

MY GMC HEARING, SEPTEMBER 2007

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Dear All,

THANK YOU, THANK YOU, THANK YOU!

Firstly I would like to thank the so many of you who have written brilliant letters to the GMC supporting me against the allegations levelled at me. It has been a very humbling experience to receive so many lovely letters from people who have much better things to do! They are so much appreciated and so good for morale. Even though I have absolutely nothing to be ashamed or guilty of, it is an odd experience being the subject of what I can only describe as a witch hunt. I thought these died out with Joan of Arc but I can assure you they are alive and kicking today! Your wonderful letters, and other factors, have resulted so far in two of the allegations being dropped! So thank you all so much!

So what is going to happen?

Because I have had so many concerned telephone calls, I thought it would be in the interests of us all to circulate a fully anonymised copy of my latest response to the GMC. This is partly because it occurred to me that some of you may think I was hiding allegations that I could not defend! Partly so that you could see for yourselves how the GMC have been behaving and assess for yourself the chances of me being struck off from the Medical Register in September!

Should this happen then I will continue to practice as best as I can within limitations (most painfully I would lose the ability to use EPD, the ability to help with disability claims and the ability to prescribe). I would do my very best to make sure that the level of care that I am providing remains high either by recruiting a doctor to work with me or by finding a suitable doctor to whom you can be referred. With this in mind I have started running training courses for doctors at my home with the second day this week. I had 5 doctors and 8 others (osteopaths, cranial osteopaths, homeopaths etc) attending – we did have a good day – everyone squashed into my conservatory!

I plan to run further days from my home and the next one will be on Friday Oct 28th 10am start. I will have to charge £50 per head to cover refreshments, lunch paperwork etc. First come first served, maximum of 12 ('cos I can't get any more into my conservatory or round the table for lunch!).

I am planning a National CFS service

It is not that I am expecting to be struck off! Far from it. In the longer term I am planning a national service for CFS with the information base being my website, with access to all necessary tests via the website, a network of trained therapists who can refer back to be if they run into problems, and access to cheap supplements in order that treatment regimes are affordable. So watch this space!

THE CASE AGAINST ME – MY REPLY TO THE GMC

June 30th 2007

Your ref: JM/2005/2757/01

Andrew Wood
Assistant Registrar
Fitness to Practise Directorate
General Medical Council 5th Floor
St James's Buildings
79 Oxford Street
Manchester M1 6FQ

Dear Mr Wood,

RE: General Medical Council v Dr Sarah Myhill

Thank you for your letter with further accusations against me. I am responding to these in full, but I thought it would also be helpful to review the current situation.

Re: Complaint from Dr PM

I have to say, I am wondering why I am bothering to respond to this complaint. I have now responded to several very similar complaints in considerable detail, with supporting evidence, which totally refute all allegations. I have been doing this since September 2005, since when the allegations you continue to parrot have been virtually unchanged.

For the sake of completeness however, I will review the current history of the GMC dealing with my allegations against me.

My 2003 GMC Hearing

This was originally scheduled for a five-day Hearing in November 2002, then postponed and extended to an eight-day Hearing in January 2003, then postponed to an eight-day Hearing in February 2003, then cancelled completely. This Hearing was cancelled on the basis that at least one allegation was fabricated, one was based on facts that were untrue and that proceedings could not continue because patients had refused to co-operate. I received a "one liner" throwaway explanation. The GMC have a duty under the GMC Fitness to Practice Regulation Rules Part 8 section 28 (3) to give a full explanation for the cancellation of my hearing. In particular:

For the fabricated allegations, who made the fabrications, and what action was taken against the person who made them? In this case, I was accused of prescribing Ritalin to hyperactive children, when I did no such thing. In another case, I was accused of not keeping a drug register when again this was completely untrue. Who made these allegations?

What actions were taken against incompetent lawyers who failed to check these falsehoods? These falsehoods were pointed out by me to the GMC at an early stage of proceedings during 2002.

