Case No: AC-2023-LON-003846

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT

NCN: [2025] EWHC 1744 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 9th July 2025

Before :

MRS JUSTICE EADY DBE

- -

Between :

DR SARAH BARBARA MYHILL	**Appellant**
- and -	
GENERAL MEDICAL COUNCIL	**Respondent**

- -
- -

The Appellant in person
Peter Mant KC (instructed by **GMC Legal**) for the Respondent

Hearing dates: 3 July 2025

- -

JUDGMENT

Contents Para No.

Introduction 1-5

The background 6-17

MPT1 proceedings and the appellant's non-attendance

Previous complaints against the applicant and the earlier ruling regarding patient A

The MPT1 decision

Failure to appeal against the MPT1 decision

The review 18-38

Preliminary issues raised in advance of the hearing

The review hearing – preliminary issues

The review hearing – the appellant's evidence and submissions

The review decision and reasoning

The grounds of appeal and the appellant's previous application to rely on fresh evidence 39-44

43.1 Under the *Ladd v Marshall* route:

43.2 Under the *Arnold* route

43.3 Under rule 34(1):

The legal framework 45-71

The Medical Act 1983 ("the Act")

General Medical Council (Fitness to Practise) Rules 2004 ("the Rules")

The MPT's approach at the review stage

Freedom of expression

The approach of the Court on appeal

Discussion, analysis, and conclusions 72-97

Fairness (grounds 1, 3, 7, 8 and 10)

Freedom of expression (grounds 4 and 5)

Outcome (grounds 2, 6 and 9)

Decision

Mrs Justice Eady DBE:

Introduction

1. The appellant is an experienced doctor, who obtained her Bachelor of Medicine, Bachelor of Surgery degree at the University of London in 1981. Having worked in the NHS for over 20 years, the appellant has not worked as a doctor since 2020, practising instead as a naturopath; as such, as her former counsel stated, the treatments the appellant provides are: "*not mainstream and often her practice involves progressive medicine and alternative remedies*". Although the appellant has said that she no longer wishes to practise as a doctor, she remains on the register maintained by the respondent pursuant to section 2 of the Medical Act 1983 ("the Act"), albeit that her registration is currently suspended; it is that suspension the appellant seeks by challenge by way of this appeal.

2. The appeal, brought pursuant to section 40 of the Act, relates to a decision of the Medical Practitioners Tribunal ("MPT"), dated 20 November 2024, by which it was determined that her fitness to practise was impaired by reason of misconduct, and that her registration as a doctor should be suspended for 12 months. The decision in question was in the nature of a review ("the review decision"); that is important, because it defines the scope, and the limits, of the current appeal.

3. The review was arranged upon the direction of an earlier MPT ("MPT1"), which had sat from 7 November to 9 December 2022 and 22-27 January 2023, delivering its decision (running to 149 pages) on 27 January 2023. Pursuant to section 35D(1)-(2) of the Act, MPT1 had considered allegations as to the appellant's fitness to practise, and, having made its findings of fact on the allegations, and that the appellant's fitness to practise was impaired, had directed that her registration be suspended for a period of nine months, with (per section 35D(4)) a review by another MPT ("MPT2") shortly before the suspension expired. The appellant was neither present nor represented at the hearing before MPT1 and, although section 40 of the Act provides that decisions of the MPT under section 35D can be appealed to the High Court ("the Court"), she did not seek to challenge MPT1's decision by way of appeal.

4. The appellant's appeal against the review decision was initially listed for hearing before the Court (Dexter Dias J) on 16 and 17 October 2024. In the event, the Court did not determine the appeal on that occasion as it was first necessary to consider the appellant's application to rely on fresh evidence. For the reasons provided in Dexter Dias J's reserved judgment of 3 March 2025 (*Myhill v GMC* [2025] EWHC 474 (Admin)), that application was refused, and the appeal was then re-listed, coming before me on 3 July 2025.

5. Although the appellant had previously been represented by counsel, since the fresh evidence hearing she acted in person. The respondent has appeared by counsel at all stages, albeit not by Mr Mant KC, who now represents its interests.

The background

MPT1 proceedings and the appellant's non-attendance

6. MPT1 had considered allegations against the appellant that had been made by two other doctors. These can be summarised as follows: (1) failing to provide good clinical care to patient A; (2) risking patient safety and undermining public health by making recommendations as to the use of agents (vitamin C, iodine, vitamin D, and ivermectin) to treat, and protect against, viral and bacterial infections (including coronavirus), failing to articulate that these were not licensed to be used as anti-viral agents and were not universally

safe when used as recommended by the appellant; and (3) failing to provide good clinical care to patient B.

7. As I have already noted, the appellant did not attend and did not seek to be represented at the hearing before MPT1. In the original skeleton argument in support of the current appeal, the appellant's decision not to attend was explained, as follows:

> "3. The Appellant did not attend or participate in [MPT1] 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. ....
> 4. Furthermore, [MPT1] was to include again 52 allegations which were all the subject of a previous ruling by MPT (01/10/20) regarding Patient A...."

8. The appellant did not, however, communicate this (or any other) reasoning to MPT1 in advance, or during the course, of that hearing. Upon the appellant's non-attendance, and having satisfied itself that she had been properly notified of the hearing, MPT1 determined to proceed notwithstanding the appellant's absence.

Previous complaints against the applicant and the earlier ruling regarding patient A

9. Diverting from the chronology at this point, it is helpful to refer to the points the appellant has made regarding the earlier history, which are matters the appellant both relies on to explain her decision not to attend the hearing before MPT1 and as evidence of animus against her on the part of the respondent which, she contends, rendered the MPT proceedings (both MPT1 and MPT2) unfair.

10. In relation to earlier allegations of misconduct, the appellant provided me with a table of some 45 complaints made against her; these go back to 2001 and include the allegations that led to the hearing before MPT1. The table suggests that complaints have been raised over time by various third parties, which have generally not been taken forward after initial screening or investigation. The appellant points in particular to four occasions (in 2003, 2007, 2011, and 2019) when a hearing had been arranged before the MPT only to be cancelled with no case to answer; on two of these occasions (2003 and 2007), the appellant says the hearings were cancelled just a few days before they were due to commence.

11. The appellant's summary in this regard is not agreed by the respondent (the table was a document handed to the Court during the course of the hearing and was received as an unagreed summary; the appellant had, however, referred to this background in her earlier skeleton arguments). In any event, it submits that this history merely suggests that appropriate action has been taken upon the receipt of complaints by various third parties, which demonstrates no animus or unfairness towards the appellant on the part of the respondent.

12. As for patient A, the appellant has referred to an earlier non-compliance decision of the MPT, from 2020, relating to her refusal to disclose patient A's medical records at the request of the respondent. Upon the respondent's complaint regarding this non-compliance, the MPT determined that, although the respondent had the power to require disclosure of medical records absent patient consent, there was insufficient evidence to conclude that the appellant had had no good reason for her non-compliance. Explaining its decision, the MPT referred to the appellant's lack of trust in the respondent (given it had previously investigated numerous complaints against her, without these being taken forward), to her reasonable belief that the

respondent could proceed without the records, to her prioritisation of patient A's interests, and to the respondent's failure to respond to various requests for clarification.

