds for the appeal can be seen in the first paragraph of the appellant's skeleton argument to this court:

> "1. The Appellant appeals under S.40 Medical Act 1983 against the decision of the Medical Practitioners Tribunal (MPT) at a Fitness to Practise Review hearing ("Review") notified on 24th November 2023 which made findings that the Appellant is unfit to Practise as of that date and went on to give a direction for suspension for a further 12 months. The Appellant attended the Review but was denied an opportunity to fairly address the issue of her fitness to practise and insight into the issues previously found against her."

8. Dr Myhill no longer wants to practise as a doctor, as set out at AS para 3:

> "[she] had been practising as a Naturopath since 2020 (and no longer practised as a GP). … The Appellant's treatments are successful albeit not mainstream and often her practice involves progressive medicine and alternative remedies."

9. By a form N244 filed on 8 October 2024, the appellant made an application for fresh evidence to be admitted in the appeal. Box 3 of the form states that she seeks:

> "An Order that the appeal court will receive evidence which was not before the lower court CPR 52.21(2)(b). I have filed and served evidence. GMC object to fresh evidence. My appeal (a re-hearing listed for 2 days

16th and 17th October) requires this evidence and the burden of proof is on me. PD 52D 19.1(2) applies."

§II. FRESH EVIDENCE

10. For these purposes, "fresh" simply means that the evidence had not been before the previous tribunal. The fresh evidence has been divided into two bundles. They have been called by the respondent EB1 (135 pages) and EB2 (324 pages). The respondent helpfully summarises, non-exhaustively, their contents as:

- "A witness statement that: (i) provides background about the appellant's work and previous involvement with the GMC (§§4-13); (ii) describes her reasons for not attending the Original Hearing (§§14-19); (iii) gives an account of the harm she says she has suffered since the Original Hearing (§§20-23); (iv) makes a series of submissions in support of her appeal that combine legal argument, reference to matters which pre-date the Review Hearing, and descriptions of what happened at and in relation to the Review Hearing (§§24-85) **[EB1/2-30]**;

- A witness statement from Patient B describing events in March 2020 **[EB1/31- 35]**;

- A series of witness statements from other professionals expressing agreement with some of the appellant's views and/or critiquing the opinions of the GMC expert witnesses **[EB1/67-135]**;

- Various publications and articles all but one of which pre-dates the Original Tribunal and the Review Tribunal (the only document that does not pre-date both is a single slide reportedly showing numbers of deaths and adverse events from different vaccines **[EB2/220]**) **[EB2]**."

11. In respect of the fresh evidence, the appellant's case is that she filed and served a bundle of fresh evidence on 1 July 2024 (correspondence having given notice on 25 May 2024 that this evidence would be served). That bundle includes a statement dated 28 June 2024 from Dr Myhill herself that addresses the issues relevant to her appeal. She submits that "the relevance of the evidence is self-evident from the grounds of appeal and it is submitted that fresh evidence was obviously required given the facts and content of the appeal."

12. In oral argument, Ms Bagley helpfully divided the fresh evidence sought into three categories (1) The "*Bolam* bundle"; (2) Patient A; (3) Patient B. *Bolam* is a reference to evidence going to the issue arising from the landmark decision of this court in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 ("*Bolam*"). There McNair J stated at 587:

> "I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art. I do not think there is much difference in sense. It is just a different way of

> expressing the same thought. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view. At the same time, that does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to be contrary to what is really substantially the whole of informed medical opinion. Otherwise you might get men today saying: "I do not believe in anaesthetics. I do not believe in antiseptics. I am going to continue to do my surgery in the way it was done in the eighteenth century." That clearly would be wrong."

13. The court was told that the *Bolam* bundle is the "biggest part", as the findings against Dr Myhill include substantially that she, as counsel summarised it, "put out on the internet information that was unsafe". The point of the *Bolam* bundle evidence is to show that the appellant was "following a body of opinion", as Ms Bagley termed it. The "expert evidence" shows that Dr Myhill's views are "safe and not exposing people to harm", and thus undermine the adverse findings made against her by the Original Tribunal and relied on by the Review Tribunal.

14. First, the respondent disputes whether the *Bolam* test is the right test for disciplinary proceedings against a doctor. *Bolam* is said to be relevant to clinical negligence claims. Second, and in any event, the evidence applied for does not show what the appellant claims for it. Therefore, the respondent opposes the fresh evidence application.

15. To understand the significance and forensic force of the fresh evidence application and how it fits into the scheme of these proceedings, it is necessary to contextualise it by setting out what can only be a concise account of the extensive disciplinary proceedings. I should add at the outset, and to narrow the focus, that the Original Tribunal did not find that its decision on Patient A impaired Dr Myhill's fitness to practise. This point was recognised and accepted by the Review Tribunal. It placed no weight at all on the Patient A allegations and findings. In these circumstances, as it had no material impact whatsoever on the initial sanction of suspension by the Original Tribunal or the subsequent finding of impairment and further suspension imposed by the Review Tribunal, I also put it to one side. This is an appeal against the Review Tribunal's fitness to practise finding, that is, its finding about impairment as at November 2023 due to proved misconduct.

§III. ORIGINAL TRIBUNAL

16. As the Original Tribunal noted at para 493, "Dr Myhill was neither present nor legally represented at the hearing." Having considered email service (rule 40(4)(b)) and the appropriateness of proceeding in absence (rule 31), the Tribunal continued with the hearing in Dr Myhill's absence. Dr Myhill set out the reasons for her absence in her appeal skeleton argument at para 3:

> "The Appellant did not attend or participate in FTP [Original Tribunal] as she felt victimised by GMC, had been practising as a Naturopath since 2020 (and no longer practised as a GP) and had lost faith in the GMC not

> least because she had been subjected to many previous allegations of misconduct, many of a similar nature, all having been unsuccessfully investigated and or pursued against her. These previous matters involved submissions of bad faith against GMC because of repeated allegations of, and investigations for, similar alleged "misconduct", for example use of B12 injections as treatment, which have never been proved as misconduct against the Appellant. The Appellant's treatments are successful albeit not mainstream and often her practice involves progressive medicine and alternative remedies."

17. The Original Tribunal's findings of misconduct are summarised in the Review Tribunal's decision:

> "7. The January 2023 Tribunal found proved that on one or more occasions tween March and May 2020, Dr Myhill promoted and endorsed the use of agents to treat and protect against viral and bacterial infections, including Coronavirus. 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.
>
> 8. The January 2023 Tribunal found that Dr Myhill's recommendations and actions risked patient safety by exposing patients to potential serious harm, including toxicity, and/or, failed to meet NICE guidance of Vitamin D dosing, and were unproven in terms of their benefits.
>
> 9. The January 2023 Tribunal found proved that Dr Myhill's recommendations and actions undermined public health by exposing patients to potential serious harm, including toxicity, and/or, failed to meet NICE guidance of vitamin D dosing, were not supported by any professional UK medical body or the NHS and were unproven in terms of their benefits.
>
> 10. The January 2023 Tribunal found that Dr Myhill had breached paragraphs 1, 15, 16, 22, 49, 65, 68, 70, 71 and 73 of GMP. [Good Medical Practice or "GMP"]
>
> 11. The January 2023 Tribunal determined that Dr Myhill's failures amounted to serious professional misconduct."

18. To understand why the Original Tribunal reached these conclusions, it is necessary to provide the relevant provisions in the GMP (with emphasis provided to identify key elements):

> "Professionalism in action
>
> **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.

Domain 1: Knowledge, skills and performance

Apply knowledge and experience to practice

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**
c take all possible steps to alleviate pain and distress whether or not a cure may be possible
d consult colleagues where appropriate
e respect the patient's right to seek a second opinion
f check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications
g wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship

Domain 2: Safety and quality
Contribute to and comply with systems to protect patients

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 available

Establish and maintain partnerships with patients
49 **You must work in partnership with patients, sharing with them the information they will need to make decisions about their care, including**:

> a their condition, its likely progression and **the options for treatment, including associated risks and uncertainties**
> b the progress of their care, and your role and responsibilities in the team
> c who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care
> **d** any other information patients need if they are asked to agree to be involved in teaching or research.
>
> Act with honesty and integrity
> 65 **You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.**
>
> Communicating information
> **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."

19. Having considered the relevant provisions of the GMP, on 27 January 2023 the Original Tribunal determined that Dr Myhill's conduct amounted to serious professional misconduct.

§IV. ORIGINAL TRIBUNAL: IMPAIRMENT

20. The Original Tribunal went on to consider the question of impairment to fitness to practise. Its finding of impairment (again summarised in the Review Tribunal's decision) was:

> "12. The January 2023 Tribunal determined 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 had 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. In terms of Patient B and the internet allegations the January 2023 Tribunal determined that Dr Myhill's fitness to practise was impaired by reason of misconduct."

21. The approach of the Original Tribunal was completely in accordance with the approach endorsed by Swift J in *Adil v General Medical Council* [2023] EWHC 797 Admin. The judge stated at para 33:

> "It is not difficult to think of examples of matters on which doctors' opinions on medical matters will differ. The simple fact that one opinion could legitimately be described as "widely accepted" ought not, of itself, provide a sufficient justification for professional discipline of medical practitioners who held a different opinion. In many instances, there will be obvious value in legitimate discussion of different or conflicting medical hypotheses, or of whether received wisdom should be revisited. Disciplinary action in such circumstances could amount to an unjustified interference with article 10 rights. Neither holding nor expressing an outlying opinion on a matter of professional practice ought to give rise to punishment, absent clear justification, for example where there is evidence of harm to patients or public health."

22. He continued at para 34:

> "… this Tribunal's use of the standard that asked whether what Mr Adil had said was "contrary to widely accepted medical opinion" (taken from paragraph 4b. of the charge sheet), was hostage to fortune. Any general practice on the part of the GMC of applying disciplinary sanctions to medical practitioners simply because they held or expressed views that were "not part of widely accepted medical opinion" (Determination on the Facts at paragraph 52) would engage the operation of article 10, and applying that standard to a particular case is clearly capable of leading to disciplinary conclusions amounting to unjustified interference with article 10 rights. From the perspective of compliance with article 10, action taken by reference to such a standard would require clear justification. As a general rule it would be preferable for the Tribunal to address such situations within the confines of standards expressly set by the GMC, and consider by reference to those standards whether the misconduct found to be taken place was sufficiently serious as to amount to impairment of fitness to practise"

23. These vital passages from *Adil* were read out to the Review Tribunal by the appellant herself as part of the preliminary issue on admissibility. This is undoubtedly the correct approach: to assess the conduct against the published professional standards. That is precisely what the Original Tribunal did and how it reached its conclusions on misconduct (first) and impairment (second). At para 484 of its decision, the Original Tribunal stated:

> "484. 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.
>
> 485. The Tribunal therefore determined to impose an order of suspension for 9 months with a review."

24. Therefore, the Original Tribunal identified without prescribing what it suggested should be the purpose, focus and scope of the Review Tribunal.

§V. FAILURE TO APPEAL

25. Once the Original Tribunal made findings of professional misconduct, Dr Myhill had the right to appeal against the sanction imposed because of the misconduct. Leave is not required. She did not appeal within the 28-day statutory time limit, nor at any point. The appellant explains (AS para 5):

> "5. When the Appellant was notified that over 100 allegations in total had been proved at FTP and that she had been found unfit to practise with a suspension for 9 months, her mistrust of GMC and the disciplinary process was exacerbated. An appeal to the High Court seemed to be an unnecessary mountain to climb, very costly and with potential cost risks. Since the Appellant has practised as a Naturopath from 2020 (not as a GP) and no longer even pays fees to GMC, no longer undergoes reappraisal and her licence to practice medicine expired in 2020 and has no medical indemnity for GP work, she did not appeal and did not expect that her professional reputation as a doctor would be smeared or that she should need to prove her innocence. However, she later discovered that her name now appeared on the GMC website as suspended for misconduct with details of the numerous (over 100) proved allegations including those in respect of Patient A and learned of mainstream press articles (including BBC news) which stated that she was a risk to patients' safety and had given false information to the public including recommending "animal

> medication". Furthermore, it later became apparent that the sanction of suspension meant that this smearing of her character would resurrect and continue indefinitely due to Review and that things could potentially get even worse. The Appellant's professional reputation has now been damaged by GMC's unfair prosecutions."