Who were the members of the Preliminary Proceedings Committee (PPC)? Which member of the PPC stated that proceedings could not continue because patients

had refused to co-operate? This is another untruth, since the GMC are happy to continue with current proceedings when patients have taken exactly the same stance this time, in 2005-07. So, what was the real reason why my 2003 Hearing was cancelled? I have written to the GMC on several occasions asking for a response to these issues and have yet to receive one.

As a result of the delay in the Hearing and the inadequate explanations, I was unable to get medical indemnity cover because the GMC's reasons for cancellation looked as if I had escaped disciplinary action on a technicality. I was forced to practice medicine for some time without indemnity cover and indeed, was threatened by the GMC with further disciplinary action because I was unable to get indemnity cover!

Recently Dropped Allegations

I note that you have dropped that allegation that I am putting babies at risk by stating my support for the Richardson Hypothesis that cot death is caused by fire retardants in mattresses. The GMC has not given me any reasons why this allegation has been dropped. I have not supplied the GMC with any additional information, so I do need to know the decision-making process which provided the basis for which this allegation was dropped.

I also note that the allegation that I lied on my job application form for the position of GP with a Special Interest in CFS at the Royal Shrewsbury Hospital has also been dropped. Forgive me for being picky here, but the question on the form was as follows:

"Have you been or are you currently subject to any fitness to practice proceedings by an appropriate licensing or regulatory body in the UK or any other country?"

The honest answer to this question was no, since my FTP Hearings of 2002-03 were all cancelled with no charges to answer. Yet I was accused of lying. This has been deeply damaging to my professional reputation, because these allegations were circulated to many members of Telford and Wrekin PCT, including Mr JC, Dr BE, Dr LW, Dr AR, Mr KM and Ms ST. I know this because I have done a Data Protection Act trawl of the Telford and Wrekin PCT. It explains why I have been ostracized by local GPs and consultants.

Current Allegations – advising GPs on management of patients with CFS

As I have explained in a letter to Rosemarie Paul of Field Fisher Waterhouse, the two allegations from GPs firstly come from one with whom I used to work and secondly from a colleague in the same practice. I have provided the GMC with evidence to show that whilst I was working with the first GP there was a major issue with professional jealousy. This first GP has simply roped in a colleague to make trouble for Myhill.

Current Allegations – My Website

There are several other allegations pertaining to my website. The story behind this is also illuminating. Initially, I was reported to the GMC by a doctor complaining that "*chronic fatigue was not a symptom of mitochondrial failure*". Since I was "*only a general practitioner*", clearly I was "*acting outside my area of expertise*" and therefore I was reported to the GMC. This doctor subsequently

retracted this accusation, but then made further complaints about my website. The specific allegations are:

a) That *"the Richardson theory of cot death is unfounded"*. Therefore, my advice to parents to not put their babies on mattresses containing fire retardants (these are chemicals such as poly brominated biphenyls (PBBs), arsenic compounds, phosphorous compounds and antimony) is flawed. The Richardson logic is that babies can be safely laid on their sides when they are sleeping on organic, chemical free mattresses or the mattresses are properly wrapped. I am considered to be "putting babies at risk" by giving this advice. *This allegation has been dropped, but no reasons why have been given.*

b) *"The use of a screening test, namely prostate specific antigen to detect prostate cancer is flawed"*. What the GMC fail to appreciate is that any such test is carried out with a full history from the patient, the GP is informed and the patient counselled with the interpretation of the result. Furthermore, the private screening tests are done by the top private laboratory in London (The Doctors Laboratory) and by measuring a free PSA compared to a total PSA the result is more accurate and reliable than standard NHS tests.

c) *"The use of magnesium sulphate by injection in acute myocardial infarction is undesirable"*. There is a huge body of literature about magnesium in the prevention and treatment of cardiovascular disease. Indeed, many hospitals continue to use magnesium sulphate infusions in acute MI. If the correct dose is given, mortality from acute MI is substantially reduced by the use of i.v. magnesium sulphate. Indeed, one could argue that it is medical negligence not to use i.v. magnesium sulphate in acute myocardial infarction! I have supplied the GMC with the relevant references.