The MPT1 decision

13. Returning then to the proceedings before MPT1 in late 2022/early 2023: having received evidence and submissions over the course of the hearing, MPT1 ultimately found a number of the allegations (although by no means all) had been proven. In particular, it held that (I take this summary from the review decision):

> "Patient A
> 5. ... on a number of occasions, between approximately July 2015 and April 2018, Dr Myhill failed to provide good clinical care to Patient A. ...
> Patient B
> 6. ... between 9 and 13 April 2020, Dr Myhill failed to provide good clinical care to Patient B after they experienced an unexpected fall. It found that Dr Myhill failed to diagnose that Patient B had a possible fractured hip that required immediate management which indicated the need for an ambulance and attendance at an Accident and Emergency department. Further, that Dr Myhill diagnosed, without clinical justification, prednisolone 20 mg, diazepam 2mg and a ketogenic diet.
> Internet Allegations
> 7. ... on one or more occasions between March and May 2020, Dr Myhill promoted and endorsed the use of agents to treat and protect against viral and bacterial infections, including Coronavirus. 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. ... 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. ... 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."

14. It was the conclusion of MPT1 that the appellant had acted in breach of Good Medical Practice ("GMP"), which sets out the principles, values, and standards of professional behaviour of all doctors (and other medical professionals). Specifically (and of particular relevance), it found the appellant had breached paragraphs 22 b. (requiring regular reflection), 68 (requiring communications with patients make clear limits of knowledge), 70 (ensuring any advertisements of services provided do not exploit patients' vulnerabilities or lack of medical knowledge), and 71 (requiring that documents are not false or misleading, and do not leave out relevant information). These failings, MPT1 concluded, amounted to serious professional misconduct.

15. Although not finding the appellant's fitness to practise was impaired in relation to patient A, MPT1 determined that a finding of impairment should be made in relation to the other allegations it had found proven, both to mark the seriousness of the misconduct and uphold proper standards. It went on to impose a nine-month suspension on the appellant's registration, with a review, considering this would provide the appellant with an opportunity to reflect on her misconduct, develop insight and remediate appropriately. In this regard,

noting it would be the appellant's responsibility "*to demonstrate how she has addressed [MPT1's] concerns*", it was observed that it might assist if, at the review stage, the appellant were able to provide evidence demonstrating (I précis) insight, reflection, and remediation. As (by virtue of paragraph 10 of schedule 4 of the Act) the substantive decision would only take effect 28 days from the date it was notified to the appellant (thus allowing for the possibility of an appeal within the statutory time limit), exercising its powers under section 38 of the Act, MPT1 made an order for the appellant's immediate suspension. Had the appellant exercised her statutory right of appeal, the substantive decision would have remained suspended, albeit the immediate order would then have continued in place.

Failure to appeal against the MPT1 decision

16. In the event, as I have already recorded, the appellant did not appeal MPT1's decision; in the appellant's original skeleton argument for the current appeal, her position in this regard was explained as follows:

> "5. When the Appellant was notified that over 100 allegations in total had been proved at [MPT1] 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 continuing indefinitely due to Review and that things could potentially get even worse. The Appellant's professional reputation has now been damaged by the GMC's unfair prosecutions."

17. In her skeleton argument for the hearing before me, the appellant has said that she "*simply did not have the time nor the money to organise a statutory appeal at such short notice*", and instead decided that she would attend the review hearing, which would not incur financial costs and which would also give her time to make arrangements in respect of her duties as a carer.

The review

Preliminary issues raised in advance of the hearing

18. Notwithstanding her earlier non-attendance before MPT1 and her decision not to challenge the earlier decision on appeal, the appellant thus made clear that she wished to attend the subsequent review hearing. Her position in this regard was also explained in the first skeleton argument in support of this appeal:

> "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 [*Bolam v Friern Hospital Management Committee* [1957]

> 2 All ER 118] 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."

19. The review hearing was arranged for 16 November 2023. In correspondence regarding the arrangements for the hearing, the appellant stated that she would wish to cross-examine three witnesses, namely: Dr Kevin O'Shaughnessy, Dr Richard Quinton, and Mrs Julia Oakford. Drs O'Shaughnessy and Quinton had provided expert evidence before MPT1; Mrs Oakford was its legally qualified chair. Responding to that request, it was pointed out that the review:

> "will focus on whether your fitness to practise remains impaired at the time of the hearing, so any evidence called by you or GMC must be relevant to that issue. [MPT2] will not reopen the findings made at your previous hearing."

That position was further clarified in subsequent correspondence, explaining:

> "The purpose of an MPT Review hearing is to determine whether or not the practitioner's fitness to practise remains impaired. It is not an opportunity to challenge the decisions made by the original MPT, nor the evidence given by witnesses at that hearing: this could only have been done via a statutory appeal to the High Court. Accordingly, the tribunal reviewing Dr Myhill's case cannot reopen the decisions made by the previous MPT, but will instead focus on Dr Myhill's current fitness to practise, bearing in mind any evidence the parties wish to present on that specific issue.
> However, the right to present evidence is a qualified right, as any evidence to be relied on by either party must be relevant to the issues the reviewing tribunal will consider. The applicable test is set out in Rule 34(1) of the GMC Fitness to Practise Rules 2004 (as amended), which empowers the Tribunal to admit (i.e. receive) evidence that is '... fair and relevant to the case before them...'"

20. Notwithstanding that indication of the approach to be adopted at a review hearing, the appellant maintained her position that she should be allowed to cross-examine the three witnesses she had identified, making applications to the County Court in order to try to secure their attendance before MPT2. The position relating to witnesses remaining unresolved, on 10 November 2023, the appellant applied for a postponement of the review hearing (also raising concerns about the late service of the GMC's skeleton argument). That application was refused on 15 November 2023, by a MPT case manager, who did not consider the appellant was prejudiced in her preparation for the hearing, further noting that the admissibility of the witness evidence would need to be determined by MPT2, so it would not assist to postpone the hearing.

The review hearing – preliminary issues

21. For the review hearing itself, MPT2 had been provided with skeleton arguments by both parties along with a 1,352 page preliminary argument bundle from the appellant. At the outset of the hearing, the appellant made an application to call the three witnesses she had already identified, stating that they were necessary:

> "... in order for her to be able to cross examine them in order to demonstrate that her hearing in January 2023 was unfair. ... that she wishes to present new facts which demonstrate evidence of insight and remediation. ... that [MPT2] should allow the witnesses to give evidence as [MPT1] was misled resulting in unfairness of the proceedings. ... 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."

22. That application was refused. Noting that it was able to admit "*any evidence*" it considered "*fair and relevant to the case*" (rule 34(1) General Medical Council (Fitness to Practise) Rules 2004), MPT2 was unable to see that the evidence in question was relevant to the review that it was required to undertake, in particular given that it did not have the power to revisit the findings of MPT1. Although the appellant did not make a further application for an adjournment, MPT2 nevertheless considered whether there was any prejudice to her in proceeding with the hearing that day. Acknowledging that the GMC had been given an extension of time for its skeleton argument, this had merely set out its position as to the MPT's powers at a review hearing, which it had consistently made clear to the appellant in correspondence since June 2023; MPT2 did not consider the appellant had been prejudiced and was satisfied it should proceed.

The review hearing – the appellant's evidence and submissions

23. In her evidence to MPT2, the appellant explained that she had not appealed MPT1's decision due to the financial costs involved; she did, however, consider the proceedings before MPT1 had been unfair.

24. The appellant explained her view that the respondent had misled MPT1 by including the allegations relating to patient A; proceeding to a hearing on these allegations was, she considered, intrinsically unfair as it was known that she would be unable to rely on patient A's medical records, stating that she had been "*refused permission by the GMC non-compliance tribunal to use patient records*" and the respondent had thus known "*I would be unable to defend myself*". As for the expert evidence received by MPT1, the appellant sought to counter the opinions expressed by Drs O'Shaughnessy and Quinton by reference to what she said was "*a huge body of evidence ... to demonstrate ... that what I was doing is supported by a body of evidence*", which she then provided to MPT2 by way of a further bundle of documentation. It was the appellant's case that the evidence given before MPT1 was incomplete and highly selective "*to support the GMC's particular view*"; she considered that the expert evidence before MPT1 was either dishonest or not expert.