§VI. REVIEW TRIBUNAL: FRESH EVIDENCE APPLICATION

26. The appellant did, however, attend the Review Hearing in November 2023. Her rationale for doing so was (AS para 7):

> "7. The Appellant felt obliged to engage with the Review proceedings which were to readdress her fitness to practise as of November 2023 so that she could demonstrate that she is in fact fit to practise, should not be publicly considered as a doctor who has committed matters of misconduct (*Bolam* principles properly applied) and should not be subjected to a sanction of suspension. This seemed to be the necessary way to correct the wrong against her."

27. At the outset of the Review Hearing, Dr Myhill made an application to introduce evidence not before the Original Tribunal. The Review Tribunal's legal chair Ms Moxon stated (B228):

> "We know that the December 2022 Tribunal [that ultimately delivered the 27 January 2023 decision], as I'll refer to them, had considered, Dr Myhill, your fitness to practise and they made the assessment, the determination, that your fitness to practise was impaired then in December of 2022. We are tasked now with whether your fitness to practise is impaired as of today and so to do that we'll consider whether there's been any development of insight or remediation since December 2022 and whether there remains a risk of repetition of any misconduct. We have no power to overturn any findings of fact of the December 2022 Tribunal and we're not able to overturn their conclusion that the facts found proved amounted to serious misconduct. So because we don't have the power to deal with that, we don't want to hear any submissions from either party or any evidence designed to persuade us that the previous Tribunal was wrong because we're not empowered to deal with that.
>
> To reiterate, the Tribunal's actual role today, then, is extremely narrow because we're going to be concerned only with whether Dr Myhill's fitness to practise is impaired as of today's date or possibly if we go into tomorrow tomorrow's date and whether a finding of impaired fitness to practise is necessary. So if it assists, what we are likely to be assisted by both parties is for any submission and evidence to focus on whether there has been a development of insight; second, whether there has been a development of remediation; and, third, any risk to further misconduct."

28. Dr Myhill told the Review Tribunal (B229-30):

> "Since the review will assess my insight in respect of the matters found against me it is important and necessary for me to determine why I do not agree with the findings which were in my absence and therefore why, despite not agreeing with those findings, my insight is not impaired and that I am fit to practise. It should not matter that I did not appeal the findings or the reasons for why I did not do so because this review hearing is still dependent on those findings and consideration of my insight about them."

29. She continued (B229):

> "I do not wish to challenge the findings of the Fitness to Practise hearing, it had its evidence base then, I wish to present new evidence not available to that Tribunal which I believe renders those findings unsound. This must be done out of fairness to the practitioner, ie, myself."

30. She further stated (B231):

> "In my absence witnesses were allowed to present their own personal opinions and chose to ignore the large body of medical opinion that supported the advice contained within my website and what I had told patients. … The second reason that I wish to cross-examine Julia Oakford [legal chair of Original Tribunal] is that in my absence she failed to apply the *Bolam* test in her assessment of GMC expert witness evidence"

31. Having heard Dr Myhill's submissions and those of counsel for the GMC, the Review Tribunal handed down the following decision:

> **"DETERMINATION**
> 1. The Tribunal was provided with written skeleton arguments from Dr Myhill and Ms Emsley-Smith, Counsel on behalf of the GMC. Dr Myhill also supplied the Tribunal with a 1352 page preliminary argument bundle.
>
> **Submissions**
> 1. Dr Myhill told the Tribunal, that she wishes to call three witnesses Mrs Julia Oakford Legally Qualified Chair of the January 2023 Tribunal, Dr Kevin O'Shaughnessy and Dr Richard Quinton, both GMC expert witnesses at that hearing. Dr Myhill said that the witnesses are necessary in order for her to be able to cross examine them in order to demonstrate that her hearing in January 2023 was unfair. She said that she wishes to present new facts which demonstrate evidence of insight and remediation. Dr Myhill submitted that the Tribunal should allow the witnesses to give evidence as the January 2023 Tribunal was misled resulting in unfairness of the proceedings. She said that the processes followed to date have not been in accordance with her Human Rights, specifically her freedom of expression and right to a fair trial.
> 2. Ms Emsley-Smith stated that the submissions made by Dr Myhill are that which could be heard by the High Court on any appeal rather than submissions relevant to a review hearing. She reminded the Tribunal

that it does not have the power to revisit the findings of fact, impairment and sanction decisions made by the January 2023 Tribunal. Further, she refuted any suggestion of bad faith on the part of the GMC legal team and the GMC, then and now.

Background

3. Dr Myhill's registration was made subject to an order of suspension for a period of nine months following a hearing in January 2023 ('the January 2023 Tribunal') which found that her fitness to practise was impaired by reason of misconduct and directed a review.

4. The Tribunal has noted Rules 29(2) and 34(1) which state:

'Rule 29(2)
(2) Where a hearing of which notice has been served on the practitioner in accordance with these Rules has commenced, the Committee or Tribunal considering the matter may, at any stage in their proceedings, whether of their own motion or upon the application of a party to the proceedings, adjourn the hearing until such time and date as they think fit.

Rule 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.

This Tribunal does not have the power to revisit the findings of the January 2023 Tribunal. The purpose of a review hearing is for this Tribunal to determine whether Dr Myhill's fitness to practise remains impaired by reason of her misconduct. It must consider Dr Myhill's insight, remediation and the risk of repetition.

5. Given that the Tribunal cannot revisit the determinations made by the January 2023 Tribunal, it was not satisfied that calling the witnesses is relevant to its duty in determining Dr Myhill's current fitness to practise. There is nothing to evidence that any of these witnesses could possibly be in a position to assist the Tribunal in determining the matters before it at this review. Much of Dr Myhill's arguments focus on what she feels is an injustice created by the January 2023 Tribunal's findings, however, that is not a matter that this Tribunal can revisit.

6. In relation to fairness, the Tribunal noted that Dr Myhill will be permitted to give evidence, should she choose to do so, and/or address the Tribunal by way of submissions.

7. Any consideration as to the success or otherwise of setting aside the witness summons by Cardiff County Court, including any possible appeal of that decision, is not a consideration for this Tribunal. The Tribunal must determine for itself whether it is fair and relevant to call the witnesses Dr Myhill seeks.

> 8. Dr Myhill made representations about the lateness of receiving the GMCs skeleton argument and a further response from the MPTS Case Management. Although Dr Myhill did not apply for an adjournment to further consider the same, the Tribunal considered whether fairness to Dr Myhill necessitated a delay in the hearing. The GMC skeleton argument set out the Tribunal's powers at a review hearing but otherwise did not add anything relevant to the Tribunal's decision. The GMC had consistently communicated to Dr Myhill since June 2023 that they objected to the three witnesses being called and why and therefore the Tribunal did not consider that any further period of consideration with the papers would assist when weighed against the delay that would be caused by adjourning.
>
> 9. Accordingly, the Tribunal determined to refuse Dr Myhill's application to call witnesses."

§VII. REVIEW TRIBUNAL: IMPAIRMENT

32. It repays setting down the relevant parts of the Review Tribunal's decision on impairment in more detail than is customary due to the particular features of the case and the issues this court must now decide:

> "17. Dr Myhill said that at the January 2023 hearing the GMC misled the Tribunal by failing to allow her to produce her own medical records of Patient A. Dr Myhill said the reason she did not attend that hearing was because it could not possibly be fair. She said that the GMC sent Patient A's medical records which were not anonymised, and it was her view that even if she anonymised the records she held she would be unable to use them, which meant her hearing was intrinsically unfair, regardless of the outcome. She said she did not appeal the decision due to the financial cost of an appeal.
>
> 20. When asked about insight Dr Myhill said that the evidence at the January 2023 hearing was unfair and asked the Tribunal to consider the other evidence she had provided to demonstrate that the January 2023 Tribunal's decision was "materially flawed". When asked about remediation Dr Myhill said that it is not relevant in her case nor in her present role as a naturopath, and she has not worked as a doctor since 2020. She said that she does not have appraisals and she wished to de-register as a doctor. She said that she had applied for Voluntary Erasure which was refused as she was subject to ongoing investigation. She said that she cannot satisfy the Tribunal's demands because she does not wish to be a doctor.
>
> 21. Dr Myhill said that both GMC experts were either dishonest or not experts and acted to support the GMCs allegations. Dr Myhill referred the Tribunal to the *Bolam* test (*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582). She advanced that she had been acting in accordance with a body of medical opinion. When asked what she had

done to remediate since the previous hearing in January 2023 Dr Myhill said that she has remediated by having provided a huge body of evidence. Dr Myhill referred to the research and references she provided in relation to Magnesium, Vitamin C, Vitamin D and Iodine. She said that Dr O'Shaughnessy's expert report was incomplete, highly selective and in parts wrong.

22. Dr Myhill confirmed that she wished this Tribunal to consider that the evidence at the January 2023 hearing was incomplete. Dr Myhill said that there have been no deaths from supplements and her recommendations for vitamins and minerals are considerably safer than prescription drugs. Dr Myhill said that the medical evidence base that she had provided demonstrated the research she had done and showed great insight. She said that the January 2023 Tribunal had no evidence and relied on Dr O'Shaughnessy's opinion of 'potential harm' not actual harm which could apply to any doctor. She said there has never been any evidence of harm to patients or any patient complaints.

…

25. When asked about an article about the effectiveness of wearing of masks during Covid on her website Dr Myhill said that her opinions are always evidence based.

27. When asked how she had addressed the concerns her misconduct had on professional standards Dr Myhill said that the GMC experts were selective and not front line doctors. She said that she has produced a huge body of evidence of her work with the general public and that she is a good doctor.
28. When asked how she had addressed the concerns her misconduct had on the protection and promotion of the health and safety of the public Dr Myhill said that she has published online articles, written books and lectures widely which protects the general public.
38. She said that she believes that she has more than balanced the GMC experts' opinions. Dr Myhill said that she has demonstrated insight and provided evidence as to why she considers the hearing in January 2023 was unfair. She said that there has been no harm to patients.

The Relevant Legal Principles

40. The Tribunal reminded itself that the decision of impairment is a matter for the Tribunal's judgement alone. This Tribunal is aware that it is for Dr Myhill to satisfy it that she would be safe to return to unrestricted practise.
41. This 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.

The Tribunal's Determination on Impairment

44. It was clear to the Tribunal that Dr Myhill has not accepted the findings of the January 2023 Tribunal and rejects the need for this review of her sanction. Rather Dr Myhill firmly wanted to use this opportunity to revisit the January 2023 Tribunal's findings because she considered the

hearing itself to have been unfair, the decisions materially flawed and the sanction unjust. Dr Myhill considers a review of whether she is fit to practise "irrelevant" as she no longer wishes to practise as a doctor.

45. The Tribunal acknowledged that Dr Myhill has done a lot of reading and research around the use of vitamins and supplements but there is no evidence that this was balanced reading. Indeed, when questioned, Dr Myhill accepted that the purpose of her reading and evidence base put before the Tribunal was to evidence that she had a "*Bolam* defence" and that a different decision should have been made by the January 2023 Tribunal. The Tribunal did not consider this to be consistent with insight, reflection or remediation. Whilst the Tribunal was of the view that this could be considered as evidence of CPD to a degree, Dr Myhill had not demonstrated balanced reading or targeted training. Instead she had sought to evidence her original position and defend the same.
48. The Tribunal noted that the persuasive burden is on Dr Myhill to demonstrate that she has gained insight, has remediated and her fitness to practise is not impaired. However, she has provided very limited evidence that her approach has changed. Dr Myhill remains unwilling to recognise that she may not be right as she has failed entirely to give weight to views other than her own. The Tribunal considered that Dr Myhill has focussed her research on material which asserts her beliefs and has an entrenched view. The Tribunal is of the opinion that Dr Myhill's actions demonstrate confirmation bias and that she has persuaded herself that she is right to the exclusion of competing views and evidence. In the Tribunal's view, doctors should be welcome to challenge and willing to reflect on their own beliefs and behaviours.
49. The Tribunal considered that the situation has not changed since January 2023. Dr Myhill has provided no real evidence of insight, neither has she attempted to remediate the matters raised by the January 2023 Tribunal hearing and therefore there remains an immediate and high risk of repetition.
50. Whilst the Tribunal noted that Dr Myhill has not worked as a doctor since 2020, it considered that given the lack of insight and remediation and the risk of repetition that there is a risk to patient safety.
51. The Tribunal considered that, the promotion and maintenance of public confidence in the medical profession, and the promotion and maintenance of proper professional standards and conduct for members of that profession, would be undermined if, in the light of Dr Myhill' lack of insight, a finding of impairment were not made.
52. This Tribunal has therefore determined that Dr Myhill's fitness to practise is impaired by reason of misconduct."