d) *"The use of Biolab's vascular screening test using Doppler ultrasound and pulse oximetry as a screening test for arterial disease is unsound"*. Again, I have supplied the GMC with the scientific background behind this test. This test is done by a highly competent practitioner, namely Dr John McLaren Howard of Biolab Medical Unit.

e) The GMC dislike my treatment of depression, namely to start off with good sleep, bright light and exercise, move on to nutritional supplements such as high dose B vitamins, B12, St John's Wort, 5HTP and exercise caution over the use of SSRIs.

My Response to the GMC's Latest Allegation

The only reason I am responding to your latest allegations is to try to protect my patient, who suffers from chronic fatigue syndrome, from having to attend the currently planned ten day hearing in Manchester. Whilst I am sure he would attend on my behalf, it is not in his best interest to have to suffer the stress this will inevitably bring before and during the hearing. This will not assist his continuing recovery. Again I am wondering why I bother to say this since it is clear from the above and also through all your dealings with my case that the wellbeing of all the patients has been an irrelevancy.

My attempts to clarify the issues

In May 2007, I wrote to the accusing doctors and expert witnesses directly, in a spirit of conciliation and good humour, so that I could point out to them directly the inaccuracy of some of the information they had submitted and weaknesses in

their arguments. This was because I believed that they had not been appraised of all the facts and that they were being drawn into a situation which was not of their making. I believed I was doing them a favour. Since I am conducting my own defence, I was putting myself at a disadvantage by appraising them of my lines of questioning. However, despite these good intentions I was warned off by Rosemary Paul of Field Fisher Waterhouse, who said in her letter of 25th May 2007

"In our view, correspondence of this nature breaches your requirement under s46 of Good Medical Practice to treat colleagues fairly and with respect. If you continue to write to witnesses in this manner (which could be construed as threatening) it could form the basis of a further allegation against you".

I suggest that in writing to warn me off contacting other people, Ms Paul is trying to intimidate me into silence.

The GMC's own adviser states there is no current case against me in February 2006

I would also draw your attention to an internal GMC memo dated Feb 10th 2006 from RS (Case officer) to NJ detailing "Evidential Concerns". This was obtained through a Data Protection Act trawl of the GMC files. It states:

"My main concerns with all of the Myhill files are that all of the patients appear to be improving and none of them are likely to give WS (witness statements) or have complained about their treatment. The issues have all been referred by the patients [sic] GP's who are concerned about the way Dr Myhill has diagnosed CFS (often over the telephone) and her expertise in this area. Without a medical expert opinion/report I do not feel this will satisfy RPT.

The GMC seem to care as little over their use of apostrophes as they do over my case. Incidentally I do not diagnose over the telephone – I only advise on management - a fact conveniently overlooked by the GMC!

Re: Complaint by Dr PM - Specifics

Introduction

Now I am responding to your letter of 5th June containing allegations from Dr PM that I have mis-treated patient D. The GMC has again demonstrated incompetence, because these allegations are incomplete. So, we have a second set of allegations in a letter dated 7th June 2007. Although your letter is dated 7th June, the allegations are dated 25th July 2007 - a date that is six weeks hence. I have pointed this out for the sake of thoroughness so that you will not accuse me of prescience. Although this would make the basis of a very interesting new allegation!

The Data Protection Act has been breached

The notes that the GMC has sent me from patient D were sent without the patient's permission. Indeed, the patient expressly forbade his notes to be used and I have a copy of his letter contained within his notes, refusing permission for the notes to be used. I am aware, however, that under the 1983 Medical Act, the GMC is allowed to take patient's notes without their permission, but in this event the notes have to be anonymised. This has not been done. Furthermore, you are obliged under the Data Protection Act to inform the patient that you will be taking

his notes without permission and also that he has a legal right to appeal against your potential actions. This you also failed to do. This patient's notes were sent to the GMC and other parties unknown without his permission or knowledge, or having been given a chance to appeal against this action.