25. When asked whether she wished to provide evidence on "*insight, remediation and/or risk of further misconduct*", the appellant stated her view that:

> "... it is not relevant in my present role as a naturopathic physician. I have not worked as a GMC-registered doctor since 2020. I do not undergo re-appraisal, I no longer have medical indemnity so the issues that you want me to comment on are not relevant to my case ... I do not want to get back onto the GMC register. I wish to de-register from the GMC, and it won't permit me to do that either so I'm caught in this ridiculous and topsy turvy situation where I can't satisfy your demands because I don't wish to be a GMC-registered doctor and have not been effectively since 2020."

Albeit also contending:

> "... the evidence that I am supplying is of course evidence of insight. It tells you that I know exactly what I am doing and I have great insight and I have spent much time researching this and gathering information in order to display that."

26. I pause to note that, in reference to the appellant's expressed wish to de-register, it was clarified at the MPT2 hearing (by leading counsel then acting for the respondent) that this had previously not been a course open to the appellant as there had been an on-going investigation. As that investigation had since concluded (resulting in the finding by MPT1), it would be open to the appellant to again apply for voluntary erasure from the register, which could then be considered by the Registrar.

27. Returning to the appellant's evidence, when asked what insight, if any, she had into the findings made by MPT1, she responded:

> "... my insight is that they had no evidence base and here I am supplying the evidence base and thereby providing a Bolam defence. ... The point of a Bolam defence is that I don't have to prove that O'Shaughnessy and Quinton were wrong, I simply have to prove that there is a body of evidence who agrees with me and that I have done. ..."

As for the question of public confidence, the appellant referred to the fact that her website had had over 27 million hits, without complaint, and that she had written eight books, two of which had won awards, stating:

> "I am a good doctor and I feel it is my duty as a doctor to put out information to people so they can use it."

Addressing the need to promote and maintain proper professional standards, the appellant responded that she thought her actions:

> "... have maintained the highest possible professional standards because – by contrast with the GMC's so-called experts who I have demonstrated chose a very selective body of evidence and did not look at the wide range of literature, and my guess is they were not frontline doctors – I have produced a huge body of evidence that demonstrates my worth to the general public. ..."

28. Cross-examined by leading counsel for the respondent, the appellant explained that she did not consider she had a duty to set out the risks of treatments referred to on her website as she was recommending dosages that gave rise to no problems, let alone toxicity. Stating that, since the decision of MPT1, she had reflected on the way she delivered information, the appellant said that "*the more I read the more I discover how effective and safe these interventions are ...*".

29. Asked about the findings relating to patient B, and whether she thought she did anything wrong in that case, the appellant responded:

> "Looking back on it, I could have done better, yes. ... I should probably have sent him to hospital sooner but, as I say, there were huge concerns on the part of the family. They were very resistant to me sending him to hospital ..."

30. Answering questions from the MPT2 panel members about her website, the appellant explained that its aim was to "*disseminate useful information to members of the public*"; asked what, if any thought she had about how the public would view that information coming from a doctor, the appellant responded:

> "Well, presumably if it comes from a doctor, then they pay greater note of it than if it was coming from an average person or a person who is not qualified. But there is not a single statement on that website that I make that I cannot evidence base ...
>
> Obviously it has to be scientifically sound, it has to be intrinsically safe and easily available to anybody who wants to access those tools. The tools that I am recommending almost invariably are nutritional supplements, maybe herbal products and I always specify dosages, durations, indications for, complications of. But the point about nutritional supplements, as I have detailed, is they are intrinsically safe. ..."

31. Asked whether she had made any changes to her website since the decision of MPT1, the appellant confirmed that she had taken down one website relating to the treatment of covid, albeit she later clarified this had been to avoid further steps being taken by the respondent. As for the research she had undertaken to arrive at her views, and whether this included seeking evidence that supported a contrary view (for example, regarding the wearing of masks), the

appellant acknowledged that she had not tried "*very hard*" to find such evidence as she had not considered this relevant to her defence.

32. The appellant was also asked questions from the MPT2 panel members regarding the findings relating to patient B, and she confirmed her belief that she had not acted improperly in terms of her advice regarding diet or drugs.

33. In her submissions to MPT2, the appellant made the point that, notwithstanding what she saw as unfair treatment for over 20 years, there had been no patient complaints against her and no incidents of serious harm. Considering that she had established that her suspension had been unfair, the appellant pointed out that the findings by MPT1 had been severely damaging to her right to freedom of speech and to her professional reputation, leading to adverse references in the media; she submitted that MPT2 "*must act for the prevention of injustice to the practitioner*", stating that to continue her suspension would be "*manifestly unfair*".

The review decision and reasoning

34. Having deliberated on its findings overnight and during the following morning, MPT2 then provided its decision on impairment. Although the appellant's oral evidence had demonstrated some limited insight into her treatment of patient B, MPT2 otherwise found it clear that she had not accepted the findings of MPT1 and rejected the need for a review of her sanction: the appellant had, rather, wanted to use the hearing as an opportunity to revisit the MPT1 findings because she considered the earlier hearing to have been unfair, the decisions reached materially flawed, and the sanction unjust. While the appellant had read, and researched, widely around the use of vitamins and supplements, her evidence had been that the purpose of her reading (and the materials she had presented to MPT2) was to establish "*a Bolam defence*" to demonstrate that a different decision should have been reached by MPT1; this did not demonstrate balanced reading or targeted training. Noting that the appellant "*constantly refers to herself as a 'good doctor'*", MPT2 found that her criticisms of the respondent, the experts called before MPT1, and the respondent's counsel, did not demonstrate reflection on the need for investigation and the maintenance of regulatory standards. The appellant had further demonstrated limited insight in relation to her website.

35. MPT2 concluded that the appellant had failed to give weight to views other than her own, remaining unwilling to recognise she may not be right, and focussing her research on material which asserted her own beliefs and maintaining her 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."

36. Finding that the position had not changed over the period of the appellant's suspension, MPT2 concluded that:

> "50. ... given the lack of insight and remediation and the risk of repetition ... there is a risk to patient safety."

Going on to find:

> "51. ... 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's lack of insight, a finding of impairment were not made."

And concluding that the appellant's fitness to practice remained impaired by reason of misconduct.

37. Having provided the opportunity for both sides to make further submissions, MPT2 adjourned to consider the question of sanction. The appellant did not remain at the hearing for the decision on sanction, which was duly sent to her in writing.

38. By its decision, MPT2 determined that the appellant's registration should be suspended for 12 months, providing her with further opportunity to reflect on her misconduct, gain insight, and remediate. Given the appellant's submissions, MPT2 considered whether it should direct the erasure of her name from the register but concluded that the lesser penalty of suspension could adequately promote the overriding objective to protect, promote and maintain the health, safety and wellbeing of the public and to promote and maintain public confidence in the medical profession and the proper professional standards and conduct of members of the profession. A further review was directed, to be carried out before the expiration of the 12 month suspension.

The grounds of appeal and the appellant's previous application to rely on fresh evidence

39. By her notice of appeal, dated 28 December 2023, the appellant has advanced ten grounds of appeal, as follows:

> "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."

40. At the hearing before Dexter Dias J, in October 2024, the appellant applied to adduce fresh evidence in support of her appeal and this was then dealt with as a preliminary point (ultimately leading to the judgment at [2025] EWHC 474 (Admin)).