§VIII. GROUNDS OF STATUTORY APPEAL

33. The appellant's stance towards the Review Hearing is set out in her skeleton argument:

> "27 The Appellant attempted to demonstrate genuine insight by providing a large bundle of a responsible body of medical opinion

> evidence to the GMC and MPT (in advance of the hearing) which show that her views do not equate to misconduct. Furthermore, the Appellant emphasised that she practises as a Naturopathic doctor which is relevant to her views.
>
> 28 MPT found that the Appellant lacked insight as she does not agree with the findings against her at FTP. No weight was given to the facts that she was absent, unrepresented, the *Bolam* test was not applied at FTP, nor was she judged by her peers."

34. Dissatisfied with the outcome of the Review Hearing, the appellant filed her appeal under section 40 of the Act by an N161 appeal notice dated 28 December 2023. There are 10 grounds of appeal:

> "GROUND 1
> MPT were wrong to make findings that C is unfit to practise by virtue of misconduct because the original findings of misconduct are unsound.
>
> GROUND 2
> MPT were wrong to make findings that C lacks insight on the facts before them and that C should therefore be subject to further suspension.
>
> GROUND 3
> MPT failed to take into account, and prevented C from addressing, the Bolam principle which would demonstrate that, while C's opinions are not "widely accepted" that C's opinions can be found in the bodies of medical and scientific opinion which C furnished to the court and wished to present to demonstrate she is fit to practise and has insight which was especially relevant as there was no evidence of harm to patients or public health.
>
> GROUND 4
> MPT wrongly concluded that C's evidence regarding vitamins and supplements was "research" that "showed some insight" when it in fact demonstrated evidence of expert peers within the same expertise and demonstrated her opinions online were not misconduct.
>
> GROUND 5
> MPT failed to afford sufficient respect to C's right under Article 10 to freedom of expression.
>
> GROUND 6
> MPT failed to afford sufficient respect to C's right under Article 8 to carry out her private practice as a Naturopath without unreasonable interference.
>
> GROUND 7
> MPT failed to take into account and or give relevant weight to the specific factual circumstances regarding the allegations in respect of Patient B namely by concluding that C's attempt to give an explanation was irrelevant and demonstrated lack of insight whereas in fact it demonstrates that there was no misconduct by C.

GROUND 8
MPT failed to allow C to adduce evidence relevant to whether it was reasonable to expect admissions to alleged misconduct maters proven as the only way to demonstrate "insight" at the review namely evidence that shows the findings of misconduct regarding Patient A are either an abuse of process, proved in bad faith and or demonstrate total incompetence by the GMC (27 findings of misconduct from 52 allegations all of which were subject to a previous MPT ruling and therefore should not have formed part of the fitness to practise hearing).

GROUND 9
MPT wrongly concluded that further suspension is appropriate and proportionate on the facts of the case and or due to C's unusual circumstances.

GROUND 10
MPT were wrong to allow 3 preliminary rulings in favour of GMC which prevented C (a litigant in person) from presenting her case namely

(1) allowing late service of GMC skeleton argument dealing with their objections to C calling evidence;
(2) refusal to postpone the hearing to allow C to appeal GMC's applications made the week before the hearing to set aside C's witness summonses (obtained by C over 6 months before and GMC having warned the witnesses in June 2023) and or to allow C reasonable time to consider the GMC skeleton argument contesting this evidence before the hearing; and
(3) refusal to allow C to call witnesses to enable evidence to be put as to her current fitness to practise and issue of insight because the combination of the 3 rulings in respect of applications, all made extremely late, interfered with C's right under Article 6 to have a fair hearing and prevented her from addressing the issues of fitness to practise and insight in a fair manner."

§IX. LEGAL AND REGULATORY FRAMEWORK

35. The legal and regulatory framework can be divided into distinct sections:

(a) The Act;

(b) The procedure rules

(c) Statutory appeal

(d) Case law on statutory appeal

(e) Fresh evidence

(a.) The Act

36. Sections 1(1)–(1B) of the Act provide:

> "(1) There shall continue to be a body corporate known as the General Medical Council (in this Act referred to as "the General Council") having the functions assigned to them by this Act.
>
> (1A) The over-arching objective of the General Council in exercising their functions is the protection of the public.
>
> (1B) The pursuit by the General Council of their over-arching objective involves the pursuit of the following objectives—
>
> (1) to protect, promote and maintain the health, safety and well-being of the public,
> (2) to promote and maintain public confidence in the medical profession, and
> (3) to promote and maintain proper professional standards and conduct for members of that profession."

37. On the question of impairment, section 35C(2) provides:

> "A person's fitness to practise shall be regarded as "impaired" for the purposes of this Act by reason [~~only~~] of—
>
> (a) misconduct;

38. Section 35D is entitled "Functions of a Medical Practitioners Tribunal". The section provides on sanction following an impairment finding:

> "(2)
> Where the Medical Practitioners Tribunal find that the person's fitness to practise is impaired they may, if they think fit—
> […]
> (b)
> direct that his registration in the register shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction"

39. Section 35D also builds in the opportunity for review of sanction and extension of suspension (here "the direction"):

> "(4A) The Tribunal may direct that the direction is to be reviewed by another Medical Practitioners Tribunal prior to the expiry of the period of suspension; and, where the Tribunal do so direct, the MPTS must arrange for the direction to be reviewed by another Medical Practitioners Tribunal prior to that expiry.
>
> (5) On a review arranged under subsection (4A) […] a Medical Practitioners Tribunal may, if they think fit—

a. direct that the current period of suspension shall be extended for such further period from the time when it would otherwise expire as may be specified in the direction."

(b.) The Rules

40. The Act operates in conjunction with procedural rules: The General Medical Council (Fitness to Practise) Rules 2014 ("the Rules"). Part 5 of the Rules relates to review hearings. Rule 18, as relevant, provides:

> "18.
> (1) This Part shall apply to any hearing (a review hearing) at which a Medical Practitioners Tribunal is to determine whether or not to make a direction under section 35D(5)"

41. Rule 21A provides valuable insight into the operation of the scheme of rules:

> "21A.
> (1) If, since the previous hearing, a new allegation against the practitioner has been referred to the MPTS for them to arrange for it to be considered by a Medical Practitioners Tribunal, it shall first proceed with that allegation in accordance with rule 17(2)(a) to (j).
> (2) The Medical Practitioners Tribunal shall thereafter proceed in accordance with rule 22 except that, when determining whether the fitness to practise of the practitioner is impaired and what direction (if any) to impose under section 35D(5), (6), (8) or (12) of the Act, it shall additionally have regard to its findings in relation to the new allegation."

42. Here there is specific provision for hearing and determining new allegations of breaches of the professional standards. Rule 22 provides the key requirements for the conduct of review hearings:

> "Procedure at review hearing
> 22.
> (1) The order of proceedings at a review hearing shall be as follows —
> …
> (c.) the representative for the GMC shall—
> (i) inform the Medical Practitioners Tribunal of the background to the case, and the sanction previously imposed,
> (ii) direct the attention of the Medical Practitioners Tribunal to any relevant evidence and may adduce evidence and call witnesses in relation to the practitioner's fitness to practise or his failure to comply

with any requirement imposed upon him as a condition of registration;

(d.) the practitioner may present his case and may adduce evidence and call witnesses in support of it;

(e.) the Medical Practitioners Tribunal shall receive further evidence and hear any further submissions from the parties as to whether the fitness to practise of the practitioner is impaired or whether the practitioner has failed to comply with any requirement imposed upon him as a condition of registration;

(f.) the Medical Practitioners Tribunal shall consider and announce its finding on the question of whether the fitness to practise of the practitioner is impaired the Medical Practitioners Tribunal may receive further evidence and hear any further submissions from the parties as to its decision whether to make a direction under section 35D(5), (6), (8), (10) or (12) of the Act."

(c.) Statutory appeal

43. The Act grants an unqualified right of statutory appeal. Section 40 provides:

> "(1) The following decisions are appealable decisions for the purposes of this section, that is to say—
>
> (a) a decision of a Medical Practitioners Tribunal under section 35D above giving a direction […] for suspension."

44. However, the Act mandates a statutory time limit for appealing at section 40(4):

> "(4) A person in respect of whom an appealable decision falling within subsection (1) has been taken may, before the end of the period of 28 days beginning with the date on which notification of the decision was served under section 35E(1) above, or section 41(10) ... below, appeal against the decision to the relevant court.
>
> (5) In **[**subsections (4) and (4A)**]** above, "the relevant court"—
> …
> (c) [in the instant case] means the High Court of Justice in England and Wales."

45. The filing in time is a statutory requirement. It will be strictly applied. However, there remains scope for arguing "exceptional circumstances" to appeal out of time (*R (Adesina) v NMC* [2013] EWCA Civ 818) ("*Adesina*").

46. As seen, under section 40 of the Act, it is open to a practitioner to appeal against the decision of a Medical Practitioners Tribunal to give a direction at any time within 28 days of the date on which notification of the direction is deemed to have been served upon the practitioner as required by section 35E. Any such appeal is by way of a statutory appeal in accordance with Part 52 of the Civil Procedure Rules (and not by

way of judicial review) and must be filed at court at any time within 28 days of the date on which notification of the decision is deemed to have been served upon the practitioner. When a Medical Practitioners Tribunal directs that a practitioner's registration should be suspended, the date upon which that direction takes effect is regulated by paragraph 10 of Schedule 4 to the Act.

47. The appeal under section 40 of the Act is by way of rehearing, in accordance with Civil Procedure Rules 1998 ("CPR") 52.21(1) and CPR PD 52D, para 19.1. Under CPR r 52.21(3), the court will allow the appeal if the Decision was either (a) wrong or (b) unjust because of a serious procedural or other irregularity in the proceedings in the Tribunal. CPR PD 52D, para 19.1 provides, emphasising the distinction with judicial review:

> "Every appeal to which this paragraph applies *must* be supported by written evidence and, if the court so orders, oral evidence and *will* be by way of re-hearing (as opposed to a review of the evidence)."

(d.) Case law on statutory appeal

48. The proper approach to the conduct of appeals has been considered by the higher courts. In *Sastry v GMC* [2021] EWCA Civ 623, Nicola Davies LJ stated at paras 102-03:

> "102 Derived from *Ghosh* [[2001] 1 WLR 1915] are the following points as to the nature and extent of the section 40 appeal and the approach of the appellate court: (i) an unqualified statutory right of appeal by medical practitioners pursuant to section 40 of the 1983 Act; (ii) the jurisdiction of the court is appellate, not supervisory; (iii) the appeal is by way of a rehearing in which the court is fully entitled to substitute its own decision for that of the tribunal; (iv) the appellate court will not defer to the judgment of the tribunal more than is warranted by the circum- stances; (v) the appellate court must decide whether the sanction imposed was appropriate and necessary in the public inter- est or was excessive and disproportionate; (vi) in the latter event, the appellate court should substitute some other penalty or remit the case to the tribunal for reconsideration.
>
> 103 The courts have accepted that some degree of deference will be accorded to the judgment of the tribunal but, as was observed by Lord Millett at para 34 in *Ghosh*, "the Board will not defer to the Committee's judgment more than is warranted by the circumstances". […] Laws LJ in *Raschid and Fatnani* [2007] 1 WLR 1460 […] stated that on such an appeal material errors of fact and law will be corrected and the court will exercise judgment but it is a secondary judgment as to the application of the principles to the facts of the case (para 20)."