Although the necessary actions are clear from the GMC's own website with respect to Data Protection, when I wrote to the GMC to ask for procedures I was told in a letter from Patricia Collins dated 21.6.07 that:

"We do not have written procedures regarding access to patient records where a patient refuses access to them"

This is further indication of the sloppy methods by which the GMC conducts its actions.

The Patient's clinical notes are incomplete

I also note that the patient's notes sent by Dr PM are incomplete. There are very few test results in the notes. In particular, the thyroid function tests, which I know to be there, are missing. This suggests to me that the clinical notes have been pruned the notes. If so, by whom have the notes been pruned and why?

I believe the above problems are a serious breach of the Data Protection Act and the pruning of notes, if proven, amounts to a serious miscarriage of justice.

The Patient is better

I have to say, I am at a loss to see what the complaint is about. Here we have patient D, who has been rendered so ill by his condition that he has been unable to work since 1989 and for the past 17 years has been virtually housebound and most of his time bedbound. As a result of my interventions, he is substantially improved, his levels of energy are greatly better, his mental state is vastly improved and his rheumatoid arthritis is in remission. This is not my assessment, but the assessments of other consultants. Indeed, I quote from letters in patient D's notes:

24.10.96 Letter from Dr P BMA - Medical Services Diagnosis, who in response to the question "What is the outlook for this patient's condition", wrote "Hopeless".

In contrast, after my treatment we read in patient D's notes:

13th March 2007 Dr A - Consultant Specialist Registrar in Rehabilitation Medicine. "I am pleased to see that Mr D is feeling much better and does not have fatigue as he has had in the past and his joints are not troublesome."

27th February 2007 Mr B - Consultant Urologist "I understand he (patient D) has been seeing an alternative physician somewhere in Mid-Wales who has gone into details about food intolerance with him and he tells me that he feels generally very much improved since he went to see her. I have encouraged him with this as I see no reason to dismiss anything that actually helps him since we have manifestly failed to achieve the same result. I have not arranged to see him again....."

So I have to say, I am scratching my head to ask myself why these doctors are complaining when the patient is substantially better using techniques which are logical, evidence based, safe, free from drug side effects and have no potential long term-problems. The only possible explanation is professional jealousy. This is an issue, which has prompted other allegations against me. However, I will go through the reports and complaints in detail.

The Thyroid hormone prescribing issue

Professor L

The first report from Professor L is his second unprofessional production. It is remarkably similar to his first opinion concerning my actions prescribing thyroid hormones. This report is unsigned and undated. In producing this report, he relies entirely on the two reports of Drs PM and RB (the patient's GPs), as well as what he describes as a "file of records". He fails to state what he means by the "file of records". Does this mean my personal record from the GMC? Or does he mean patient D's notes? Or both? This needs clarifying. If the latter, then he cannot fail to have seen the letter in which the patient refuses permission to use his notes, in which case Prof L is failing in his duty as an expert witness because the notes have not been anonymised. Prof L has also failed to notice that the GP notes are incomplete, since there are no results of thyroid function tests other than those which I did. I note that Prof L has no expertise in treating patients with chronic fatigue syndrome. He also fails to notice that the patient is much better.

I note that Professor L comes to his conclusion without seeing patient D, or assessing him professionally, and without looking at my clinical notes or speaking to me.

Professor L accuses me of prescribing thyroid hormones to a patient with normal thyroid function tests and failing to follow up in six weeks, which he considers to be the appropriate interval. In my opinion, Professor L is a hypocrite! In a paper jointly authored by Professor L (Br J Psychiatry, 2002 Apr;180:327-30), he treats 446 thyroid-antibody-positive women with normal thyroid function tests with a starting dose of 100mcgms of thyroxine. This is a considerably higher dosing schedule than the one I used.