41. In his consideration of the application, Dexter Dias J first set out the relevant context for his decision:

> "65. ... there has been a finding of fact on misconduct by [MPT1] ...
> 66. given that the issue of the appellant's misconduct has been determined by [MPT1], has not been appealed, and is not subject to application to appeal out of time, the issue is estopped since ... the principle of res judicata, of which issue estoppel is part, applies in disciplinary tribunals ...
> 67. ... 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 ... 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. ...
> ...
> 71. ... 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. ...
> 72. It was ... clear to her that the purpose of the review was just that: to review her suspension, not conduct a retrial of the misconduct findings ..."

42. Allowing that fresh evidence might, however, be allowed to be adduced on an appeal in certain circumstances, Dexter Dias J considered the appellant's application under three possible routes: (i) *Ladd v Marshall* [1954] 1 WLR 1489, asking whether the evidence could

not have been obtained with reasonable diligence for the hearing below, whether it would probably have had an important influence on the decision, and whether it was apparently credible; (ii) *Arnold v National Westminster Bank plc* [1991] 2 AC 93, requiring consideration as to whether the evidence could not have been obtained with reasonable diligence for the hearing below and whether it would put an entirely different complexion on the case; and (iii) under rule 34(1) of the GMC (Fitness to Practise Rules) 2004, when the question was one of overriding fairness.

43. For the reasons set out in detail in his judgment, Dexter Dias J was clear that there was no proper basis for the admission of the fresh evidence in this case:

43.1 Under the *Ladd v Marshall* route:

> "87. ... (1) With reasonable diligence, all the fresh evidence applied to be admitted could have been obtained before the [MPT1] Hearing, save for those identified limited aspects of it that add nothing of substance; (2) The appellant chose not to provide it to [MPT1] 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 [MPT1]; (4) In any event, there is no evidence in the tranche of fresh evidence that postdates the [MPT1] 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 [MPT1], that is on its twin critical findings of Dr Myhill's misconduct and impairment. ..."

43.2 Under the *Arnold* route: taking the view that his analysis under *Ladd v Marshall* also answered the question whether the fresh evidence could have been obtained exercising reasonably diligence for these purposes, Dexter Dias J approached the second issue raised (whether the evidence would put an entirely different complexion on the case) must contain both *Ladd v Marshall* questions of important influence and credibility, observing that it was obvious that evidence that was "*obviously flawed or lacking credibility cannot exert much influence or effect the necessary change of complexion*"; he continued:

> "93. 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 principle [MPT1] and [MPT2] 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 [counsel for the appellant]. 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."

43.3 Under rule 34(1):

> "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."

44. Although the appellant sought to make various criticisms of Dexter Dias J's ruling in her submissions before me, I am not aware that she has sought to challenge his decision on appeal; certainly there has been no application for a postponement pending the determination of any application for permission.

The legal framework

The Medical Act 1983 ("the Act")

45. Section 1(1) of the Act provides for the continued existence of the respondent, going on to set out its objectives, as follows:

> "(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— (a) to protect, promote and maintain the health, safety and well-being of the public, (b) to promote and maintain public confidence in the medical profession, and (c) to promote and maintain proper professional standards and conduct for members of that profession."

46. By section 35, the respondent is provided with the power to "*advise on conduct, performance or ethics*" in such manner as it thinks fit.
47. Section 35C applies where an allegation is made to the respondent against a practitioner that his/her fitness to practise is impaired. By subsection 35C(2) it is stated that "*impaired*" is to be understood as specified by that provision, which will include impairment by reason of "*misconduct*".
48. In *Roylance v GMC (No.2)* [2000] 1 AC 311, at p 331B, it was held that:

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

49. In *R (Remedy UK Limited) v GMC* [2010] EWHC 1243 (Admin) Elias LJ identified two principal kinds of "*misconduct*": (1) that which is sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise, and (2) that which involves conduct of a morally culpable or otherwise disgraceful kind. The present case concerns the former; in this regard, Elias LJ explained:

> "Misconduct falling within the first limb need not arise in the context of a doctor exercising his clinical practice, but it must be in the exercise of the doctor's medical calling. There is no single or simple test for defining when that condition is satisfied."

50. As for the approach to be adopted to determining whether a doctor's fitness to practise should be regarded as "*impaired*", in *Cohen v GMC* [2008] EWHC 581 (Admin), per Silber J at paragraph 62, it was held that account must be taken:

> "... of "*the need to protect the individual patient, and the collective need to maintain confidence profession as well as declaring and upholding proper standards of conduct and behaviour of the public in their doctors and that public interest includes amongst other things the protection of patients, maintenance of public confidence in the* [profession]". In my view, ... when fitness to practice is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all the other relevant factors known to them in answering whether by reason of the doctor's misconduct, his or her fitness to practice has been impaired. It must not be forgotten that a finding in respect of fitness to practice determines whether sanctions can be imposed: section 35D of the Act."

In *R (Zygmunt) v GMC* [2008] EWHC 2643, at paragraph 32, Mitting J agreed with that passage from *Cohen* albeit with the qualification that, in the second sentence, the question for the Panel is whether fitness to practise *is* (rather than "*has been*") impaired.

51. An allegation of impairment is first investigated by an Investigation Committee, which will determine whether it ought to be considered by a MPT (section 35C(5)). Where an allegation is thus referred to be considered by the MPT, section 35D is then engaged, which provides (relevantly):

> "(1) Where an allegation against a person is referred under section 35C(5)(b) above ... – the MPT[Service] must arrange for the allegation to be considered by a Medical Practitioners Tribunal, and (b) subsections (2) and (3) below shall apply.
> (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; ...
> ...
> (4) Where a Medical Practitioners Tribunal have given a direction that a person's registration be suspended— (a) under subsection (2) above;
> subsections (4A) and (4B) below apply.
> (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; ...
> …
> but, ... shall not extend any period of suspension under this section for more than twelve months at a time."

By subsection 35E(3A) it is made clear that, in exercising a function under section 35D, a MPT must have regard to the overriding objective.

52. Section 40 of the Act provides for a right of appeal, as follows:

> "(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 …;
> …

> (3) In subsection (1) above— (a) references to a direction for suspension include a reference to a direction extending a period of suspension; ...
> (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 ... appeal against the decision to the relevant court.
> ...
> (5) In subsections (4) and (4A) above, the "relevant court"- ... (c) ... means the High Court of Justice in England and Wales."

53. The right to appeal to the High Court is not made subject to any grant of permission, and, although there is a 28-day time limit for such an appeal, it has long been clear that this is to be read subject to the qualification that the Court has a discretion in exceptional circumstances to extend time for the filing of such an appeal: *Adesina v NMRC* [2013] EWCA Civ 818; *Stuewe v Health and Care Professionals Council* [2023] EWCA Civ 1605.

General Medical Council (Fitness to Practise) Rules 2004 ("the Rules")

54. The Rules are made pursuant to the powers afforded the respondent under the Act and set out the procedure that will be followed when considering allegations of impairment to fitness to practise.

55. Part 2 of the Rules deals with the investigation of allegations. By rule 12 (which falls under Part 2) it is provided that certain decisions, taken at this investigatory (pre-referral to the MPT) stage, may be the subject of review by the Registrar.

56. Part 3 deals with the actions that are to be taken following a referral to the MPT, and Part 4 (rule 17) sets out the procedure to be followed before the MPT at the stage where it is to be determined whether a practitioner's fitness to practise is impaired (what I have referred to as MPT1, although this is often referred to as the "*fitness to practise*" stage or hearing, and the MPT as the "*fitness to practise panel*").