49. The approach to section 40 appeals had also been examined in this court by Yip J in *Yusuff v General Medical Council* [2018] EWHC 13 (Admin) ("*Yusuff*"):

> "20. I conclude having reviewed all the relevant authorities that at a review hearing:

(a.) The findings of fact are not to be reopened;

(g.) An appeal under section 40 of the Medical Act 1983 is by way of rehearing but as Foskett J observed in *Fish v General Medical Council* [2012] EWHC 1269 (Admin) at [28] ["*Fish*"]: "it is a rehearing without hearing again the evidence".

(h.) It is well established that the court should give proper deference both to the Tribunal's specialist nature and to the fact that the Tribunal has the advantage of seeing and hearing witnesses give evidence. I have in mind the much quoted passage from the judgment of Auld LJ in *Meadow v General Medical Council* [2006] EWCA Civ 1390 [2007] QB 462, [197]:

"... it is plain from the authorities that the Court must have in mind and give such weight as is appropriate in the circumstances to the following factors:

i) The body from whom the appeal lies is a specialist tribunal whose understanding of what the medical profession expects of its members in matters of medical practice deserve respect;

ii) The tribunal had the benefit, which the Court normally does not, of hearing and seeing the witnesses on both sides;

iii) The questions of primary and secondary fact and the overall value judgment to be made by the tribunal, especially the last, are akin to jury questions to which there may reasonably be different answers."

25. Equally, it is clear that the Court can and will interfere to correct material errors of law and fact and will exercise its own judgment as to the application of the principles to the facts of the case (see *Raschid and Fantani v GMC* [2007] EWCA Civ 46; [2007] 1 WLR 1460 at paragraph 20). The Court will also intervene if there has been some material unfairness in the proceedings before the Tribunal."

50. While Yip J in *Yusuff* at para 21 referred to para 28 of *Fish*, the passages of Foskett J's judgment around this paragraph are instructive on the approach of the court to findings of fact:

"26. The appeal is brought under section 40 of the Medical Act 1983 which provides a practitioner with a right of appeal to the High Court inter alia from a decision of an FTP under section 35D giving a direction for suspension. By virtue of section 40(7) on an appeal under section 40 the High Court may -

(a) dismiss the appeal;

(b) allow the appeal and quash the direction or variation appealed against;

(c) substitute for the direction or variation appealed against any other direction or variation which could have been given or made by a Fitness to Practise Panel; or

(d) remit the case to the Registrar for him to refer it to a Fitness to Practise Panel to dispose of the case in accordance with the directions of the court.

27. The issue for the court is whether the FTP's determination was wrong: see CPR 52.11(3).

28. Whilst the appeal constitutes a "re-hearing", it is a re-hearing without hearing again the evidence.

29. I venture to repeat certain quotations from earlier cases that I made in the case of *Chyc v General Medical Council* [2008] EWHC 1025 (Admin) concerning the approach of this court to challenges to findings of fact. I referred in *Chyc* to what was said by the Judicial Committee of the Privy Council in *Gupta v General Medical Council* [2002] 1 WLR 1691 where the following appears at paragraph 10:

> "[T]he obvious fact [is] that the appeals are conducted on the basis of the transcript of the hearing and that, unless exceptionally, witnesses are not recalled. In this respect, these appeals are similar to many other appeals in both civil and criminal cases from a judge, jury or other body who has seen and heard the witnesses. In all such cases the appeal court readily acknowledges that the first instance body enjoys an advantage which the appeal court does not have, precisely because that body is in a better position to judge the credibility and reliability or the evidence given by the witnesses. In some appeals that advantage may not be significant since the witnesses' credibility and reliability are not in issue. But in many cases the advantage is very significant and the appeal court recognises that it should accordingly be slow to interfere with the decisions on matters of fact taken by the first instance body. This reluctance to interfere is not due to any lack of jurisdiction to do so. Rather, in exercising its full jurisdiction, the appeal court acknowledges that, if the first instance body has observed the witnesses and weighed their evidence, its decision on such matters is more likely to be correct than any decision of a court which cannot deploy those factors when assessing the position. In considering appeals on matters of fact from the various professional conduct committees, the Board must inevitably follow the same general approach. Which means that, where acute issues arise as to the credibility or reliability of the evidence given before such a committee, the Board, duly exercising its appellate function, will tend to be unable properly to differ from the decisions as to fact reached by the committee except in the kinds of situation described by Lord Thankerton in the well known passage in *Watt or Thomas v Thomas* [1947] AC 484, 484-488."

30. The passage from Lord Thankerton's opinion was as follows:

> "I do not find it necessary to review the many decisions of this House, for it seems to me that the principle embodied therein is a simple one, and may be stated thus: I. Where a question of fact has been tried by a judge without a jury, and there is no question of misdirection of himself by the judge, an appellate court which is disposed to come to a different conclusion on the printed evidence, should not do so unless it is satisfied that any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses, could not be sufficient to explain or justify the trial judge's conclusion; II. The appellate court may take the view that, without having seen or heard the witnesses, it is not in a position to come to any satisfactory conclusion on the printed evidence; III. The appellate court, either because the reasons given by the trial judge are not satisfactory, or because it unmistakably so appears from the evidence, may be satisfied that he has not taken proper advantage of his having seen and heard the witnesses, and the matter will then become at large for the appellate court. It is obvious that the value and importance of having seen and heard the witnesses will vary according to the class of case, and, it may be, the individual case in question."

31. I referred also to *Threlfall v General Optical Council* [2004] EWHC 2683 (Admin), at paragraph 21, where Stanley Burnton J, as he then was, said this:

> "Because it does not itself hear the witnesses give evidence, the court must take into account that the Disciplinary Committee was in a far better position to assess the reliability of the evidence of live witnesses where it was in issue. In that respect, this court is in a similar position to the Court of Appeal hearing an appeal from a decision made by a High Court Judge following a trial …."

32. So those are the parameters for considering the issues raised in this appeal in relation to the findings. It is plain that where the conclusion of the FTP is largely based on the assessment of witnesses who have been "seen and heard", this court will be very slow to interfere with that conclusion. Nonetheless, the court has a duty to consider all the material put before it on an appeal in order to discharge its own responsibility, appropriate deference being shown to conclusions of fact reached on the basis of the advantage of having seen and heard the witnesses. Where this court does not feel disadvantaged by not having heard the witnesses, and the issues can be addressed with little emphasis on the direct assessment of the evidence by the Panel, it is in a position to take a different view in an appropriate case."

51. While Yip J in *Yusuff* quoted from parts of the well-known judgment in *Meadow*, I would add the much-cited observation of Sir Anthony Clarke MR at para 32:

> "32 In short, the purpose of FTP proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practise today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past."

52. This is of relevance to how the Review Tribunal had to consider the task it was duty-bound to consider in November 2023, whether Dr Myhill was impaired at that point.

53. Yip J also mentioned *Fatnani and Raschid v General Medical Council* [2007] EWCA Civ 46. In that case, Laws LJ (with whom Chadwick LJ and Sir Peter Gibson agreed) said:

> "As it seems to me the fact that a principal purpose of the Panel's jurisdiction in relation to sanctions is the preservation and maintenance of public confidence in the profession rather than the administration of retributive justice, particular force is given to the need to accord special respect to the judgment of the professional decision-making body in the shape of the Panel."

(e.) Fresh evidence

54. While the principle of issue estoppel ordinarily operates to prevent the re-litigation of matters decided by a court of competent jurisdiction (excepting otherwise recognised appeal routes), the common law has developed exceptions to such estoppel. Perhaps most notably, in *Ladd v Marshall* [1954] 1 WLR 1489, Lord Denning provided what has subsequently proved to be a highly influential account of a test to admit fresh evidence. He explained at 1491:

> "The principles to be applied are the same as those always applied when fresh evidence is sought to be introduced. In order to justify the reception of fresh evidence or a new trial, three conditions mast be fulfilled: first, it must be shown that the evidence could not have been obtained with reasonable diligence for use at the trial: second, the evidence most be such that, if given, it would probably have an important influence on the result of the case, though it need not be decisive: thirdly, the evidence must be such as is presumably to be believed, or in other words, it must be apparently credible, though it need not be incontrovertible."

55. An alternative test for assessing the admissibility of fresh evidence was formulated by the House of Lords in the case of *Arnold v National Westminster Bank PLC* [1991] 2 AC 93 ("*Arnold*"). In *Salem v GMC* [2017] EWHC 840 at para 10, Dove J applied the *Arnold* test on issue estoppel and fresh evidence:

> "10. In resisting the reopening of these matters, Mr Dunlop on behalf of the respondent contends that it is now too late for the appellant to seek to disturb the findings and conclusions of the 2011 MPT panel and that the appeal against the MPT's findings in 2011 is the subject of an issue estoppel preventing the re-litigation of the points which were decided by

> the MPT in 2011. Mr Dunlop relies upon the decision of the House of Lords in *Arnold v National Westminster Bank PLC* [1991] 2 AC 93."

56. Dove J then helpfully quoted a substantial passage from the speech of Lord Keith in *Arnold* appearing at 108E-109C:

> "It is to be noted that there appears to be no decided case where issue estoppel has been held not to apply by reason that in the later proceedings a party has brought forward further relevant material which he could not by reasonable diligence have adduced in the earlier. There is, however, an impressive array of dicta of high authority in favour of the possibility of this. It was argued for the defendants that exceptions to the rule of issue estoppel should be admitted only in the case of the earlier judgment being a default or a foreign judgment and further that an exception should not be recognised where the point at issue had actually, as here, been raised and decided in the earlier proceedings, but only where the point might have been but was not so raised and decided. The later dicta are, however, adverse to these arguments. It was argued that there was no logical distinction between cause of action estoppel and issue estoppel and that, if the rule was absolute in the one case as regards points actually decided, so it should be in the other case. But there is room for the view that the underlying principles upon which estoppel is based, public policy and justice, have greater force in cause of action estoppel, the subject matter of the two proceedings being identical, than they do in issue estoppel, where the subject matter is different. Once it is accepted that different considerations apply to issue estoppel, it is hard to perceive any logical distinction between a point which was previously raised and decided and one which might have been but was not. Given that the further material which would have put an entirely different complexion on the point was at the earlier stage unknown to the party and could not by reasonable diligence have been discovered by him, it is hard to see why there should be a different result according to whether he decided not to take the point, thinking it hopeless, or argue it faintly without any real hope of success. In my opinion your Lordships should affirm it to be the law that there may be an exception to issue estoppel in the special circumstance that there has become available to a party further material relevant to the correct determination of a point involved in the earlier proceedings, whether or not that point was specifically raised and decided, being material which could not by reasonable diligence have been adduced in those proceedings. One of the purposes of estoppel being to work justice between the parties, it is open to courts to recognise that in special circumstances inflexible application of it may have the opposite result, as was observed by Lord Upjohn in the passage which I have quoted above from his speech in the Carl Zeiss case [1967] 1 A.C. 853, 947."

§X. MAXIMS OF ISSUE ESTOPPEL

57. Before me, there has been much legal argument about the approach this court should take to fresh evidence in a statutory appeal where the fresh evidence is directed at disturbing intact previous findings of fact on professional misconduct by a disciplinary tribunal. It is likely that this issue will arise not infrequently (see but one example in *Salem*). Issues immediately arise of res judicata, issue estoppel and the admissibility of fresh evidence.

58. My point of embarkation is to set down the principles that seem to me to arise in such cases. I emphasise that this analysis has been the basis of my decision in this fresh evidence application.