What I actually did was to measure the levels of thyroid hormones and the initial result was as follows:

Free T3 4.5pmol/l (3.0-6.2)

Free T4 14.4pmol/l (12.0-22.0)

TSH 2.3 mIU/L (0.4-4.0)

Clinically, patient D was hypothyroid. In this event, with a low normal T4 and all the symptoms of hypothyroidism, a trial of thyroid hormones was instigated. Because of the problem with food intolerance (sodium thyroxine has an excipient, namely lactose, which is often not tolerated by milk allergic patients), generic thyroid was used. The patient was started on 1/2 grain for one month, then 1/2 grain twice daily for one month then one and a half grains for a month (equivalent to 100mcgms of thyroxine). Clinically, he was much improved and a follow-up blood test arranged by the GP showed a free T4 of 14.5 and a TSH of

3.3, suggesting that the patient was still being under-treated even though clinically he was improved.

Interestingly, patient D informed me on 20.3.07 that when he asked to see his GP notes, there was a TSH result there measured on 20.12.06 showing a "borderline free T4" and a TSH of 5.5, which had been flagged up as being abnormal. This result is now missing from his GP clinical notes. I suspect they have been conveniently pruned out, but I cannot prove this.

Professor L's report has many failings, but a major one is that he relies on blood tests alone to judge whether or not this patient requires thyroid replacement therapy. There are a great many references in the literature and I have provided many of them already to Professor L and to the GMC, which shows that one cannot judge any patient on the basis of blood tests alone. He states that the results of the bloods are "within normal ranges". Actually, laboratories no longer refer to normal ranges, because this suggests that there is a normal range for the population. Instead, laboratories have chosen to use the words "reference range". This subject was discussed at length by a World Health Authority report and I refer to that now. Please note the report emphasises the importance of clinical assessment of the patient as follows:

I quote from the WHO letter in response to Diana Holmes's request for clarification on this issue:

"Most professionals working in the laboratory are aware of the limits of interpretation of laboratory results and particularly of borderline cases. You rightly say that the "normal" range may not be an appropriate reference for decision-making. Indeed this is why laboratory experts are advised to abandon the term "normal" range and replace it by reference interval while keeping in mind that the limit values for the reference interval will depend on the selected population that was investigated for their establishment"..... "Unfortunately we often observe an unsatisfactory communication between the laboratory and the practitioners, which may in some cases be the reason for misinterpretation of laboratory results".

I also quote from the Association for Clinical Biochemistry report "UK Guidelines for the use of thyroid function tests" section 3.1.2 guiding treatment with thyroxine, in which they state:

"In the majority of patients 50-100mcgms of thyroxine can be used as the starting dose..... Thereafter alteration of the dose is achieved by using 25-50mcgms increments and repeat measurement of TSH 2-3 months after a change in dose. This will result in the majority of patients becoming clinically euthyroid with a normal TSH and having thyroxine replacement in the range 75-150mcgms. This strategy will prevent over-replacement in patients and decrease possible adverse effects noted in terms of cardiovascular outcome"

In my treatment of patient D, I follow this advice to the letter. In fact, my treatment regime results in a slight under-dosage.

The second thing that Professor L does is that he relies on the opinion of an endocrinologist, Dr KJ, which had been requested by Dr RB. This endocrinologist also committed the cardinal sin of assessing the need for thyroid hormones simply by looking at blood tests and without assessing the patient. This is a major failing of any clinician, let alone an endocrinologist.

In his report, Professor L expounds at length the side effects of thyroid hormones, but omits the critical detail, which is that all these side effects are dose dependant. All the side effects he describes pertain to overdosing with thyroid hormones. With proper monitoring, clinically and biochemically there are no side effects. Again, this is where clinical assessment of the patient is essential. He fails to consider this. In actual fact, this patient has been substantially improved by this intervention.

Finally, he states *"that it is normal practise to monitor four to six weeks after starting T4"*. Again, he does not specify what he means by monitoring. Actually, monitoring means assessment of the patient clinically as well as biochemically. His recommendations to monitor at four to six weeks are in direct opposition to the British Thyroid Society advice, which recommends monitoring at two to three months after initiating thyroid therapy.