57. Rule 17 (the only rule within Part 4) sets out the steps that will be undertaken at the outset of the hearing (to ensure a fair procedure) (rule 17 (a)-(d)), before then setting out the principal three stages of the decision-making process: (1) the first stage will require the MPT to hear evidence and submissions on the factual allegations and make (and announce) its findings of fact (rule 17 (e)-(j)); (2) secondly, the MPT will receive further evidence and submissions on the question whether, on the basis of its findings of fact, the practitioner's fitness to practise is impaired, and will then announce its decision on this question (rule 17 (k)-(l)); (3) thirdly, the MPT will hear any further evidence and submissions, before making its decision on sanction (rule 17 (m-(n)).

58. Review hearings are dealt with separately under the Rules, under Part 5. The procedure at a review hearing is addressed by rule 22 and is materially different from the fitness to practise hearing. Specifically, there is no stage at which the review MPT makes findings of fact about the allegation against the practitioner; rather, by rule 22(c)(i):

> "the representative for the GMC shall- (i) inform the Medical Practitioners Tribunal of the background to the case, and the sanction previously imposed, ..."

While evidence may be called (by the respondent and the practitioner) and submissions made, these go to the question (see rule 22(e)):

> "... whether the fitness to practise of the practitioner is impaired or whether the practitioner has failed to comply with any requirement imposed on him as a condition of registration;"

59. The MPT's general powers are set out at Part 8 of the Rules. Specifically, by rule 34(1) it is provided that the MPT:

> "... may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law."

The MPT's approach at the review stage

60. The provisions of the Act, supported by the procedure laid down by the Rules, make clear it is the fitness to practise panel (so, MPT1), charged with conducting the hearing under rule 17, that is to make findings of fact regarding an allegation of impairment of fitness to practise. Thus, section 35D(1) states that, after the initial investigation, an allegation that has been referred is to be considered by a MPT. Rule 17 then specifies the procedure to be followed in undertaking that consideration (rule 17 (e)-(j)). This first MPT is also required to make a finding as to whether the practitioner's fitness to practise is impaired and, if so, to determine sanction, but it will only move to those further stages after it has made its findings of fact on the allegation (as rule 17 makes clear). Section 35D then provides for an entirely separate review stage: this may be directed by the initial MPT (section 35D(4A)); if so, another MPT will undertake that review, and may then make a further direction as to sanction. Under the terms of section 35D, however, the "*allegation*" will not be "*considered*" by the second MPT at the review stage. As rule 22 makes plain, the function of the review MPT will be limited to determining whether the practitioner's fitness to practise *is* impaired (that is – using the present tense – at the time of the review, not looking back to the date of the conduct which was the subject of the original allegation; see *Zygmunt*).

61. The position thus laid down by the Act and the Rules is unremarkable; at common law, given that there has already been a determination on the evidence as to the relevant facts, an issue estoppel would arise (and it is clear that the doctrine of issue estoppel applies in the context of disciplinary tribunals: *R (Coke-Wallis v Institute of Chartered Accountants of England and Wales* [2011] UKSC1). The coherence of the statutory structure is, however, reinforced by the fact that an appeal lies as of right against a decision of the MPT to the Court: the practitioner who wishes to dispute the findings made by the Fitness to Practise MPT (MPT1) can thus pursue that challenge by way of appeal, and, if they do so, a suspension imposed by way of penalty will not take effect until that is resolved.

62. In *Salem v GMC* [2017] EWHC 840, it was conceded on behalf of the respondent that there might exist special circumstances where such an estoppel would not arise at the review stage; that is, per *Arnold v National Westminster Bank plc* [1991] 2 AC 93, where further material which could not, by reasonable diligence, have been adduced at the first hearing is now available, and this is such as would have put an entirely different complexion on the matters determined at the fitness to practise panel stage. Before me, the respondent has argued that the concession in *Salem* was wrongly made: (1) the analogy was drawn with *Arnold*, applying common law principles, but the regulatory proceedings in question were founded upon the statute, which did not permit of such a "*special circumstances*" exception; and (2) in any event, *Arnold* was clearly distinguishable as, in contrast to the position under the Act, it was considered significant that there was no right of appeal against the earlier decision in issue, such that an injustice might arise if such an exception were not allowed. While I consider there is force in those submissions, this is not a case where I am required to resolve this question. I return to this issue below, but the short point is that the decision of Dexter Dias J has already addressed the *Arnold* test: considering whether "*fresh evidence*" might be relied on by the appellant to challenge the decision of MPT1 on the original allegations, applying *Arnold*, he was clear that the requisite conditions were not met.

63. The only issues for the MPT at the review stage are, therefore, (1) whether, considered at that point in time (the practitioner having been given the opportunity to address the issues identified at the earlier stage) the practitioner's fitness to practise is impaired; if so, (2) having regard to the overriding objective, what sanction should then be imposed. Determining those questions does not involve going behind, or re-opening, the determination which resulted in the original decision under section 35D(2) (see *Obukofe v GMC* [2014] EWHC 408 (Admin) at paragraph 26); indeed, the findings of fact made by the first, fitness to practise MPT are not to be re-opened (see *Yusuff v GMC* [2018] EWHC 13 (Admin) at paragraph 20 a.).

64. It has been acknowledged in the case-law that this limitation at the review stage might present a difficulty for the practitioner who remains unable to accept the findings of the first MPT. Thus, in *Yusuff*, Yipp J expressly acknowledged that, while the initial findings of fact "*are not to be reopened*", that does not mean the practitioner has to accept those findings; as explained at paragraph 20 *Yusuff*:

> " ...
> b. The registrant is entitled not to accept the findings of the Tribunal;
> c. In the alternative, the registrant is entitled to say that he accepts the findings in the sense that he does not seek to go behind them while still maintaining a denial of the conduct underpinning the findings;
> d. When considering whether fitness to practise remains impaired, it is relevant for the Tribunal to know whether or not the registrant now admits the misconduct;
> e. Admitting the misconduct is not a condition precedent to establishing that the registrant understands the gravity of the offending and is unlikely to repeat it;
> f. If it is made apparent that the registrant does not accept the truth of the findings, questioning should not focus on the denials and the previous findings;
> g. A want of candour and/or continued dishonesty at the review hearing may be a relevant consideration in looking at impairment.

65. In *Blakeley v GMC* [2019] EWHC 905 (Admin) Lewis J (as he then was) re-visited this point, considering how, in a case involving allegations of dishonesty, a doctor might demonstrate current fitness to practise at the review stage, notwithstanding they were unable to acknowledge the wrongdoing they were found to have committed by the original MPT. Answering that question, Lewis J opined as follows:

> "27. In such cases, remediation, and insight, may be demonstrated in a number of ways. These include, by way of example, the following. A doctor may accept that, with the benefit of hindsight, what he or she did was wrong (or dishonest) even though the doctor did not consider at the time consider that he or she was acting dishonestly. Alternatively, the doctor may accept that members of the public would view the conduct as dishonest and undermining their trust in the doctor even if the doctor considers that the conduct, viewed in context, was excusable or not dishonest.
>
> ...
>
> 31. It may well be a difficult exercise to balance concerns about ensuring that the doctor understands why conduct is unacceptable, so that there is no risk of repetition, but not forcing the doctor to admit guilt for something that he or she does not accept doing. A bland reference by the doctor to accepting the findings of the Tribunal may be insufficient. The individual doctor may accept the findings in the sense that it is not possible to go behind those findings and they stand as the adjudication on the conduct. The doctor, however, has to demonstrate how, given those findings, he or she can reassure the Tribunal that sufficient insight has been acquired and the doctor knows and understands why the conduct was considered unacceptable and

> cannot be repeated. That is subtly different from the doctor having to accept that he or she did what they are accused of (or, as here, that the conduct fell below objective standards of honesty). ..."

Freedom of expression

66. It is a key part of the appellant's case that the review decision fails to respect her right to freedom of expression under article 10 of the European Convention on Human Rights ("ECHR").