1. A res judicata is a decision on the merits made earlier by a relevant tribunal or court of competent jurisdiction.
2. Res judicata applies to disciplinary proceedings which are civil proceedings (Supreme Court in *R (Coke-Wallis) v Institute of Chartered Accountants of England and Wales* [2011] UKSC 1 paras 22-24, 27 ("*Coke-Wallis*")).
3. Res judicata is characterised by two chief species: action estoppel and issue estoppel.
4. In this context, estoppel is simply where a party is stopped (legally prevented) from denying the truth of a "particular state of affairs" (Snell's *Equity* (35th edn, 2024) 12-004).
5. Issue estoppel arises where a party seeks to relitigate an identical issue between the same parties that has been determined in previous proceedings by a competent court or tribunal and remains undisturbed.
6. A finding of fact by an earlier tribunal on professional misconduct that (a) has not been appealed, and (b) for which no application for extension of time is made, is a determination to which issue estoppel applies.
7. Issue estoppel is not, however, an absolute bar to challenging the misconduct finding and is capable being disapplied in special cases or special circumstances (*Thoday v. Thoday* [1964] P. 181, 197-198 per Diplock LJ; *Arnold v. National Westminster Bank Plc* [1991] 2 AC 93 ("*Arnold*")).
8. A review hearing is not a retrial or an appeal and issue estoppel applies to undisturbed previous findings of fact on professional misconduct.
9. At a review hearing, which is part of civil proceedings, the review tribunal is bound to proceed on the basis of undisturbed findings of fact on professional misconduct (that is, take them into account and rely on them) and has no power to reopen or "go behind" them, unless there are special circumstances, including a successful application to admit fresh evidence indicating that the findings are wrong.
10. There are three chief routes to challenging misconduct findings with fresh evidence (1) *Ladd v Marshall*; (2) the wider discretion of the court to do justice (*Arnold*, applied in *Salem*); (3) rule 34(1).
11. **Route 1**: fresh evidence applied to be admitted via *Ladd v Marshall* necessitates an examination of:
    (1) Reasonable diligence;
    (2) Probable important influence;

(3) Apparent credibility.

12. **Route 2**: the *Arnold* discretion (which is also consistent with and gives effect to the overriding objective to deal with the case justly) where the court is satisfied that there are "special circumstances" to admit fresh evidence on condition that it:
    (1) Could not by reasonable diligence have been discovered by the time of the impugned decision;
    (2) Would put an entirely different complexion on the issue.
13. **Route 3**: whether the evidence, if failing the tests under Routes 1 and 2, nevertheless should be admitted as a question of overriding fairness, even if it is not strictly "admissible in a court of law" (Rule 34(1)), an exercise in which it will be useful to consider Route 1 and Route 2 factors (inter alia) without being bound by them, to structure the evaluation of fairness.
14. The principles of issue estoppel also apply to section 40 statutory appeals where previous disciplinary tribunal findings of fact on professional misconduct remain intact and for which no application to appeal out of time is made.
15. Similarly, however, in statutory appeals the previous undisturbed misconduct findings can be challenged through fresh evidence properly admissible through Route 1 and/or Route 2 with a view to showing that the findings of fact are wrong.

59. I step back to reflect on what underpins all this. There is nothing new in it. The concept of issue estoppel can be traced back at least to the 18th century and featured in *Kingston (Duchess) Case* (1776) 2 Smith's LC 644, 645. The significance of res judicata, of which issue estoppel is part, was explained a century later by Brett MR in *Re May* (1885) 28 Ch D 516 at 518:

> "It is a very substantial doctrine, and it is one of the most fundamental doctrines of all courts, that there must be an end to all litigation, and that the parties have no right of their own accord, having tried a question between them, and obtained a decision of a court, to start that litigation over again on precisely the same question."

60. Nearing another century onwards, Lord Diplock explained issue estoppel in this way in the much-cited case of *Thoday v Thoday* [1964] P 181 at 198:

> "… There are many causes of action which can only be established by proving that two or more different conditions are fulfilled. Such causes of action involve as many separate issues between the parties as there are conditions to be fulfilled by the plaintiff to … establish his causes of action; and there may be cases where the fulfilment of an identical condition is a requirement common to two or more different causes of action. If in litigation upon one such cause of action any of such separate issues as to whether a particular condition has been fulfilled is determined by a court of competent jurisdiction, either upon evidence or upon admission … neither party can, in subsequent litigation between one another upon any cause of action which depends upon the fulfilment of the identical condition, assert that the condition was fulfilled if the court has in

> the first litigation determined that it was not, or deny that it was fulfilled if the court in the first litigation determined that it was."

61. The subsequent application to admit fresh evidence to overturn a previous undisturbed determination through *Ladd v Marshall* has frequently been said to present the applicant with a formidable or "high hurdle" (recently repeated, albeit in a public law context, in *R(Al-Siri) v SSHD* [2021] EWCA Civ 2137 ("*Al-Siri*") at para 66). In *Al-Siri*, the Court of Appeal explained the wide applicability of *Ladd v Marshall*:

> "67. It follows that the *Ladd v Marshall* test applies (by analogy in public law cases) to attempts to overturn final decisions on the basis of new material, not because the challenge is based on fraud or deception, but because of the high importance ascribed to finality in litigation. Indeed, although *Ladd v Marshall* was a case of an appeal seeking to challenge a judgment based on an allegation that it had been obtained by fraud, Denning LJ made plain that the test was one generally applicable to the admission of fresh evidence on appeal."

62. My approach, however "high" the hurdle may or may not be, is to simply apply the tests in a systematic way by examining each of their constituent elements. The principle of finality informing the admissibility tests embodies the strong public interest in litigation whether about an action (action estoppel) or an issue (issue estoppel) being concluded in a timely and orderly way. This is closely associated in modern expression with the overriding objective principles of dealing with cases proportionality, not permitting them to take up court resources unduly, and preventing delay to other cases through exhaustive re-litigation of determinations that have already been made and not appealed.

63. I have in this ruling to consider the sole question of the application to admit the identified fresh evidence into these appeal proceedings.

§XI. DISCUSSION: OVERALL APPROACH

64. Any analysis must begin by a clear understanding of what the application amounts to and why.

65. **First**, there has been a finding of fact on misconduct by the Original Tribunal. This finding is source for (a) the Original Tribunal's impairment finding, and (b) the Review Tribunal's subsequent impairment finding. The appellant now seeks to disturb the finding of fact on misconduct as "unsound". The route to challenging the finding is by the admission into this appeal of fresh evidence.

66. **Second**, given that the issue of the appellant's misconduct has been determined by the Original Tribunal, has not been appealed, and is not subject to application to appeal out of time, the issue is estopped since, as the Supreme Court made clear, the principle of res judicata, of which issue estoppel is part, applies in disciplinary tribunals (*Coke-Wallis* paras 22-24, 27, cited in *Salem* at para 12). Indeed in *Coke-Wallis*, Lord Collins provided an account of how res judicata has been applied in disciplinary proceedings in other jurisdictions (para 58):

> "See also in *New Zealand Dental Council of New Zealand v Gibson* [2010] NZHC 912 (dentist bound by findings of disciplinary tribunal). In some cases the same result has been achieved by finding that the disciplinary tribunal is functus officio after the first decision: *Chandler v Alberta Association of Architects* [1989] 2 SCR 848 (Canadian Supreme Court)."

67. **Third**, the principle of finality which underpins issue estoppel mandates that, subject to exceptions to the rule, a matter that a previous court has settled should not be revisited without good reason or special circumstances (I summarise greatly: see foregoing maxims). There are important public policy principles behind this. A finding of fact in disciplinary proceedings may be challenged without the need for leave through the statutory appeal process, subject only to the application being made within the specified statutory time limits, granting a very wide right to challenge determinations the practitioner rejects.

68. In this case, the appellant knew about the statutory time limit. In a letter from the GMC to Dr Myhill dated 17 February 2020 (B112), she was told:

> "Any doctor found impaired by a tribunal can appeal the decision under Section 40 of the Medical Act 1983 within 28 days of being notified of the tribunal's decision."

69. A similar notification about her unqualified right to appeal was sent on 30 January 2023 containing all the relevant appeal guidance along with the decision letter from the Original Tribunal. It came in the form of a pro forma notification of how and when the suspension takes effect and appeal rights:

> "Note for the information of practitioners on the suspension of registration by direction of a Medical Practitioners Tribunal."

70. On 6 March 2023, since no appeal had been filed and the suspension accordingly took effect, the GMC sent an email notifying Dr Myhill of the fact. Although the letter contained a section for Dr Myhill to confirm receipt of the notification that she had not appealed, she did not respond.

71. Instead, the GMC had received an email from Dr Myhill on 15 February 2023 addressed to the GMC's legal adviser (Sean Bennett). She asked for further copies of the expert reports provided to the Original Tribunal. Therefore, Dr Myhill was given full and timely notification of her statutory appeal rights and was provided with a hyperlink to the website with the rules contained in the CPR. In her statement in the fresh evidence bundle to this court, the appellant states at para 2:

> "Review of my Suspension then took place on 16th and 17th November 2023 (which I do now appeal)."

72. It was therefore clear to her that the purpose of the review was just that: to review her suspension, not conduct a retrial of the misconduct findings. She maintains at para 29 of her fresh evidence statement that this court should not accept the findings of the Original Tribunal "regardless of whether the FtP [Original Tribunal] findings were challenged at the time and or appealed or not."

73. Her fresh evidence is sought to be admitted into these appellate proceedings to prove the unchallenged findings were, in her phrase, "unsound". That is, she wishes to go behind the Original Tribunal's findings and have the point, in 2022-23 litigated exhaustively over six weeks at the Original Hearing, relitigated on the section 40 statutory appeal before the High Court. It appears immaterial to Dr Myhill that she did not appeal the Original Tribunal's findings by observance of the proper procedural rules. She claims a right to appeal the adverse findings of the Original Tribunal now through the device of appealing the Review Tribunal extension of suspension without making any application for an extension of time to appeal, which would require exceptional circumstances (as clarified in *Adesina*).

74. **Fourth**, and ordinarily, if the right of appeal is not taken up, then the finding of fact remains undisturbed.

75. **Fifth**, it is the next step that is critical in this case. Issue estoppel is not an absolute bar. Should the admission of fresh evidence be sought to challenge the otherwise estopped issue, then one of the relevant fresh evidence tests must be met. Therefore, the court must examine the possible routes to admissibility. I consider first *Ladd v Marshall*, then *Arnold*, before saying something about rule 34(1) and its applicability to statutory appeals.

§XII. ROUTE 1: *LADD V MARSHALL*

76. Ms Bagley put the appellant's case in this way:

> "There was a political narrative at the time of the prosecution [disciplinary proceedings]: a narrative for people to take vaccines. Dr Myhill's view is not mainstream, but that does not mean it is not responsible. The vaccines were of an experimental nature and had a provisional licence, but could not be fully licenced if there was an alternative treatment. There were alternatives such as vitamin D and iodine (ivermectin). Naturopathic medical practitioners did not want to say anything, as it was opposite to the narrative [meaning: they were afraid to speak out due to fears of disciplinary proceedings and thus were effectively silenced]. So that is the political context in trying to get the *Bolam* issue before the public."

77. Ms Bagley submits that it is an "absurdity" to suggest that the appellant is compelled to accept findings which are "unsound". Therefore, this court could (a) "look at insight in a different way" (Dr Myhill has the higher insight of understanding that the findings are wrong) or (b) apply *Arnold* and revisit the findings of the Original Tribunal. In any event, it is submitted, the three *Ladd v Marshall* conditions are met, rendering the fresh evidence admissible for these purposes. The fresh evidence should be "kept here" and assessed here and the case should not be remitted to the Tribunal. The High Court is the place to "get fair justice", not the Tribunal.

78. The respondent submits that it would be "entirely unprincipled and unprecedented" to indulge Dr Myhill in reopening the findings she had every opportunity to challenge at first instance and then appeal. That is what her fresh evidence application is really about: undermining unchallenged findings. Indeed, "there is no shortage of higher

authority that court does not hear witnesses on appeal", subject to the exceptional justification in *Ladd v Marshall* being established. There always remains the possibility of appealing out of time if something "genuinely new arises", Article 6 ECHR must entail that. Thus, the appellant is not "trapped" in the "Kafkaesque" labyrinth she claims. If she professes the same unorthodox views at the next review, she may be erased from the Register. She has the option of stating that she will not repeat these views to the public. That is her choice. She has chosen not to seek leave to appeal the Original Tribunal decision, but to take the invalid route of appealing the Review Tribunal determination which is inherently unimpeachable. The fresh evidence application should be refused. The *Ladd v Marshall* test is not met on any of the three conditions.