In writing professional reports, Professor L has a much wider remit than what he does or does not do in his own clinical practice. It is his duty to appraise the court of the wide ranging opinions held with respect to using thyroid hormones. This he fails to do. For him to suggest that my actions are short of acceptable standards in relation to the prescription of thyroxine is based on his beliefs, not standard recommendations for medical practice. It is not acceptable to espouse such opinions, which are not evidence-based and indeed, mislead the court. He recommends that I be censored as a result, when in fact it is he that should be the subject of such censorship.

Statements of Dr PM and RB.

Dr PM is a GP who has not been directly involved in the care of patient D. He has taken it upon himself to criticise the management of another doctor's, (Dr RB's), patient. Dr PM is in breach of the Data Protection Act and possibly other patients' rights by sending to the GMC a full copy of the patient's notes, when the patient has expressly forbidden those notes to be used in the way that Dr PM did. Furthermore, he did this without informing the patient. Even if the notes had been anonymised, the patient still has rights about what happens to those notes and by whom they are seen. In this case, patient D had no idea that his notes were being used without being anonymised and without his permission.

Dr PM is fully aware of the serious nature of the patient's illness. As a result of his illnesses, patient D was forced to give up a string of highly successful businesses that he was running in a major city and give up work through ill health. Patient D has been unable to work and has experienced a miserable quality of life for almost twenty years. Despite seeing a great many consultants and general practitioners, as his notes testify, his quality of life has deteriorated progressively.

As a result of the simple nutritional, dietary and lifestyle interventions that I have made, combined with thyroid hormones, the patient is substantially improved. Not only are his levels of energy very much better so that he is no longer housebound, but he is able to socialise normally and take holidays, his level of suffering is substantially reduced and his arthritis in effect is in remission. If improvement is continued, he may be able to start a new career.

It is the duty of any doctor to do their best by that patient. This is enshrined in the General Medical Council's own Code of Conduct. Of the fourteen directives, thirteen of them pertain to the patient. It is my duty to do my best by that patient by whatever means are at my disposable. Whilst I do my best to explain

to GPs the methods that I use, if the GPs are not co-operative then I must put the well being of the patient first. In his letter of complaint, Dr PM is placing much more importance on the doctor/patient relationship than on the patient getting well. It appears he is not in the slightest bit interested in the patient's improvement. He is also clearly not the slightest bit interested in the methods that I use to achieve this. Dr RB says in his statement:

"I also feel that she tries to baffle with science. Much of what she says in her letters is largely unintelligible and I think she is trying to impress the patient."

I have to disagree with this point. Not only do my patients readily grasp the arguments contained in my letters, but when they put the necessary interventions in place they improve. As I have pointed out to the GMC before I run training courses for doctors interested in this approach to medicine, I have honed my approach and explanations over 25 years and I make it my business to simply and clarify these issues.

The vast majority of GPs with whom I have contact take a more mature point of view, as epitomised by the letters from the consultants involved in patient D's case. That is, that not all of us know everything. If a patient is able to find a safe and logical road to recovery, then they should be supported in their efforts. Indeed, this is enshrined in the "Helsinki Agreement" (<http://www.wma.net/e/policy/b3.ht>). This is further epitomised in extracts from the above two letters from a consultant in rehabilitation medicine and a consultant urologist. It is my duty as a doctor to explain to the GPs exactly what I am doing and why and give a scientific and rational basis for the line of treatment. If the GP cannot get his head round the biochemical issues that I expound, that is no fault of mine.

The ideas that I am using are evidence-based and well established in fields of nutritional, allergy and environmental medicine. My patients find it very easy to understand these ideas and indeed my information sheets have been honed over 25 years of experience in order that people can readily come to grips with these new ideas. As stated, it is my experience that most GPs welcome this approach and find that the doctor/patient relationship is substantially enhanced when they can understand the reason why these interventions are effective.