67. Article 10.1 states the right to freedom of expression, which includes the freedom to hold opinions and to receive and impart information and ideas without interference by public authority. The right is, however, qualified, and article 10.2 makes clear that:

> "The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary."

68. As to how the application of article 10 is to be approached by the Court, that was made clear in *DPP v Ziegler* [2020] QB 253 at paragraph 63 (the guidance provided by the Divisional Court being approved and applied in the subsequent appeal to the Supreme Court, see [2022] AC 408 at paragraphs [16] and [58]); relevantly, considering a limitation to the right afforded by article 10, the following questions were identified:

> "...
> (4) ... is the interference in pursuit of a legitimate aim as set out in paragraph 2 of article 10?
> (5) if so, is the interference 'necessary in a democratic society' to achieve that legitimate aim? This question will in turn require consideration of the well-known set of sub-questions which arise in order to assess whether an interference is proportionate: (a) Is the aim sufficiently important to justify inference with a fundamental right? (b) Is there a rational connection between the means chosen and the aim in view? (c) Are there less restrictive alternative means available to achieve that aim? (d) Is there a fair balance between the rights of the individual and the general interest of the community, including the rights of others?"

69. In *Adil v GMC* [2023] EWCA Civ 1261, it was held that the aim of protecting public health and safety was engaged when a sanction was imposed for comments likely to undermine public health and cause harm to the public - aims that it was legitimate for the respondent to pursue (see the discussion in *Adil* at paragraphs 47-62). Moreover, given that the guidance provided in GMP covers expressions of medical opinion, a sanction flowing from a finding of a breach of such professional standards could amount to an interference or restriction prescribed by law (*Adil*, paragraphs 73-81).

The approach of the Court on appeal

70. The approach of the Court on an appeal under section 40 of the Act was made clear by Nicola Davies LJ in *Sastry v GMC* [2021] EWCA Civ 623:

> "102 ... (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 circumstances; (v) the appellate court must decide whether the sanction

> imposed was appropriate and necessary in the public interest 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."

71. In *Adil v GMC* [2023] EWCA Civ 1261, it was further explained:

> "38. That is not to say ... that the Court will give no weight to the views of the Tribunal. It is well established that a professional disciplinary tribunal is generally best placed, by reason of its experience and expertise, to weigh the existence or seriousness of the professional misconduct alleged, and the effect which its sanctions will have in protecting the public, promoting and maintaining the standards to be observed by individual members of the profession in the future, and promoting public confidence in the profession. Accordingly an appeal court will afford an appropriate measure of respect and deference to the views of the professional tribunal as to whether and to what extent conduct undermines confidence in the profession or affects public safety; and the measures necessary to maintain professional standards and provide adequate protection to the public.
> 39. The degree of deference will depend upon the circumstances of the case. Where the issue is one of law, the appellate court is well placed to determine it for itself. On the other hand, where it involves an evaluative judgment of whether conduct undermines public safety or public confidence in the profession, and what sanction is necessary to promote the statutory objectives, a considerable degree of respect is due to the experience and expertise of the professional tribunal. This is all the more so where the judgement depends in part upon an evaluation of the oral evidence or submissions made by the practitioner in person before the tribunal, which the appellate court does not have an opportunity to see and hear and evaluate for itself. Nevertheless if the court, despite paying such respect where it is due, is satisfied that the decision was wrong or the sanction was inappropriate, then the court will interfere."

Discussion, analysis, and conclusions

72. In submissions at the hearing before me, the appellant stated that, in pursuing her appeal, she had three aims: (1) to demonstrate that the respondent's procedures were unfair, in particular the review hearing in her case, but her wish was to establish a right to a fair trial for all doctors ("*fairness*"); (2) to assert the right to freedom of clinical opinion for all doctors ("*freedom of expression*"); and (3) to escape what she described as the respondent's "*relentless prosecution*" of her, with her reputation intact ("*outcome*"). It seems to me that this is a helpful way of approaching grounds of appeal, which can be seen to fall within the headings the appellant has identified, as follows: (1) *fairness*: grounds 1, 3, 7, 8 and 10; (2) *freedom of expression*: grounds 4 and 5; (3) *outcome*: grounds 2, 6 and 9.

Fairness (grounds 1, 3, 7, 8 and 10)

73. Under this heading, ground 10 provides an obvious starting point, as it raises objections to the preliminary rulings made prior to, and at the outset of, the review hearing.

74. The first objection is two-fold and relates to the late service of the respondent's skeleton argument for the review hearing and to the refusal to then grant a postponement; the latter point represents a challenge both to the decision of the MPT case manager of 15 November 2023 and that of MPT2 at the outset of the hearing. The appellant's application for a postponement (made on 10 November 2023) was essentially put on two bases: (1) she was

prejudiced by the late service of the respondent's skeleton argument; (2) there were unresolved issues relating to the witness evidence. On the first point, as both the case manager and MPT2 had noted, the limitations to the scope of the review hearing had been made clear to the appellant in correspondence in the preceding months; the respondent's skeleton argument merely re-stated that position. Whether or not an extension of time ought to have been granted for the skeleton argument, the appellant was plainly not prejudiced in this regard and, given the need for the hearing to take place before the expiration of the period of suspension, there was no rationale for granting a postponement on this basis. On the second point, as the case manager correctly observed, the admissibility of the proposed witness evidence would be a matter for MPT2 (see further below), and its decision in this regard would then determine whether the various issues raised by the appellant (including the County Court witness summons issues) still fell to be addressed. As for the further decision by MPT2 (albeit absent a specific application by the appellant at that stage), given it had concluded that the witness evidence was not relevant to the issues it was required to decide, there was no proper reason for postponing the review hearing because of any outstanding procedural issues relating to the calling of those witnesses.

75. The further objection raised under ground 10 relates to the decision taken by MPT2 that the appellant was not entitled to call Drs O'Shaughnessy and Quinton, or Mrs Oakford. In developing her case on this point, the appellant has placed reliance on rule 22 of the Rules, where it is provided (at paragraph (d)) that: "*the practitioner may present his case and may adduce evidence and call witnesses in support of it*". Accepting that this a provision that allows for the calling of witness evidence by a practitioner at a review hearing, it is plainly not without limitation. Seeing this provision in context, it is apparent that the evidence must relate to "*the practitioner's fitness to practice or ... failure to comply with any requirement imposed ...*" (see rule 22 paragraphs (c) and, albeit with slightly different wording, (e)). Ultimately it must be for the MPT panel conducting the review hearing to determine whether the proposed evidence is admissible; that is, whether it would be fair and relevant to the case to be decided (see rule 34(1)). On the review, MPT2 was required to determine whether the appellant's fitness to practise "*is impaired*" (rule 22(f)); that is, whether it was impaired *at that stage* (*Zygmunt*). In approaching its task, MPT2 was required to do so on the basis of MPT1's earlier findings on the allegations that had initially led to the fitness to practise proceedings (*Obukofe*); those findings had not been the subject of an appeal (the statutory means by which a challenge to the findings is to be pursued) and were, therefore, not to be re-opened (*Yusuff*). The appellant's arguments on this preliminary point made clear she wished to question the witnesses about the fairness of the MPT1 hearing (which she had decided not to attend), that is: whether the doctors had given "*highly selected evidence ... to support their personal opinions*" or whether Mrs Oakford had been misled regarding the non-compliance ruling regarding patient A. Those were not, however, questions relevant to the review that MPT2 had to determine. As such, the ruling made regarding this witness evidence was plainly correct, and this ground of appeal falls to be dismissed.