Discussion of *Ladd v Marshall*

79. I accept two submissions of general approach made by the appellant. First, that each case is fact-specific without any universally applicable or artificially restricting rules of law. I conclude that the court must examine the factual circumstances fully and fairly on their own terms and then apply those facts to the tripartite *Ladd v Marshall* test. Second, the condition that the evidence would "probably" be of important influence simply means more likely than not. There is no need for the evidence to have an inexorable or inevitable effect altering the result. I examine the elements of the *Ladd v Marshall* test in this order (summarising the description of the constituent parts) (1) reasonable diligence; (2) credibility; (3) influence.

(1.) Reasonable diligence

80. The appellant's submission that her *Bolam* bundle was submitted one month before the Review Hearing misses the point. The real question is what was available at the time that the original findings of misconduct and impairment were made by the Original Tribunal. Dr Myhill's misconceived approach to fresh evidence is evident from her submission to the Review Tribunal when she said, "I wish to present new evidence not available to that [Original] Tribunal" (B229). The question is whether the evidence was available to her by reasonable diligence to be presented to the Original Tribunal.

81. There is no reason that the material that the appellant seeks to put before this court in the two further fresh evidence bundles could not have been put before the Review Tribunal and indeed the Original Tribunal. Dr Myhill chose not to do so. The appellant submits that in the bundles she now wishes to adduce there are "127 [studies] that postdate the Review Hearing in November 2023". However, she has not identified any evidence that is materially different in substance to that which was previously available to her in the 1352 page bundle she did present at the Review Hearing. This is the critical consideration: what was available to her at the time of the Original Hearing or the Review Hearing. Mere repetition of studies on the same themes, offering the same broad conclusions as in studies available in October 2022 and November 2023, adds nothing to the persuasiveness of this application.

82. I accept overall the respondent's submission that in fact there are only "a very small number of truly new documents". There is the "single slide" detailing figures for negative health outcomes and deaths in respect of various vaccines. It is a

freestanding document that purports to speak for itself, but lacks context or independent expert evidential support.

83. As to the further statement by Dr Myhill herself, it is clear that this contains substantial passages of criticism of the GMC, assertions about why she did not attend the Original Tribunal, criticism of the Original Tribunal decision, narrative about what happened at the Review Hearing and criticism of the Review Tribunal decision. It is difficult to understand how this constitutes fresh evidence, properly understood. It is largely self-serving and argumentative, largely constituting submissions disguised and presented as "fresh evidence".

84. As to Patient B, it remains unclear why this statement dated 1 June 2024 could not have been put before the Original Tribunal and in any event the Review Tribunal. Indeed, Patient B's statement in the fresh evidence bundle states at para 1 that the statement is to "confirm and clarify evidence I have previously given (including my statement dated 30th March 2021 taken by GMC)." It could plainly have been provided to the Original Hearing with reasonable diligence, and the Review Hearing.

85. The statements from other medical and related professionals are from people broadly sympathetic to Dr Myhill's views. They do not possess the vital qualities of independence, balance and could not conceivably amount to expert evidence in a CPR-compliant sense. In any event, they lack the requisite undertakings. I do not understand the appellant to present them as independent CPR-compliant expert evidence. It is unclear why they could not have been put before the Original Tribunal let alone the Review Tribunal. As the respondent summarises it in its skeleton argument (para 9):

> "The appellant's assertion that *"many of the relevant studies relied upon in the appeal evidence had not yet been published"* is wrong (c.f. skeleton §19(1)(ii)): (a) all of the papers (other than a single slide) in Evidence Bundle 2 pre-date both the Original Hearing and the Review Hearing; and (b) there is nothing in the statements of any of the witnesses to suggest that they would have given materially different evidence if asked to provide a statement at the time of the Original Hearing or the Review Hearing (c.f. skeleton §19(1)(iii))."

86. This is accurate. The evidence, save the single slide, fails the reasonable diligence test.

(2.) Credibility

87. The appellant sought to adduce the evidence that goes to her core case that there is no misconduct as she has a "*Bolam* defence". To recapitulate, Ground 3 acknowledges that Dr Myhill's opinions are not "widely accepted", but nevertheless can be "found in the bodies of medical and scientific opinion which she furnished to the court and wished to present to demonstrate she is fit to practise." At the Review Hearing, the appellant stated in answer to a question from the Tribunal about her insight:

> "DR MYHILL: Of course my insight is that they had no evidence base and here I am supplying the evidence base and thereby providing a *Bolam* defence. As I said I am reiterating. The point of a *Bolam* defence is I don't

> have to prove that O'Shaughnessy and Quinton were wrong [the Original Tribunal medical experts], I simply have to prove that there is a body of evidence who agrees with me and that I have done."

88. The appellant's skeleton states in respect of Ground 2:

> "28. MPT found that the Appellant lacked insight as she does not agree with the findings against her at FTP. No weight was given to the facts that she was absent, unrepresented, the Bolam test was not applied at FTP, nor was she judged by her peers."

89. In this context, Ms Bagley submitted that the studies she wishes to admit as fresh evidence were "developing studies relied on by this responsible body of doctors." She was asked in terms by the court if there was any evidence that the material or any of it that Dr Myhill presents in her *Bolam* bundle constitutes the views of a "responsible body" of medical opinion. Counsel frankly accepted that there was no such evidence such as one would find in a medical negligence case, providing opinion on whether a certain approach amounted to a responsible body. Therefore, the proposition had been asserted without it being evidenced. Indeed, if Dr Myhill did possess such evidence, she would have immediately directed the court to it as it would strongly support her case. There is an absence of evidence that the views expressed in the bundle represent those of a "responsible body" of medical opinion. The multiplicity of documents and references provided by Dr Myhill cannot be confused for their substantive worth. I have examined the bundle. It is impossible at this point succinctly to provide an analysis of every document, study, paper and comment. However, there are clear dominant themes.

(a.) Dr White

90. Ms Bagley pointed to the 77 doctors who are signatories to the letter of support that the appellant put before the court on 16 October 2024, the first day of the listed appeal hearing (see **Annex**). This includes two professors and 18 consultants. One of these doctors is Dr White. Dr White has been erased from the register. As Ms Bagley recognised, the basis of his erasure was "very similar in nature to the line taken by the GMC against Dr Myhill". In the circumstances, the weight that his support can provide must be limited. When asked about this, Ms Bagley added that "numerous doctors have been prosecuted by the GMC". That is no basis for the further necessary step in the argument that such prosecutions have been unfounded. There is no such evidence before the court.

(b.) Balance and objectivity

91. The remaining doctors' critique the evidence of the experts who gave evidence at the Original Hearing must be by way of providing medical expertise. Yet they are not advanced as CPR-compliant experts. One wonders how the court is to assess the value of these statements, given that there is no CPR compliance. I do not understand the application is for them to give evidence orally during the course of the two days of the appeal hearing. That would be impossible. If the application is for their evidence to be simply read, I cannot see how that provides the GMC with any opportunity to challenge the contents of the statements that are presented by way of fait accompli.

92. The court is bound to have concerns about the balance and objectivity of these statements. One has only to examine the contents of the Dr Myhill's previous "*Bolam* bundle" to understand the kind of "expertise" she relies upon. It must be remembered that this bundle was presented to the Review Hearing and was mentioned by the Review Tribunal in its ruling on Dr Myhill's admissibility application. As noted previously, Ms Bagley referred to iodine as an alternative Covid treatment. One study the appellant relies on is entitled:

> "Regular Use of Ivermectin as Prophylaxis for COVID-19 Led Up to a 92% Reduction in COVID-19 Mortality Rate in a Dose-Response Manner: Results of a Prospective Observational Study of a Strictly Controlled Population of 88,012 Subjects"

93. The balance and worth of the article is contextualised by the "Conflict of interest statement", detailing the associations of the authors:

> "Lucy Kerris is a paid consultant for both Vitamedic, an ivermectin manufacturer, and is co-founder, as well as acting as a paid consultant, for Médicos Pela Vida (MPV), an organization that promotes ivermectin as a treatment for COVID-19 and discourages COVID-19 vaccination. Flavio A. Cadegiani was a paid consultant (USD 1,600.00) for Vitamedic, an ivermectin manufacturer. Dr. Cadegiani is a founding member of the Front Line COVID-19 Critical Care Alliance (FLCCC), an organization that promotes ivermectin as a treatment for COVID-19. Pierre Kory is the President and Chief Medical Officer of the Front Line COVID-19 Critical Care Alliance (FLCCC), an organization that promotes ivermectin as a treatment for COVID-19 and discourages COVID-19 vaccination. Dr. Kory reports receiving payments from FLCCC."

94. This casts a vital light on the impartiality of the study. The court next examines another of the studies that Dr Myhill has cited. It is entitled: "COVID-19 Masks Are a Crime Against Humanity and Child Abuse: Testimony of a virologist". It is from Dr. Margarite Griesz-Brisson MD PhD who is described as "a Consultant Neurologist and Neurophysiologist with a PhD in Pharmacology, with special interest in neurotoxicology, environmental medicine, neuroregeneration and neuroplasticity." The document states (in extract):

> "For children and adolescents, masks are an absolute no-no.
>
> "Where are our health departments, our health insurance, our medical associations? It would have been their duty to be vehemently against the lockdown and to stop it and stop it from the very beginning.
>
> "Why do the medical boards give punishments to doctors who give people exemptions?
>
> "Who is responsible for this crime? The ones who want to enforce it? The ones who let it happen and play along, or the ones who don't prevent it? [..]It's not about masks, it's not about viruses, it's certainly not about your health. It is about much much more. I am not participating. I am not afraid."

95. To suggest that children wearing face masks is "child abuse" attests to the lack of balance and professional objectivity of the view. Returning to the *Ladd v Marshall* test, it lacks credibility. I cannot see how studies such as this "probably" would have had "an important influence" on any tribunal assessing Dr Myhill's conduct and fitness to practise.

96. To provide another example, the letter of support has a section on face masks. It is headed: "Mask wearing is ineffective (from Dr Clare Craig's report)", echoing the view of Dr Myhill. Dr Craig provides a statement in the fresh evidence bundle. While her statement has a statement of truth at the end, it does not contain any CPR expert declaration. Dr Craig states at para 1.2:

> "Since September 2020 I have carried out independent, autonomous, comprehensive and unpaid research into SARS-CoV-2 and COVID-19 (hereinafter 'Covid'), offering an unbiased, multi-faceted perspective on the pandemic."

97. Dr Craig summarises her conclusion on face masks in this way:

> "5.4. **Wider evidence base on effects of masking:** There was an established broad body of evidence that has been added to over the last few years which shows the lack of significant impact on transmission rates from masking. Historical and recent reviews, including those from the World Health Organization (WHO) and various researchers, consistently find limited support for the effectiveness of masks in the general population."

98. What is puzzling for a professional maintaining her independence is that she does not include any studies that point in different direction, but includes a series of references supporting of her thesis, and indeed Dr Myhill's. This is the approach that Dr Myhill took in her original *Bolam* bundle. There she cited an article from the "Swiss Policy Research" website. The article is called "The Face Mask Folly in Retrospect". It asks, "Why has much of the world nonetheless fallen for the face mask folly?" It describes how Sweden "resisted" the face mask folly and was subject to "vicious attack" by the international media as part of the "global madness".