Actually, the biochemical explanation of fatigue is something that all doctors learn as part of their undergraduate training. My patients who have done Biology GCSE have no difficulty in understanding these ideas. Even those patients who do not have the advantages of such an education quickly grasp the essentials. I find this is important, because once understood, this then gives them good incentive for taking the package of nutritional supplements in order to correct the biochemical lesions.

Dr PM is also guilty of muddling up symptoms with diagnoses. Rheumatoid arthritis presents a clinical picture, but it is just a clinical picture. A true diagnosis should imply causation, which when addressed results in resolution of a patient's symptoms. There are a great many scientific papers showing that many cases of rheumatoid arthritis are indeed caused by food intolerance and this is borne out in this case. This patient's arthritic symptoms are greatly improved by elimination of specific foods.

When I write to GPs, I invariably copy the letter to the patient because this is a major part of their care plan, I try to explain many of these issues in that letter. GPs are welcome to, and indeed often do, get back to me or my website for

further clarification. I am afraid I cannot help those GPs who refuse to broaden their minds and look up background information. If they choose to remain ignorant, that is hardly my fault. Indeed, under the new NHS Plan, patients have the right to a copy of any letter written about them by one professional to another.

The idea that chronic fatigue syndrome is a symptom of mitochondrial failure has been widely discussed, there are a great many references to this in the scientific literature and I would be very happy to enlarge on this issue further at my hearing. I have submitted a paper to "Medical Hypotheses", which is currently under peer review. Indeed, I am told by the President of the Patients' Association for Mitochondrial Disorders that my website is the most used amongst their sufferers. I am happy to call this President to give evidence at my Hearing.

Dr RB

Dr RB is actually patient D's GP. He has been extremely helpful to patient D and the impression that I got from patient D is that Dr RB was supportive of the interventions I was suggesting. If he had any concerns, then Dr RB has never contacted me or my office with any of them. My office is open five days a week and can be contacted by telephone, letter, fax and e-mail and all the contact details are at the top of my letter. If he had any concerns, then he could have addressed them to me directly.

Conclusions

I conclude that I have no case to answer for many reasons, but these are the main ones:

- According to the date, the allegations have yet to be made. The allegations are dated 27th July 2007.
- The patient's notes have been sent to the GMC and distributed more widely without the patient's permission. Indeed, the patient has expressly forbidden these notes to be used. The patient was not informed that the notes were being circulated. The notes have not been anonymised. The patient has no idea who has copies of his confidential medical notes, or why.
- I do not understand why a complaint is being made against me. The patient is substantially better clinically using interventions which are completely safe, which have been properly monitored, and all relevant parties have been informed at all stages. In doing this, I have fulfilled all of the GMC's criteria for good medical practice.
- Dr PM and Dr RB are accusing me of undermining the doctor/patient relationship. Actually, this has only occurred because of their actions. Instead of embracing my suggestions and helping the patient as much as was within their power, they have obstructed treatment of this patient, caused him considerable distress as a result of this complaint and distributed his private, personal medical notes without his permission.
- The report from Professor L is based on his personal beliefs. It is not evidence-based. His report is not based on seeing and assessing the patient clinically, he has not properly assessed thyroid function tests or communicated with me to look at my clinical history, examination, tests

and assessment. In the past, I have supplied Professor L with the evidence base for using thyroid hormones, which emphasises the importance of clinical assessment. I have also supplied him with guidelines about the optimum time for follow-up, which is two to three months. These papers he continues to ignore. In my opinion he is being hypocritical in his opinions.

- Dr PM has not supplied the GMC with a complete set of the patient's notes. In particular, the results of thyroid function tests and possibly other medical tests are missing.

So, I am facing a mixed bag of complaints, which emanate from professional jealousy, ignorance of simple nutritional, allergy and lifestyle interventions, which completely overlooks the fact that the patient is substantially improved.

I conclude that I have no case to answer.

Yours sincerely,

Dr Sarah Myhill