76. Grounds 1 and 3 also seek to challenge MPT2's approach to the review it was required to undertake. Ground 1 attacks the original findings made by MPT1, the appellant saying that an unfairness arises in relation to the hearing before MPT2 because she was not allowed to challenge errors in the evidence before, and the findings made by, MPT1. Ground 3 essentially makes the same point, albeit by criticising MPT2 for not permitting the appellant to make good what she has called her "*Bolam defence*" – her case that, while not "*widely accepted*", her opinion can be found within the body of evidence provided within the further bundle of documentation she provided to MPT2 during the course of the hearing. In her submissions, the appellant has questioned whether her additional documentation was actually considered by MPT2, given the limited time available and the absence of questions to her about that material.

77. Ground 1 is, I am clear, without merit. Had the appellant wished to challenge the evidence relied on by the respondent at the hearing before MPT1, she could have done so by exercising her right to attend and/or make representations at that hearing; she chose not to do so. The appellant has given various reasons for the decision she made, but none come close to suggesting there was a denial of a fair opportunity to participate in the hearing. I return to patient A's case below, but the short answer to the point she makes in that regard is that there was nothing to stop her attending before MPT1 to explain why she considered pursuit of the patient A allegations to be unfair. As for the appellant's more general complaint of having been victimised by the respondent: (i) the history does not support that, suggesting only that a number of allegations made against the appellant (by parties other than the respondent) have not been pursued beyond the initial stage; (ii) to the extent that, over a period of some 20 years, four hearings had been cancelled (the last being in 2019), that would not render it unfair to arrange a hearing (consistent with the obligation to do so under section 35D(1) of the Act) in November/December 2023; and (iii) in any event, any grievance the appellant might have regarding the respondent, would not explain why she should not attend a hearing before the independent panel members of a MPT to put her case. The appellant has also said she would have faced difficulties attending the hearing given her caring responsibilities, but that is not an issue she raised with MPT1, and there are plainly accommodations that could have been made to overcome such difficulties.

78. Furthermore, had the appellant wished to challenge the MPT1 finding of misconduct, she had a statutory entitlement to do so by way of appeal to this Court pursuant to section 40 of the Act. She made the decision not to adopt that course. In explaining her choice in this respect, the appellant has referred to the potential costs involved, but she has, of course, chosen to pursue her current appeal where the same considerations arise. It may be that this change in position reflects the subsequent impact the original misconduct finding had on the appellant's professional reputation, but that does not overcome the difficulty that arises from her failure to exercise her right of appeal against the original MPT1 fitness to practise decision. The short answer to ground 1 is, therefore, that, given the appellant's own decision not to challenge the findings of MPT1 by way of her right of appeal, there was no unfairness at the review stage in MPT2 proceeding, as it was required on the basis of those findings.

79. Ground 3 takes the point no further. First, as already explained, at the review stage MPT2 was not addressing the same questions as MPT1 and was not re-visiting the evidence from the earlier hearing, which was what the appellant was asking it to do by reference to this documentation. As Dexter Dias J has found, with reasonable diligence almost all of this material could have been provided by the appellant to the MPT1 fitness to practise hearing, and, even if this were permissible (and see the discussion of this point when considering the legal framework, above), there were no "*special circumstances*" (per *Salem*) that would justify reliance on this documentation at the review stage so as to allow the earlier decision to be re-opened. Moreover, in considering this documentation for the purposes of the appellant's earlier application, Dexter Dias J concluded that the material was neither credible nor would have been likely to have had an important influence on the result of the case before MPT1.

80. Second, and in any event, it is clear that MPT2 panel did consider the documentation provided by the appellant (this bundle became exhibit "D3" before MPT2) and had time to look at it during the hearing and in the time it then took before giving its decision. Not only was the appellant asked some questions by one of the panel members (Dr McGowan) regarding this material, it is also apparent that MPT2 had regard to this evidence when reaching its decision on the question of the appellant's fitness to practise; doing so, MPT2 reached the view that this was not balanced reading, but was focused on material which asserted the appellant's beliefs, demonstrating an entrenched view rather than insight, reflection or remediation.

81. Accepting (as the appellant stressed to me during the hearing) that it is not the Court's role to form a view as the merits of the opinions expressed in the material relied on by the appellant, I have to keep in mind the purpose of the review hearing, which was to consider whether the appellant's fitness to practise was – judged at that stage – impaired. The appellant's emphatic reliance on documentation that was neither balanced nor supported by evidence that would demonstrate it emanated from a "*Bolam-compliant "responsible body" of skilled practitioners in the field*" (per Dexter Dias J at paragraph 93 of his decision, recording the concession made by the appellant's counsel in this regard) did not suggest that she would comply with the requirements of professional standards (as laid down in GMP) to reflect (paragraph 22 b.), to make clear the limits of her knowledge (paragraph 68), to ensure that any advertisement of her services would not exploit vulnerabilities or a lack of medical knowledge (paragraph 70) or to make sure not to leave out relevant information (paragraph 71).

82. For all the reasons provided, I am satisfied that MPT2 approached its task correctly and, having had proper regard to the material before it (which included that adduced by the appellant), reached a decision that was entirely justified by the evidence.

83. To the extent (as it would appear) that ground 7 represents an attack on the misconduct finding by MPT1 in relation to patient B, that is impermissible: for the reasons already provided, it is not open to the appellant to use this appeal (which relates to a decision at a review stage) to try to go behind an earlier fitness to practise decision that she chose not to appeal. As for the decision made by MPT2 relating to patient B, it was expressly accepted that the appellant's evidence had demonstrated "*some limited insight*" in this regard. Given the appellant's testimony before MPT2, that was an entirely fair conclusion. As it fails to engage either with the scope of the task that MPT2 had to undertake, or with the conclusion that was actually reached regarding patient B, ground 7 provides no arguable basis of challenge to the review decision.

84. Ground 8 is similarly focused on the earlier fitness to practise hearing before MPT1 and the decision reached on that occasion regarding patient A. There is an overlap in this regard with the appellant's case under ground 10. It is the appellant's argument that it was unfair to pursue allegations of misconduct against her regarding patient A when it was known that she would not be able to rely on this patient's records when presenting her defence; she states that, at an earlier non-compliance hearing, "*the GMC itself … had expressly forbidden me to use medical records essential to my defence*".

85. The non-compliance ruling relied on by the appellant represented a decision by the MPT of 1 October 2020. Neither the MPT, nor the respondent, had thereby "*forbidden*" the appellant from using patient A's medical records to defend herself in any fitness to practise hearing. The MPT had, however, taken the view that there was insufficient evidence for it to conclude that the appellant had no good reason for not complying with a request from the respondent for copies of patient A's records; in this regard, it was considered that the appellant had put patient A's interests first. At the same time, the MPT had expressly recognised that the respondent has the power to require disclosure of medical records even if the patient has not consented to that disclosure. Given the clear ruling by the MPT at the non-compliance hearing, the appellant would have thus known that the respondent was entitled to require disclosure of patient A's records even without patient consent. To the extent that she still considered that she could not act contrary to patient A's wishes, however, it would have been open to the appellant to take that point before MPT1. The fact that she did not do so was a result of the appellant's decision not to attend that fitness to practise hearing. To the extent that the appellant was not permitted to re-open the earlier findings relevant to patient A by calling Mrs Oakford to suggest the respondent had in some way misled MPT1 regarding the non-compliance ruling: (i) the appellant's characterisation of that ruling is simply wrong; and (ii) this was irrelevant to the matters to be determined by MPT2, not least as MPT1 had found

there was no impairment arising in respect of patient A and thus there was nothing for the appellant to remediate in this regard.