99. The section of the original *Bolam* bundle dealing with face masks is labelled "Masks are ineffective and may increase rate of infection with CV 19" (B192). Dr Myhill cites the abstract of an article on Cambridge.org. In the box below she has extracted from the abstract of article as follows:

> "We examined the association between face masks and risk of infection with SARS-CoV-2 using cross-sectional data from 3,209 participants in a randomized trial of using glasses to reduce the risk of infection with SARS-CoV-2. Face mask use was based on participants' response to the end-of-follow-up survey. We found that the incidence of self-reported COVID-19 was 33% (aRR 1.33; 95% CI 1.03 – 1.72) higher in those wearing face masks often or sometimes, and 40% (aRR 1.40; 95% CI 1.08 – 1.82) higher in those wearing face masks almost always or always, compared to participants who reported wearing face masks never or almost never."

100. On surface inspection, this appears to support her claims. However, in her extract the appellant has chosen to omit the next sentences in the abstract:

> "We believe the observed increase in the incidence of infection associated with wearing a face mask is likely due to unobservable and hence nonadjustable differences between those wearing and not wearing a mask. Observational studies reporting on the relationship between face mask use and risk of respiratory infections should be interpreted cautiously, and more randomized trials are needed."

101. The court having read the study, notes that it contains the following further passages:

> "The World Health Organization has recently revised their guideline on infection prevention and control in the context of COVID-19, recommending face mask use to reduce SARS-CoV-2 transmission in certain situations, including 'when in crowded, enclosed, or poorly ventilated spaces'"

102. The footnotes to the study list further research papers attesting to the possible protective effects of wearing face masks.

> "In controlled settings, mechanistic studies suggest that when masks are worn correctly, the risk of infection should be strongly reduced" (Bagheri, G, Thiede, B, Hejazi, B, Schlenczek, O and Bodenschatz, E (202 1) An upper bound on one-to-one exposure to infectious human respiratory particles. Proceedings of the National Academy of Sciences)
>
> "Kwon et al., self-reported 'always' use of face mask outside the home was associated with around a 65% reduced risk of predicted COVID-19"
>
> (Kwon, S, Joshi, AD, Lo, C-H, Drew, DA, Nguyen, LH, Guo, C-G, et al. (2021) Association of social distancing and face mask use with risk of COVID-19. Nature Communications)

103. The application to admit the evidence as fresh evidence to this court and hear it here without remitting it means that the Dr Myhill seeks to establish the value and validity of her listed studies without any expert assistance for the court. I cannot see a way for the court to gauge the value of the evidence without the kind of detailed analysis that the court has been forced to undertake for the purposes of the fresh evidence application. The resulting process is likely to be disproportionately long. This is a factor against the admission of this material on interests of justice grounds. The court has a duty to be fair, but the overriding objective insists on the court conducting the case "in ways which are proportionate" (CPR Part 1.1(2)(c)). I return to this theme in the interests of justice analysis under the *Arnold* route to admissibility. Therefore, the research papers have been cited in a highly selective way. This is an example of how unbalanced the appellant has been and how misleading a consideration of this evidence can be without detailed and careful contextualisation and expert interpretation and assistance.

104. All this goes to the credibility of the way the evidence has been presented and speaks to the balance and creditworthiness of the appellant's approach. Should the court

admit this material as presented, without expert assistance, the process of examination is likely to be extensive and onerous. This leads to the next of the *Ladd v Marshall* conditions, probable influence.

105. Before doing so, I observe that to the extent that the witness statements she has provided from professionals who endorse her use of vitamin dosing as anti-viral agents, and Covid 19, such statements are subject to the same weaknesses as Dr Myhill's stance:

> (1) The views run contrary in vital respects to NICE guidelines, the two independent experts who testified at that Original Hearing and whose central evidence was substantially accepted by the Original Tribunal; and
>
> (2) There is no independent or credible evidence that the views are accepted by any responsible body of medical opinion.

(3.) Influence

106. I begin by looking under this heading at the previous study. It is difficult to conceive how it can be said to "probably" have an "important influence on the result of the case", that is whether there is misconduct (contravention of professional standards in the ways alleged and found by the Original Tribunal) and impairment (similarly). A series of hyperlinks from the internet without reliable evidence explaining the value of the studies and their recognition by any responsible body of medical opinion or supported by independent expert evidence is insufficient. That is what the fresh evidence presented by the appellant substantially amounts to: study after study without any authoritative analysis of their value or acceptance by any responsible body of medical opinion.

107. Dr Myhill's stance is not recognised by any responsible body of medical opinion she has put before the court. While the respondent claims that her opinions were "wild", it is better at this point and more temperate to conclude that they were not properly evidenced and not supported by responsible bodies of medical opinion or independent expert opinion. As noted, Dr Myhill's views run contrary to NICE guidelines, the medical experts who gave evidence at exhaustive length at the six-week Original Hearing unchallenged and indeed the findings of the Original Tribunal, which she has not sought to appeal through any legitimate procedural route, even though she had an unqualified right to appeal without any leave requirement.

Conclusion on *Ladd v Marshall*

108. In Dr Myhill's skeleton argument at para 19, having made submissions about reasonable diligence, the following is submitted:

> "(1) The evidence would probably have an important influence on the result of the case.
>
> (2) The evidence is credible and comes from a variety of expert witnesses with relevant experience, and from Patient B himself and from the Appellant."

109. This is assertion without justification. This flaw affects much of this application. I find that:

(1) With reasonable diligence, all the fresh evidence applied to be admitted could have been obtained before the Original Hearing, save for those identified limited aspects of it that add nothing of substance;
(2) The appellant chose not to provide it to the Original Tribunal when it made its decisions on misconduct and impairment;
(3) There was nothing preventing the appellant presenting the vast preponderance of the evidence, and certainly its substance, to the Original Tribunal;
(4) In any event, there is no evidence in the tranche of fresh evidence that postdates the Original Tribunal decision that is credible or apparently credible;
(5) Similarly, there is no evidence that would probably have had an important influence on the result of the case before the Original Tribunal, that is on its twin critical findings of Dr Myhill's misconduct and impairment.
(6) Therefore, none of the three conditions in *Ladd v Marshall* are met.
(7) The application to admit the evidence as fresh evidence under *Ladd v Marshall* is refused.

§XIII. ROUTE 2: SPECIAL CIRCUMSTANCES UNDER *ARNOLD*

110. In oral submissions the appellant directed the court to how in *Salem*, Dove J applied the test in *Arnold*. *Salem* was a section 40 appeal to the High Court against an adverse finding of misconduct by the MPT following a GMC complaint. The appellant doctor did not appear at the MPT and was not represented. Ms Bagley took the court to para 10 of *Salem* in which *Arnold* was referred to. She "invited" the court to consider two routes to revisiting the findings below (1) a "conventional test", or (2) a "root and branch" approach under *Arnold*. Ms Bagley accurately set out the two limbs of the *Arnold* test. She submitted that there is "a power to apply *Arnold* and revisit the findings". One must be careful about not confusing revisiting findings and the admissibility of fresh evidence. Certainly, at any future hearing Ms Bagley will be entitled to develop her submissions.

111. I must also make clear that the respondent's position on *Arnold* was carefully calibrated. In *Salem* it was conceded that *Arnold* applied to GMC review hearings. Before me, the respondent accepted solely for the sake of the fresh evidence application that the *Salem* concession was correctly made. This is because on the evidence, the respondent submitted that the two-limbed *Arnold* test is not met here. However, whether and to what extent *Arnold* applies to review hearings is a matter the respondent reserves its position on and may wish to develop in due course. My analysis of *Arnold* proceeds with those important caveats. There may well need to be further argument about its applicability to review hearings in due course.

112. To constitute the "special circumstances" envisaged by *Arnold* and exceptionally admit fresh evidence with a view to revisiting an otherwise estopped issue, the court must apply a two-part test. First, whether the evidence could not have been

discovered by the person relying on it by the time of the impugned decision using reasonable diligence; second, whether the evidence would put an entirely different complexion on the issue. The point is to overall "work justice between the parties". The issue being examined ultimately and inescapably is Dr Myhill's misconduct. Her impairment is grounded in that. Her claim of "insight" is not a recognition that she has done anything wrong (misconduct), but conversely that she was right all along and the misconduct finding is "unsound".

(1.) Reasonable diligence

113. It is pointless to repeat the *Ladd v Marshall* analysis on reasonable diligence. There is no material difference in the tests. Dr Myhill could have produced the critical evidence by the time of the Original Hearing and the Original Tribunal's impugned decision.

(2.) Different complexion

114. The limited residue of evidence not available by reasonable diligence by the time of the Original Hearing (such as the single slide) adds nothing of substance to the issue and certainly does not put "an entirely different complexion" on it.

115. Looking at the fresh evidence as a whole, putting issues of reasonable diligence to one side, it does not come close to putting an entirely different complexion on the issue. This is because of the obvious flaws in the evidence noted in the *Ladd v Marshall* analysis. Here is evidence from medical practitioners offering opinions without anything to indicate that the evidence is CPR-compliant and properly admissible as expert evidence. If it is not expert opinion, what is it? If it purports to be evidence to meet a *Bolam* test, there are two fundamental flaws. First, *Bolam* is a test of medical negligence, not professional misconduct. The question for a disciplinary tribunal is whether the conduct of the practitioner complies or breaches the recognised standards of professional conduct. That is the principled the Original Tribunal and the Review Tribunal correctly took. Second, and even if Dr Myhill's *Bolam* bundle were relevant to the question of misconduct, there is no evidence to support the claim that this is a *Bolam*-compliant "responsible body" of skilled practitioners in the field, as acknowledged by Ms Bagley. The views are not recognised by the NHS or NICE and there is no expert evidence presented attesting that these views are the views of the requisite responsible body. Instead, this is a series of opinions of people who support Dr Myhill's views. As I have indicated in the *Ladd v Marshall* analysis, there is very real concern about the independence, objectivity and intrinsic worth of the opinions examined, and this is obvious on a paper analysis without hearing oral evidence, a further step in this admissibility argument that would manifestly disproportionate, and which in any event neither party requested.

116. It seems to me clear that the "entirely different complexion" condition in *Arnold* must contain both the *Ladd v Marshall* questions of important influence and credibility. That is because the extent of the difference of complexion on the issue must take account of the apparent credibility of the evidence. Evidence that is obviously flawed or lacking credibility cannot exert much influence or effect the necessary change of complexion. That is obvious.

§XIV. Rule 34(1)

117. Rule 34(1) applies to the admissibility of evidence to a review tribunal in medical practitioner disciplinary proceedings. What distinguishes a review tribunal's power to admit such evidence is that the rule explicitly states that evidence may be admitted even if it would not be admissible in a court of law. However, the High Court hearing a statutory appeal is plainly a court of law. Therefore, I cannot see that this is a route for the admission of evidence in this statutory appeal hearing.

§XV. ABUSE OF PROCESS

118. The respondent presents a further basis for opposing the fresh evidence. It is submitted that the appellant's course amounts to an abuse of process. The basis of the submission is the well-known series of cases that include *Hunter v Chief Constable of the West Midlands Police & Ors* [1981] UKHL 13 *("Hunter")* and *Johnson v Gore Wood & Co (a firm)* [2002] AC 1 ("*Johnson v Gore*"). In *Hunter*, Lord Diplock said at 541B, in identifying an abuse of process, that:

> "[…] the initiation of proceedings in a court of justice for the purposes of mounting a collateral attack upon a final decision against the intending plaintiff which has been made by another court of competent jurisdiction in previous proceedings in which the intending plaintiff had a full opportunity of contesting the decision in the court by which it was made."

119. In similar vein, Lord Bingham said in *Johnson v Gore* at 31A-B:

> "abuse of process, as now understood, although separate and distinct from cause of action estoppel and issue estoppel, has much in common with them. The underlying public interest is the same: that there should be finality in litigation […]. The bringing of a claim or the raising of a defence in later proceedings may, without more, amount to abuse if the court is satisfied (the onus being on the party alleging abuse) that the claim or defence should have been raised in the earlier proceedings if it was to be raised at all."

120. While I have considered these authorities carefully at the invitation of the respondent, I am not convinced that this fresh evidence application necessitates an examination of abuse of process. The proper approach is to consider issue estoppel first and the legitimate routes to disapply it. Issue estoppel plainly applies. Dr Myhill fails to meet the tests to disapply its operation and admit the fresh evidence. Therefore, there is no need to consider abuse of process for the purposes of the fresh evidence application, the admissibility application already having failed.