86. Finally, for completeness, I note that, in her submissions for (and at) the appeal hearing, the appellant made a number of criticisms of the respondent and/or MPT2 in not exercising various powers under rule 12 of the Rules, relating to reviews of decisions. Rule 12, however, appears within Part 2 of the Rules, dealing with the investigation of allegations; the powers of review that rule 12 contemplates are thus engaged at a far earlier stage of the process than the review hearing with which this appeal is concerned.

Freedom of expression (grounds 4 and 5)

87. To the extent that ground 4 is part of the appellant's challenge to the earlier MPT1 fitness to practise finding, I have addressed this point when dealing with ground 3 above. The appellant also seeks to pursue this challenge, however, by way of reliance on her right to freedom of expression pursuant to article 10 ECHR, a submission also made by ground 5. The point the appellant makes is that, by pursuing the allegations made against her to a fitness to practise hearing, she is being attacked for exercising her rights to free speech and freedom of clinical opinion; that, she says, continued before MPT2, when she was denied the right to rely on her "*Bolam defence*", which would have been made good by the evidence she sought to adduce. The appellant further objects that she has been forced into what she characterises as a "*catch 22*" situation, whereby her honest presentation of her views was held to be evidence of a failure of insight and lack of remediation.

88. As I have already noted, the right to freedom of expression under article 10 ECHR is not an absolute right; it is allowed that the right might be the subject of limitation where necessary for the pursuit of a legitimate aim, as set out in article 10.2. A sanction that follows from a finding by the MPT that a doctor's fitness to practise is impaired by reason of their conduct in breach of professional standards as laid down by the respondent (pursuant to its powers under section 35 of the Act) by way of the GMP, is, however, an interference or restriction prescribed by law (*Adil*, paragraphs 73-81). The legitimate aims that are potentially engaged are the interests of public safety and protection of health (*Adil*, paragraph 47), aims that were plainly engaged in the present case given the conclusion that there was a risk to patient safety and that a finding of impairment was necessary to maintain public confidence and uphold standards.

89. As for the question of proportionality, the aims of public safety and protection of health are clearly sufficiently important to justify interference with the right to freedom of expression, and there is a rational connection between a regulatory suspension applied to a doctor and those aims. As for whether there might be a less restrictive alternative means available, I note that MPT2 considered all lesser forms of sanction before arriving at the conclusion that a further period of suspension was the least serious sanction it could impose having regard to the over-arching objective under the Act. That, it seems to me, was a judgement that the MPT was best placed to determine; as the Court of Appeal observed in *Adil* (paragraph 38), a professional disciplinary tribunal is generally best placed, by reason of its experience and expertise, to determine the effect that its sanctions will have in protecting the public, promoting and maintaining the standards to be observed by individual members of the profession in the future, and promoting public confidence in the profession.

90. Turning more generally to the question whether the review decision strikes a fair balance between the rights of the appellant and the general interest of the community, including the rights of others (per *Ziegler*), I acknowledge the difficulty the appellant perceives in accepting the earlier fitness to practise findings in order to then demonstrate the required insight, reflection and remediation. Ultimately, however, that reveals an inability on the appellant's part to allow that there might be a different view as to how she can exercise what she

describes as her freedom of clinical opinion, and to appreciate that merely deploying the arguments of those who agree with her might not demonstrate insight and reflection. Allowing (per *Yusuff* and *Blakely*) that the appellant was entitled not to accept the findings of the earlier fitness to practice MPT, it did not amount to a disproportionate interference with her right to freedom of expression to impose a period of suspension during which she might reflect on her views in the light of other opinions, or consider whether there might indeed be a need to provide information about limitations or risks of certain treatment. In the circumstances of this case, I am satisfied that the hearing before MPT2, and the sanction imposed by way of the review decision, did not give rise to a disproportionate interference with the appellant's article 10 rights.

Outcome (grounds 2, 6 and 9)

91. Grounds 2, 6 and 9 each focus on MPT2's decision on sanction, albeit the sole premise underpinning ground 2 is the appellant's contention that a finding of lack of insight was not a permissible conclusion because it failed to take account of her evidence and submissions on the conclusions reached by MPT1 at the original fitness to practice hearing – a point I have already addressed in relation to grounds 10, 1 and 2, under the heading of "*fairness*", above.

92. By ground 6, the appellant invokes her article 8 ECHR right to a private and family life, contending that the sanction of suspension, with a further review, wrongly interferes with her ability to carry out her private practice as a naturopath. It is the appellant's case that the findings made in relation to her website has mean that she has been unable to freely use that means of communication and promotion, and has been further constrained in interviews, and authorship more generally; she complains of the negative press articles that have resulted from the original fitness to practice findings and the review decision, saying these have interfered with her private and professional life and reputation.

93. Allowing that the right to respect for private and family life provided by article 8 has been interpreted broadly, and can include the right to develop a personal identity, to forge relationships, and to participate in essential economic activities, this is, again, not an absolute right and may be subject to interference in accordance with the law and such as is "*necessary in a democratic society in the interests of national safety, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others*." The way the appellant's case under ground 6 is put in this respect focuses the challenge squarely on the proportionality assessment: it is her contention that insufficient respect has been given to her rights under article 8.

94. The answer to this ground is largely the same as in respect of the appellant's arguments under grounds 4 and 5, relevant to freedom of expression. There is, however, an additional consideration, which also arises in her former counsel's written argument relating to ground 9, concerning the appellant's wish to be de-registered as a doctor, a status she does not need for her practise as a naturopath. As the point is put in the appellant's first skeleton argument (albeit there contending for no sanction):

> "73. The Appellant's circumstances are exceptional ... since she no longer practises as a GP and therefore should no longer fall under the jurisdiction of the GMC. The Appellant's Naturopath practise will never entirely agree with mainstream GMC practises and therefore the GMC makes continuous like allegations against her and have done so since 2001. The Appellant is entitled to leave GMC jurisdiction ..."

Although not strictly accurate, in that it is not the respondent that makes "*continuous like allegations*" against the appellant, the point the appellant makes is that, given her wish only to practise as a naturopath, she should be free to remove herself from the medical register and, therefore, from the jurisdiction of the respondent and the MPT.

95. The answer to the appellant's concern would seem to have been provided by leading counsel for the respondent during the course of the review hearing: if there are no outstanding investigations against the appellant, it is likely that her request for voluntary erasure from the

register will be viewed differently from earlier occasions when an investigation was still on-going. Whether or not such a request would have been successful after MPT1's suspension decision, the appellant remained on the register at the review stage, however, and MPT2 was thus required to consider the sanction that it deemed appropriate.

96. As the decision on sanction makes clear, the appellant's particular circumstances were very much at the forefront of MPT2's deliberations. The fact that she no longer practised as a doctor, and did not wish to do so in the future, was a matter that was taken into account when first considering the possibility of taking no action. Given, however, the serious nature of its findings on impairment, MPT2 concluded that this would not be sufficient, proportionate, or in the public interest. In the circumstances at that point, that seems to me to be an obviously permissible decision; as the appellant acknowledged in her evidence at the review hearing, greater note is inevitably paid to information that comes from a doctor, and MPT2 was entitled to conclude that some form of sanction was necessary given the need for public trust in those who appear on the medical register. MPT2 also went on to consider whether, giving effect to the appellant's clear desire to no longer fall within the "*jurisdiction*" of the respondent, erasure – usually a more punitive sanction than suspension – might be the appropriate course in this case. The panel was, however, unable to find that erasure was a necessary step, given that a period of suspension could adequately promote the aims of the overriding objective. That it seems to me, was a decision that was open to MPT2, which was, as the specialist professional disciplinary tribunal, best placed to exercise that judgement.

Decision

97. Having regard to all of the points raised by the appellant's grounds of appeal, as amplified in her two skeleton arguments and in her oral submission, and for all the reasons provided, I duly dismiss this appeal.