§XVI. CONCLUSION

121. The appellant's fresh evidence application fails to meet any relevant test of admissibility and must be refused.

122. The court will reconvene to hear the rest of the appeal on the basis of the material already before the Review Tribunal. That is the approach authorised under the Act, the Rules and the common law.

ANNEX

16 October 2024

Joint Letter from:

Children's Covid Vaccines Advisory Council (CCVAC)
Doctors for Patients UK (DfPUK)
Health Advisory and Recovery Team (HART)
UK Medical Freedom Alliance (UKMFA)

To: **Whom it may concern:**

re: Dr Sarah Myhill MBBS

Dr Myhill has been suspended from the practice of medicine by the General Medical Council for her advocacy of vitamin D, vitamin C, iodine and ivermectin in the treatment of acute SARS Covid 19 infection. She also detailed how masks are ineffective at preventing SARS Covid 19 infection. She is appealing this decision and has requested support from other Doctors and Health Professionals.

We are writing to support her clinical use of these interventions.

- Dr Sarah Myhill is an extremely experienced doctor. She has spent over 40 years treating patients with ME, Chronic Fatigue, post viral syndromes and acute infections in her capacity as a GP. She has written books on the management and treatment of ME and carried out studies on the importance of mitochondrial health in these conditions. She has studied biochemistry, immunology, physiology and nutrition extensively which has enabled her to offer the best advice to her patients, on the treatment of acute infections, including Covid-19, and in prophylactic measures and the optimal nutritional support.
- She practices evidence-based medicine and has always stayed abreast of published studies and data in this field.

Ivermectin (IVM):

There are many published papers, showing that ivermectin is a helpful treatment for acute Covid and can be used, and was used in many parts the world, for prophylaxis against C19. Ivermectin is an extremely safe and well tolerated drug for which the developers were awarded the Nobel Prize for Medicine in 2015. It has over 20 different biochemical effects many of which are extremely useful in the early treatment of acute covid. A meta-analysis of 19 RCT studies on ivermectin as a treatment for acute covid and 4 RCTs in its use as a

prophylactic treatment was peer-reviewed and published in the American Journal of Pharmacology in July/August 2021.[1]

It features in protocols which have been used all over the world to help those suffering with acute covid, long covid, the vaccine injured and for the prophylaxis of covid infections. [2]

There are numerous papers and articles written on the drug itself, its safety, effectiveness, mechanisms of action (of which there are at least 20). [3]

Real-life data is extremely compelling in the effectiveness of IVM. It 'obliterated' 97% of cases when used in Delhi in the summer of 2020.[4]

It has also been used successfully topically in combination with Iota-Carrageenan.[5]

Its mechanisms of action are fully discussed in a lengthy review. [6] One of IVM's mechanisms of action is as a zinc ionophore allowing the zinc to enter the infected cell where it prevents viral replication. Therefore, early treatment with IVM has proved to be extremely effective.

Vitamin D:

Those who struggled with acute covid were shown to be Vit D deficient. Sunbathing in the UK for 10 minutes between 11am and 2pm would produce 1000 IU a minute in a white Caucasian skin, and therefore a total of 10,000 iu. This dose therefore is extremely safe and a sensible one for people to take who are mostly indoors and live in such an overcast northerly country.[7]

Data has been put together in a detailed review by over 200 scientists and clinicians,[8] who conclude, *"Research shows low vitamin D levels almost certainly promote COVID-19 infections, hospitalizations, and deaths. Given its safety,* ***we call for immediate widespread increased vitamin D intakes****."*

---

[1] Bryant A, Lawrie T, et al Ivermectin for Prevention and Treatment of COVID-19 Infection: A Systemic Review, Meta-analysis and Trial Sequential Analysis to Inform Clinical Guidelines.
https://journals.lww.com/americantherapeutics/fulltext/2021/08000/ivermectin_for_prevention_and_treatment_of.7.aspx

[2] https://covid19criticalcare.com/covid-19-protocols/

[3] https://covid19criticalcare.com/ivermectin/

[4] Justus R Hope, Jun 2021 updated Jun 7 2021.
https://www.thedesertreview.com/news/national/ivermectin-obliterates-97-percent-of-delhi-cases/article_6a3be6b2-c31f-11eb-836d-2722d2325a08.html

[5] Carvallo Héctor, Hirsch Roberto, Alkis Psaltis, Contreras Veronica. Study of the Efficacy and Safety of Topical Ivermectin + Iota-Carrageenan in the Prophylaxis against COVID-19 in Health Personnel. Journal of Biomedical Research and Clinical Investigation. November 2020.
https://doi.org/10.31546/2633-8653.1007

[6] Zaidi, A.K., Dehgani-Mobaraki, P. The mechanisms of action of ivermectin against SARS-CoV-2—an extensive review. *J Antibiot* **75**, 60–71 (2022). https://doi.org/10.1038/s41429-021-00491-6

[7] https://pubmed.ncbi.nlm.nih.gov/31746327/

[8] www.vitamindforall.org

Vitamin D modulates thousands of genes and many aspects of immune function, both innate and adaptive. The scientific evidence[9] shows that:

· Higher vitamin D blood levels are associated with lower rates of SARS-CoV-2 infection.
· Higher D levels are associated with lower risk of a severe case (hospitalization, ICU, or death).
· Intervention studies (including RCTs) indicate that vitamin D can be a very effective treatment.
· Many papers reveal several biological mechanisms by which vitamin D influences COVID-19.
· Causal inference modelling, Hill's criteria, the intervention studies & the biological mechanisms indicate that **vitamin D's influence on COVID-19 is very likely causal**, not just correlation.

Vitamin D is well known to be essential, but most people do not get enough. Two common definitions of inadequacy are deficiency < 20ng/ml (50nmol/L), the target of most governmental organizations, and insufficiency < 30ng/ml (75nmol/L), the target of several medical societies & experts.[10] Too many people have levels below these targets. **Rates of vitamin D deficiency <20ng/ml exceed 33% of the population in most of the world, and most estimates of insufficiency <30ng/ml are well over 50% (but much higher in many countries).**[11] Rates are even higher in winter, and several groups have notably worse deficiency: the overweight, those with dark skin (especially far from the equator), and care home residents. These same groups face increased COVID-19 risk.

It has been shown that 3875 IU (97mcg) daily is required for 97.5% of people to reach 20ng/ml, and 6200 IU (155mcg) for 30ng/ml,[12] intakes far above all national guidelines. Unfortunately, the report that set the US RDA included an admitted statistical error in which required intake was calculated to be ~10x too low.[4] Numerous calls in the academic literature to raise official recommended intakes had not yet resulted in increases by the time SARS-CoV-2 arrived. Now, many papers indicate that vitamin D affects COVID-19 more strongly than most other health conditions, with increased risk at levels < 30ng/ml (75nmol/L) and severely greater risk < 20ng/ml (50nmol/L).[1]

Evidence to date suggests the possibility that the COVID-19 pandemic sustains itself in large part through infection of those with low vitamin D, and that deaths are concentrated largely in those with deficiency. The mere possibility that this is so should compel urgent gathering of more vitamin D data. Even without more data, **the preponderance of evidence indicates that increased vitamin D would help reduce infections, hospitalizations, ICU admissions, & deaths**.

---

[9] The evidence was comprehensively reviewed (188 papers) through mid-June [Benskin '20] & more recent publications are increasingly compelling [Merzon et al '20; Kaufman et al '20; Castillo et al '20]. (See also [Jungreis & Kellis '20] for deeper analysis of Castillo et al's RCT results.)

[10] E.g.: 20ng/ml: National Academy of Medicine (US, Canada), European Food Safety Authority, Germany, Austria, Switzerland, Nordic Countries, Australia, New Zealand, & consensus of 11 international organizations. 30ng/ml: Endocrine Society, American Geriatrics Soc., & consensus of scientific experts. See also [Bouillon '17].

[11] Palacios & Gonzalez '14; Cashman et al '16; van Schoor & Lips '17 Applies to China, India, Europe, US, etc.

[12] Heaney et al '15; Veugelers & Ekwaru '14

Decades of safety data show that vitamin D has very low risk: Toxicity would be extremely rare with the recommendations here. The risk of insufficient levels far outweighs any risk from levels that seem to provide most of the protection against COVID-19, and this is notably different from drugs. Vitamin D is much safer than steroids, such as dexamethasone, the most widely accepted treatment to have also demonstrated a large COVID-19 benefit. **There is no need to wait for further clinical trials to increase use of something so safe, especially when remedying high rates of deficiency/insufficiency should already be a priority.**

Recommend that adults not already receiving the above amounts get 10,000 IU (250mcg) daily for 2-3 weeks (or until achieving 30ng/ml if testing), followed by the daily amount above. This practice is widely regarded as safe. The body can synthesize more than this from sunlight under the right conditions. Also, the NAM (US) and EFSA (Europe) both label this a "No Observed Adverse Effect Level" even as a daily maintenance intake.

Vitamin C:

The use of Vit C is sensible and helpful. It is an essential vitamin as it cannot be made by the human body. It is an anti-inflammatory, antihistamine and as C19 can attach to the H1 receptors on cells, it makes absolute sense to recommend Vit C. to block viral entry.[13]

Vitamin C is also an antioxidant, supports the immune system, eye health, collagen production, bone health, fetal development, reduces in gout, promotes healing, supports cardiovascular health, lowers BP, and is essential for brain function and memory. We require 2 oranges a day in our diet to receive sufficient Vitamin C for all these functions. [14]

Iodine:

This is a crucial micronutrient that plays a vital role in human nutrition. It has a key role in mitochondrial function and the production of the energy for life-ATP. It is also essential for the healthy functioning of all the glands of the body, especially the production of thyroid hormones by the thyroid gland.

Iodine deficiency is a Public Health crisis in many countries. It is estimated that 96% of the adult population in the UK are iodine deficient. According to the WHO 59.9% of Europeans have been shown to be iodine deficient.[15]

Mask wearing is ineffective (from Dr Clare Craig's report)

---

[13] Histamine receptors H1 is an alternative receptor for SARS-Co-V2. https://journals.asm.org/doi/10.1128/mbio.01088-24

[14] https://www.healthline.com/nutrition/vitamin-c-benefits

[15] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)14920-3/fulltext

Wider evidence base on effects of masking: There was an established broad body of evidence that has been added to over the last few years which shows the lack of significant impact on transmission rates from masking. Historical and recent reviews, including those from the World Health Organization (WHO) and various researchers, consistently find limited support for the effectiveness of masks in the general population.

Masking harms: The submission outlines various negative consequences associated with prolonged mask usage. These include impaired communication, increased risk of falls among the elderly, aggravated respiratory problems, re-traumatization of abuse victims, and exacerbation of existing mental health issues. It emphasizes that the human connection, crucial for effective healthcare delivery, is significantly hindered by mask wearing, leading to sub-optimal care and potentially harmful outcomes.

We the undersigned express our whole hearted support of Dr Myhill's efforts to treat her patients safely and using the best evidence available.

Yours sincerely

Dr Rosamond Jones, retired Consultant Paediatrician, convenor Children's Covid Vaccines Advisory Council

Dr Ayiesha Malik, General Practitioner, co-founder, Doctors for Patients UK

Dr Clare Craig, diagnostic pathologist, co-chair, Health Advisory and Recovery Team

Dr Elizabeth Evans, retired doctor, CEO, UK Medical Freedom Alliance

Cosignatories

Professor Angus Dalgleish, MD, FRCP, FRACP, FRCPath, FMedSci, Professor of Oncology, University of London; Principal, Institute for Cancer Vaccines & Immunotherapy

Professor John A Fairclough, BM BS, BMed Sci, FRCS, FFSEM(UK), Professor Emeritus, Honorary Consultant Orthopaedic Surgeon

Lord Moonie, MBChB, MRCPsych, MFCM, MSc, retired member of House of Lords, former Parliamentary Under- Secretary of State 2001-2003, former Consultant in Public Health Medicine